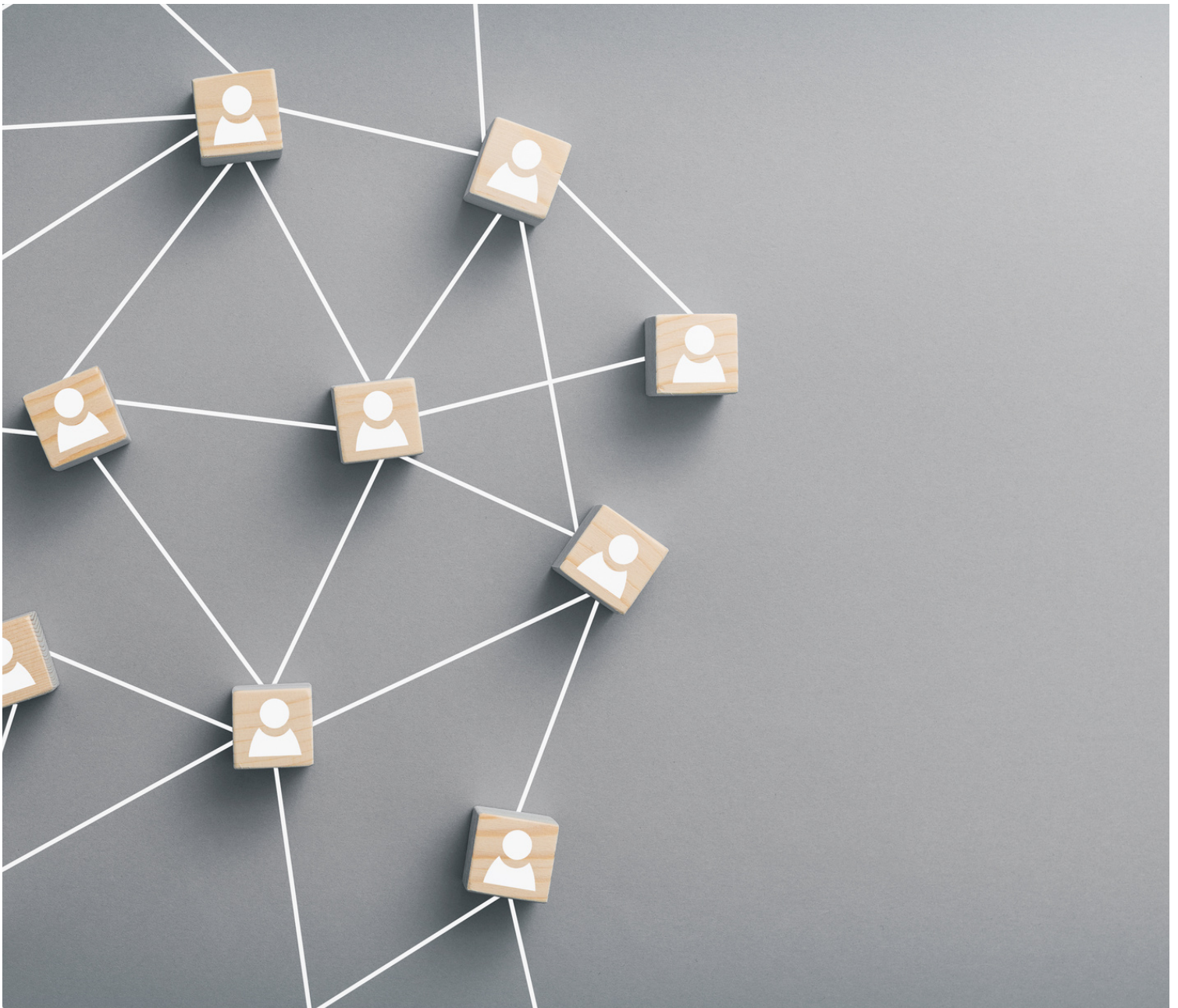




Institute of Behavioral Research

OPIOID-TREATMENT LINKAGE MODEL (O-TLM) RESOURCE GUIDE



O-TLM RESOURCE GUIDE

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ACRONYMS & ABBREVIATIONS

Abbreviation	Meaning
ACA	American Corrections Association
AA	Alcoholics Anonymous
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
BH	Behavioral Health
CBH	Community Behavioral Health
CBT	Cognitive Behavioral Therapy
CIT	Crisis Intervention Team
CJ	Criminal Justice
CM	Contingency Management
DSMV	Diagnostic and Statistical Manual - 5
EBP	Evidence-Based Practice
HHS	U.S. Department of Health and Human Services
JCOIN	Justice Collaborative Opioid Innovation Network
MA	Methadone Anonymous
MARS	Medication-Assisted Recovery Services
MAT	Medication-Assisted Treatment
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MOUD	Medication for Opioid Use Disorder
NA	Narcotics Anonymous
NAMI	National Alliance for Mental Illness
NIDA	National Institute on Drug Abuse
OU	Opioid Use
ODU	Opioid Use Disorder
OTP	Opioid Treatment Program
O-TLM	Opioid-Treatment Linkage Model
SAMHSA	Substance Abuse and Mental Health Services Administration
SU	Substance Use
SUD	Substance Use Disorder
TC	Therapeutic Community

EXECUTIVE SUMMARY

The Opioid-Treatment Linkage Model (O-TLM) Resource Guide

The Opioid-Treatment Linkage Model (O-TLM) Resource Guide offers best practices and innovative solutions for delivering substance use (SU) and opioid use (OU) treatment to support an optimal continuum of services. Developed within the Behavioral Health Services Cascade (Belenko, Knight, et al., 2017) and the Opioid Cascade of Care (Williams, Nunes, & Olfson, 2017), the following chapters represent a range of services that should be available to individuals to prevent harms from SU and OU, including screening and assessment, referral, treatment initiation and retention, and continuing care.

The O-TLM Resource Guide is specifically designed to help community corrections staff, community behavioral health (CBH) providers, and medications for opioid use disorder (MOUD) clinicians expand and enhance SU and OU treatment services for individuals reintegrating into communities upon release from correctional facilities. The strategies and resources presented in the guide are informed by knowledge generated from pilot studies, local community initiatives, and state and federally-funded programs. Altogether, the content illustrates:

- How health and social service agencies can use the Cascade of Care to identify client treatment needs and appropriate treatment options that align with empirically-established criteria
- Strategies for incorporating Cascade-informed recommendations into case plans
- Methods for staff and clinicians to overcome common barriers to client referral and receipt of services.

CHAPTER 1

COLLABORATION



Introduction

This chapter gives an overview of collaboration and how to build a group for collaboration purposes. In order to build a successful collaborating group, it is helpful to understand the different roles of the members. Each member of a collaborating group brings different viewpoints based on their roles, and it is only with regular meetings and discussion can a collaborating group be successful in accomplishing their shared goals and vision. This chapter also discusses some helpful tools for groups, although not an exhaustive list of tools that may be helpful for the group. Finally, this chapter elaborates on examples of some evidence-based collaboration models in the realm of SU/OU treatment and the benefits of collaboration on SU/OU. It is important to have this understanding of collaboration before being introduced to the different elements of the sequential intercept model that the later chapters of this guide are broken into.

Chapter Objectives

- Understand how to put a team together
- The importance of having a shared objective, scope, and goals for a collaborating group
- Understand the roles and backgrounds of stakeholders in the collaborating group as well as why having these varying backgrounds is important for collaboration
- Recognize tools that are helpful in facilitating collaboration among groups

Collaboration Overview

While there has been much emphasis on interdisciplinary and multidisciplinary teams, these concepts differ from that of a collaborating group. Both teams and collaborating groups include individuals who have varying backgrounds, viewpoints, and roles within their organization(s). However, there are some fundamental differences between teamwork and collaboration.

Teams Versus Collaboratives

Teams come together for a specified period of time to accomplish a task or a project. Once this task or project is accomplished, the team disbands and continues their individual work. In a team, there is a clear level of hierarchy that dictates the role of each member in the group. Often management chooses which individual is the leader of the team based on skills, experience, or expertise. In a team setting, each member should have the skills to communicate effectively within the hierarchal structure of the team. In order to accomplish the task or project, a team relies on each individual or small group to complete their portion of the project with very little or no overlap between each person's individual task. Once each individual or small group has their portion of the project complete, all of the pieces are compiled for the final product.

Although accomplishing teamwork in a group setting is ideal, there are some instances where a collaborative is preferred. Rather than having a hierarchy of different levels, a collaborative has no definitive leader and all members in the group are seen as equals. Collaboratives also work towards accomplishing a goal; however, these goals go beyond a single organization or individual. The collaborative works together and builds on their varying expertise to accomplish the goal together. While there may be some individual or small group work, the collective group supports each other to accomplish the goal together.

Creating a Collaborative Group

This section gives an overview of creating a collaborative group. This is the first step in forming a likeminded group to reach a particular long-term goal. Some tips and suggestions will be given to aid in recruiting collaborative members as well as a discussion on the need to recruit stakeholders of differing viewpoints. The information gathered for assembling a collaborative is adapted from stages in assembling teams and coalitions. While some of the stages in assembling teams and coalitions are not relevant, we can assume that the introductory stages are similar to the process of developing a collaborative. It is important to note the differences expressed earlier in the comparison of teams and collaboratives as present research groups the two concepts together despite the differences.

Pre-Development Activities

Rather than beginning with the first step of assembling a collaborative group, agencies should acknowledge the activities that work towards building support for a specific cause. In the area of SU treatment for justice-involved individuals, data should be gathered and analyzed to determine gaps in services.

Additionally, building awareness of the issue will aid in creating partnerships with other organizations (discussed later in this section) as well as funding opportunities. It is through this pre-development stage that the organizing agency begins to think of the partner agencies and resources that will be needed for the collaborating group to successfully operate.

Recruitment of Individuals and Member Organizations

Although implied, agencies and organizations working towards the same or similar goal of SU treatment access for justice-involved

individuals should be invited to participate in the group. Some examples of these agencies would include city or county judges, law enforcement officers, parole or probation officers, community-based treatment providers, and individuals with lived experiences. These actors may all have differing viewpoints, but have a stake in reducing substance use disorder (SUD)/opioid use disorder (OUD) in members of the community. Therefore, each perspective should be valued and considered during the collaboration process. Members of varying agencies or organizations should be sought for membership in the collaborative group. The purpose of a collaborative group is to have diverse perspectives and reach a consensus on a solution that would tend to the needs of individuals with a SUD while incarcerated and in the community.

The collaborating group not only needs to consider recruitment for the initial meeting, but also the importance for long-term sustainment of the collaborative. Butterfross (2020) suggests a Buddy Program for recruitment of new individuals and organizations. This system is an active form of seeking additional collaborative members that places the new potential member with an existing collaborative member to answer questions and make the new member feel welcome.

Steps of Creating a Collaborative Group

1. Pre-Development Activities
2. Member Recruitment
3. Develop Collaborative Group Structure
4. Implementation

Buddy Program

STEP 1: Determine the stakeholders who could help with the efforts but are not already part of the collaborative.

STEP 2: For each stakeholder or organization not already in the collaborative, a member with the best connection starts the recruitment process and volunteers as the "buddy".

STEP 3: The buddy contacts the prospective stakeholder/organization and encourages the recruit to join the collaborative. The buddy is in place to answer any questions.

STEP 4: Official documentation is sent to the prospective member (i.e. brochure, roster, by-laws, calendar of meetings, press coverage, program materials, etc.).

STEP 5: Once the buddy is aware of the next collaborative meeting, they contact the prospective member and encourage them to attend the meeting.

STEP 6: At the meeting, the buddy will greet the prospective new member, acclimate them to the setting, introduce them to other members.

Reference

Adapted from: Butterfross, F. D. (2020). Buddy program for member recruitment. Coalitions Work. Retrieved April 8, 2022, from <https://acrobat.adobe.com/link/track?uri=urn%3Aaaid%3Aascds%3AUS%3A7ce47562-fd89-400a-bf65-52fe095681fe#pageNum=1>

Initial Collaborative Meeting. The initial meeting is one of the most important aspects of creating a collaborative group. One agency should take leadership of the collaborative in order to coordinate future meetings and activities of the group. This first meeting will have attendees decide whether to participate in the collaborative group. During this meeting, the collaborative group should set the vision, objectives, and goals (Butterfross, 2019).

In order for a group to be successful, a clear objective, vision, and goals are needed. The determination of these aspects typically happens upon group formation with consensus from the whole group. Without a clear vision, the group may be working towards different goals, whether that be personal goals or towards a goal that reflects a misunderstanding of the collaborative group's goals (Tompkins, 2004). The use of a logic model can prove to be helpful in developing a shared vision, objectives, and goals that require all participants to share input.



Key Terms

Objectives are the action items towards reaching the collaborative group's vision. The objectives should be specific and have timelines on completion.

A **vision** refers to the main impact the collaborative group wants to have (i.e. the issue the group wants to solve). The vision statement should be the guiding principle of the collaborative group's actions.

Goals are the steps that make up an objective. These are the smaller victories made towards reaching the vision.

Develop Collaborative Group Structure

Tools in this stage of development include a memorandum of understanding (MOUs), establishing a shared language, and determining a communication process. All of these tools will be explained further in this chapter. The central thought behind this stage is laying the framework of the collaborative's sustainability. This framework should be revised regularly to update the vision, MOUs, etc. As time goes on, conditions change and therefore the vision of the collaborative may change. During this stage, a logic model can be useful in determining the actions of the group and how those strategies will help the group reach the determined objectives and goals.

Implementation

Once the group is gathered, differences are put aside, and the structure of the collaborative group is determined, the group can then implement a strategy to reach the determined objectives. Working as a collaborative group does involve long-term communication between the group members and agencies. Groups may be able to work together without communication, but this does not meet the standards or produce the benefits of a collaborative group.

Stakeholders and Their Roles

All of the subsections below are an overview of different stakeholders that can be utilized in a collaborative group. These stakeholders will ideally have some kind of collaboration in determining

treatment for the justice-involved population in need of SU treatment. This is not an exhaustive list of the stakeholders that should be utilized in collaborative efforts, rather this is a list of some of the most common stakeholders with roles during stages of the Opioid Services Cascade.

Criminal Justice System

Supervision Officers

Justice-involved individuals may be required to visit with parole and/or probation officers as part of their sentencing or as a condition of their release. Therefore, parole and probation officers play a central role in linking justice-involved individuals to SU treatment. Ideally, these officers will not only monitor substance use and conduct drug testing but actively refer justice-involved individuals to community-based treatment. It is important for supervision officers to be aware of all treatment types and providers in their respective communities. With such a pivotal role in the opioid service cascade, supervision officers prove to be valuable members of any collaboration model.

Police Officers

Being the first point of contact with justice-involved individuals, police officers serve as gatekeepers to community-based treatment or the justice system. Officers can be trained as crisis interventionists (see the "Crisis Intervention Team" section further in this chapter) and use their judgement to take individuals to treatment providers or even recommend the justice-involved individual's case be handled in drug treatment courts (described later in this chapter). Police officers have some element of collaboration with other members of the criminal justice system, however, the knowledge and connection with community service providers would increase collaborative efforts and positive effects of collaboration.

Courts

Whether a disposition is more punitive or rehabilitative lands mostly on courts and their actors (i.e. judges, lawyers). Judges decide the sentencing of the justice-involved individual such as probation versus parole versus incarceration. If convicted, the court actors will also decide the length of sentencing and any conditions of community supervision, incarceration, and/or treatment. However, the sentencing guidelines vary by local government with little to no collaboration with federal courts. The National Judicial Opioid Task Force (NJOTF) (2019) has taken it upon itself to release an overview of findings and recommendations for the court system in relation to the opioid epidemic.

Community-Based Setting

Behavioral Health Providers/Substance Use Treatment Providers

Behavioral health providers and SU treatment providers directly monitor and provide treatment for justice-involved individuals. These treatment providers will likely overlap with counselors, social workers, case managers, and other professionals. Substance use may be a co-occurring disorder with mental illness, thus, a variety of approaches (i.e., clinical, therapeutic) may need to be utilized for one client.

Treatment may happen in a variety of manners including but not limited to MOUD, medication assisted treatment (MAT), therapy, and any combination of treatment types. Furthermore, treatment can happen in a variety of settings and lengths of time. Justice-involved individuals may sometimes start treatment while incarcerated, thereby requiring a smooth transition to community-based treatment providers. Providers may choose to have clients admitted into in-patient treatment or outpatient treatment.

Counselors

Counseling is an integral part of substance use treatment (SAMHSA, 2005b). Counselors have a role in understanding addiction and teaching justice-involved individuals the tools they need in comprehending their addiction and how to combat it. Counselors can be found in a variety of settings including but not limited to private practice, behavioral health treatment centers, substance use treatment centers, jails, and prisons. Counselors' abilities to work in diverse settings puts them in a unique position to reach many clients. It is important to note, counselors do not prescribe medication, rather they can work concurrently with justice-involved individuals on MOUD (SAMHSA, 2021a).

Case Managers

Case managers work one-on-one with justice-involved individuals through every stage of the recovery continuum. Additionally, case management focuses on all aspects of the justice-involved individual's life to support them in reaching their treatment goals. Case management is individualized and prioritized based on the justice-involved individual's strengths and needs. Case managers are available through a variety of community-based resources and can provide referrals to a variety of wraparound services such as behavioral health, medical care, prescription assistance, substance use treatment, etc.

Social Workers

Similar to counselors, social workers can provide therapeutic services and tools for clients to comprehend and combat their addiction. Due to their training, social workers can be utilized in the screening and assessment process for justice-involved individuals (Lombardi et al., 2018). Social workers work in similar settings as counselors; with a unique mix of clinical and therapeutic training, social workers are valuable members in the fight against the opioid epidemic. Although similar, social workers are better equipped to refer clients to sociocultural resources (e.g., housing, financial assistance, child care, transportation) and work with them through any barriers that would prevent treatment initiation and retention (Council on Social Work Education, 2020).

Peer Navigators/ Peer Support Specialists

It is highly advisable to have individuals with lived experience to either advise collaborative efforts or work with justice-involved individuals. These peers are more likely to connect and build trust with justice-involved individuals thus resulting in greater willingness to seek and continue treatment.

Other Stakeholders

Government

The role of government should be thought of beyond the means of creating legislature, they may also support changes in public policy. Numerous social issues have been brought to the attention of government officials, further creating support and awareness of the issue. Additionally, the government has the authority of increasing or decreasing the budget going towards social issues. Whether at the local or federal level, the inclusion of professionals involved in the government will aid the efforts of a collaborative group.

Researchers

Research is critical for addressing the opioid epidemic. Through research, we are able to see trends in opioid use, overdose, and treatment efforts. Social research not only enables scientists to determine which screening and assessment tools are effective, and which treatment modalities show promise, but also encourages new methods of thinking that challenge the barriers justice-involved individuals may encounter. Research articles advise collaborative groups, governments, and others on new ways of thinking that can have positive impacts. Researchers have an understanding of program planning, implementation, and evaluation, all of which can lend knowledge to the collaborative group's processes.

Collaboration Tools

The below subsections give a brief overview of some useful tools for collaboration. These are some examples of tools and are not an exhaustive list of tools for collaborative groups to use.

Memorandum of Understanding

Memorandum of Understanding (MOUs), or formal agreements, can be developed among a variety of agencies working within the criminal justice system to encourage information sharing (SAMHSA, 2005b). Information related to screening, assessment, treatment progress, outcomes, diagnoses, and ancillary needs should be shared among agencies across different points in the cascade of care to ensure service continuity or the initiation of services at the appropriate time (SAMHSA, 2005b). A sample MOU can be found in **Appendix A**.

Cross-Training

In brief, cross-training is a term that references the training of collaborative group members on roles separate from those they usually perform (Volpe et al., 1996). Essentially this type of training gives group members additional perspectives other than their own. For instance, a parole officer could be cross-trained with a case manager. In this case, a parole officer will learn the everyday responsibilities of the case manager and their role in community reentry support for justice-involved individuals. The case manager would also be cross-trained on the parole officer's duties and gain a deeper understanding of the processes the parole officer must follow for each justice-involved individual.



Note: Positional Clarification

The overview of each stakeholder and their role in substance use treatment given earlier can be considered cross-training. However, collaborative groups should go into more depth on each member's role in substance use treatment and prevention. The brief descriptions given earlier in this chapter are meant to give ideas of each stakeholder that can be brought to the collaborative group.

There are three different types of cross-training that vary in the intensity of training modalities (Marks et al., 2002). The least intense type of cross-training is *positional clarification*. This modality gives a brief overview of each team member's job and responsibilities. Positional clarification is typically given verbally to all team members, although a written description could prove to be helpful to reflect on job descriptions at a later time. *Positional modeling* is similar to positional clarification in that a verbal description is given, but each group member also shadows teammates in order to learn more about their role and responsibilities. Finally, *positional rotation* is the most time and resource-intensive form of cross-training. Since this form of cross-training is much more intensive, most research studies have focused on this form of cross-training. In this type of cross-training, each member works in different roles on a rotating basis.

Research has shown effectiveness and desirable outcomes in cross-training group members (Hedges et al., 2019; Gorman et al., 2010; Marks et al., 2002). However, it is important to note some of the limitations of cross-training. Cross-training is still a relatively new concept, and therefore, research on long-term effectiveness is limited. Gorman et al. (2010) discuss an even larger issue in that cross-training, especially using positional rotation, is limited by the job complexity and knowledge and skills of the group members. For example, a parole officer paired with a buprenorphine waivered practitioner is a pairing that is unable to learn much from each other. While the parole officer would benefit from positional modeling and understanding the prescribing rules and regulations, they would not be able to perform the job function.

Despite these limitations, Marks et al. (2002) discovered that some form of cross-training was better than none and lead to a greater knowledge of each group member's role. Further, the two more intense cross-training modalities showed improved outcomes in group interactions and coordination. For the purpose of this guide, positional clarification can be found earlier in this chapter in regard to some stakeholders in the cascade of care. This gives organizations a starting point when collaborating and cross-training group members using positional modeling or positional rotation.

Shared Terminology

A study by Hollis (2016) detailed the difficulties of collaboration between criminal justice agencies and community-based organizations. Hollis noted that a lack of shared terminology between the groups led to a breakdown in communication during collaborative meetings. Those individuals involved in criminal justice used jargon and acronyms that were not familiar to community-based organizations and vice versa. Miscommunication often happened during these collaborative meetings rather than

problem-solving and working towards a shared goal.

Therefore, it is highly advised that collaborative groups explain any jargon or agency-specific terminology used when presenting or speaking. An additional method would be to create a "codebook" of the terms and acronyms used for future reference and to help acclimate new collaborative group members.

Logic Model

Literature on creating collaborations continually comes to a consensus that a breakdown in communication and an unclear goal lead to ineffective collaborative groups. Logic models can be used in several different stages of a program or intervention from planning to evaluation. In the case of collaborations, logic models are useful in the planning stages by helping collaboratives to identify a clear goal, activities that work towards specified outcomes, and the long-term goal of the collaborative group's efforts (Family and Youth Services Bureau, 2020; Kekahio et al., n.d.).

The different sections of a logic model flow from one section to another by showing the relationship between the previous section to the following section. Logic models will aid a collaborating group in determining the shared goal and the framework of the actions in getting to the determined goal (Family and Youth Services Bureau, 2020; Kekahio et al., n.d.). The goal statement is what starts the logic model and should be at the top of the model (Bureau of Justice Assistance, 2019). An example logic model can be found in **Appendix B**.

There are a few components that are the basic foundations of a logic model (Bureau of Justice Assistance, 2019; Family and Youth Services Bureau, 2020; Kekahio et al., n.d.). Inputs list the resources the intervention/program will use in reaching the group's goal. These resources are not only material objects but can include financial resources, required staff or community members, knowledge, partnerships, or other supports that will be utilized to reach the goal. The resources listed under the inputs section will dictate the activities that will take place. These activities are not the outcomes of the intervention, rather, they are the specific actions that will lead to the outcomes of the intervention. In the logic model, each of the determined activities will lead to specific outputs. The outputs of the activities will then lead to outcomes, whether those be short-, medium-, or long-term outcomes.



Note: Outcomes

Typically, **short-term outcomes** show a change in knowledge, awareness, attitudes, skills, and intentions. **Intermediate outcomes** focus on higher level changes such as behaviors, policies, systems, etc. **Long-term outcomes** go hand-in-hand with the goal of the intervention.

Essentially, the short-term outcomes can be seen as changes at the personal level; intermediate outcomes as changes in the societal level; and long-term outcomes at a global level.

Optional, although important, sections of the logic model include external factors and assumptions. External factors are those aspects that have an impact on the program; these should be factors that are either positive or negative and affect the program's activities and outcomes (Bureau of Justice Assistance, 2019). Assumptions are those factors that the program assumes are in place that enables the success of the program. For instance, an assumption for post-incarceration SU treatment could be stable transportation to the treatment provider or consistent public transportation to the treatment provider.

Keep in mind that the visual logic model that is produced should correspond to a logical narrative of the process from start to finish. It is helpful to think of an 'if-then' process to determine if the logic model flows correctly or if there are additional gaps that need to be filled (Family and Youth Services Bureau, 2020).

Collaboration Models

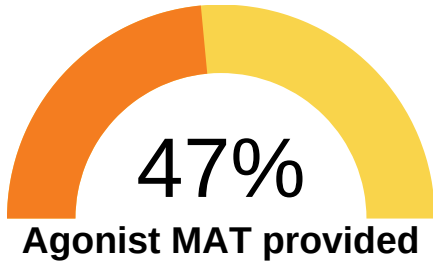
The models listed in the section below are examples of collaborations that are already in place. Although there are only three listed collaboration models in this section, these are meant to be examples and are not an exhaustive list of collaboration models.

Drug Courts

Drug courts are prevalent in the United States, but their availability varies widely across municipalities. In short, drug courts are specialized courts that justice-involved individuals may be sent to if they have a SUD and are arrested for drug-related offenses. Those individuals sent to drug courts typically have court-mandated SU treatment and go through random drug testing, regular court hearings, and visits with probation officers (Gottfredson et al., 2007; Matusow et al., 2013). Due to the structure of this model, it is important for there to be a cross-agency collaboration between the justice system staff and treatment providers.

Gottfredson et al. (2007) studied the Baltimore drug court to determine whether there was an impact on reduced crime and drug use among those randomized to drug treatment courts. Study participants who were in the drug treatment court group went through intense supervision as well as court-mandated treatment. The outcomes showed overall crime and drug use were lower among drug court participants. Further, it was found that the elements of drug testing and drug treatment did reduce polysubstance use as well (Gottfredson et al., 2007).

Although drug courts can increase treatment initiation and other positive outcomes, they are not without limitations. Matusow et al. (2013) found close to 50% of the surveyed drug courts did not offer methadone or buprenorphine as part of justice-involved individuals' treatment, and there were more constraints on methadone than buprenorphine. Counseling was involved more often than not (92% vs. 8%) in MAT mandated by drug courts (Matusow et al., 2013), showing the importance of counselors in the drug court system.

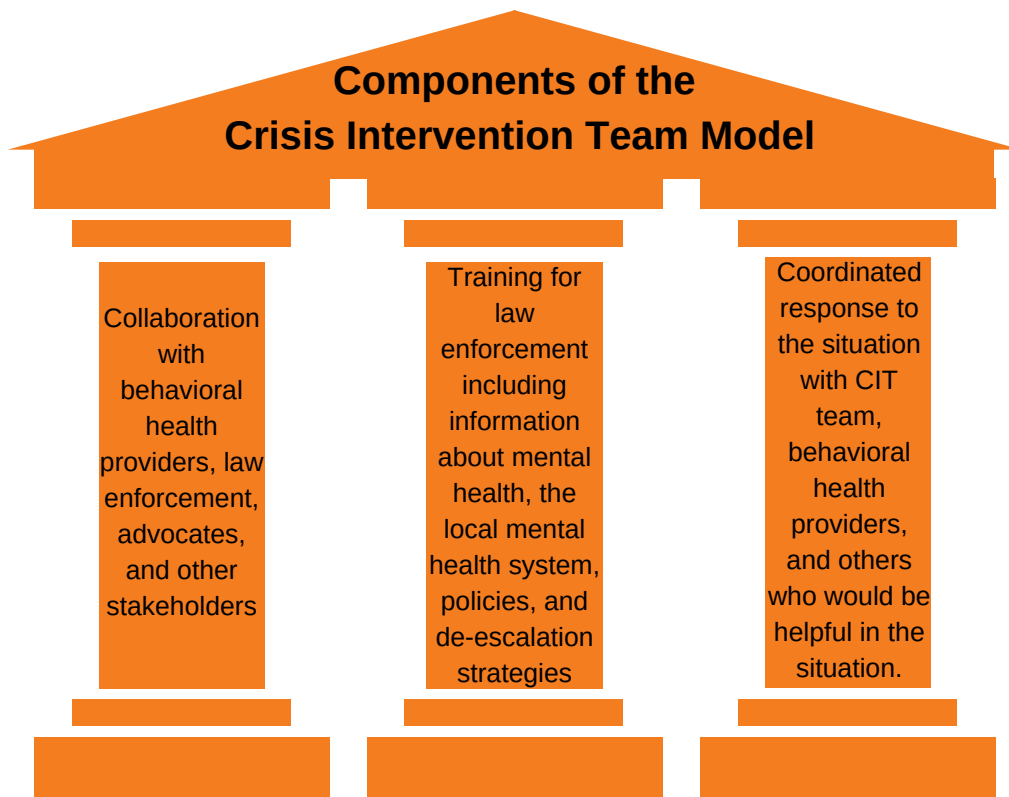


Treatment types available as part of drug courts according to data from Matusow et al. (2013)

To summarize, law enforcement officers, jails, the court system, and justice-involved individuals collaborate in the setting of drug courts. Once a decision is made for treatment, counselors and staff from treatment facilities collaborate within this system as well. Family and peer support play an important role in the justice-involved individual successfully completing the requirements set forth by the drug courts.

Crisis Intervention Team

The Crisis Intervention Team (CIT) model was created in the 1980s as a new policing strategy when encountering individuals experiencing a mental health crisis or substance use (Compton et al., 2011). This model’s framework is built on collaboration and utilizes some cross-training. When members of law enforcement on a CIT encounter an individual with a mental health crisis or substance use, their training in behavioral health enables them to calm the individual and get them the help they may need. In some instances, this requires the officer to take the individual to a behavioral health treatment center.



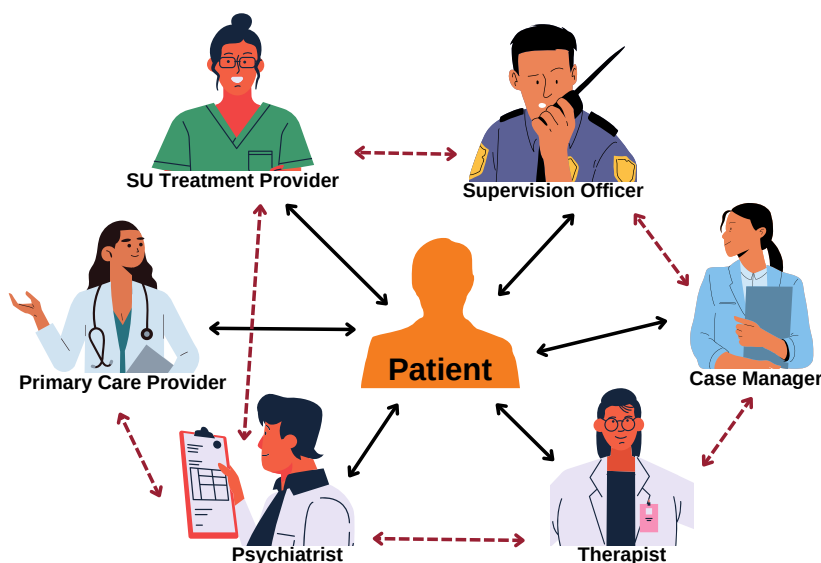
Training as a CIT should be voluntary and officers should be screened to determine fit for the position as a CIT member (Watson et al., 2017). Once an officer is accepted into the CIT specialty, they go through training on behavioral health, stigma, and response methods to keep themselves and the individual safe (Watson et al., 2017). A key piece of CIT training is linking the individual to psychiatric or substance use treatment (Watson et al., 2017). Research has shown an improvement in officer-level outcomes, such as knowledge, attitudes, and self-efficacy, after being trained as a CIT officer (Compton et al., 2014). The hope of implementing a CIT is to reduce the incarceration of individuals experiencing a mental health crisis or substance use and initiate treatment instead (National Alliance on Mental Illness [NAMI], n.d.). Therefore, the collaboration between the criminal justice system and behavioral health treatment providers is essential for the success of the program. For additional information on forming a CIT, you can explore [this guide](#) by SAMHSA.

Collaborative Care Model

Although not originally inclusive of the criminal justice system, we could take the medical collaborative care model and expand it to include the criminal justice system. The basis of this model is grounded in patient-centered care within a medical home (Duncan, 2017), in other words, the client is the focus of a group of medical professionals who all collaborate and cater to the patient's needs. In the setting of substance use treatment for the justice-involved individual, this collaboration would contain key stakeholders such as the supervision officer, primary care provider, substance use treatment provider, a representative from each of the social service agencies the client utilizes, as well as the client and their family/peers that provide support.

This model is important in sharing key information that pertains to the treatment of the client (Rackets, 2021). For instance, the sharing of information through the collaborative care model on medications prescribed to the client will reduce the chance of negative drug interactions. Through shared communication among the collaborative group members, all of the client's medical information is relayed to all parties involved in the care of the client. Additionally, the supervision officer that meets with the client will have access to information in determining compliance with substance use treatment.

Visual Representation of the Collaborative Care Model



Summary

This chapter gave an overview of the importance of collaboration in SU treatment for justice-involved individuals. The chapter begins with the steps of organizing and creating a collaborative group of individuals and/or organizations with shared goals. It is through collaborative efforts of a variety of stakeholders that change can be made. What follows is an explanation of the roles of the most important stakeholders in a collaborative group. Although these stakeholders are not an exhaustive list, they play a large role in SU treatment for justice-involved individuals. These stakeholders should be included in collaborative group efforts toward process improvement and other beneficial system changes for justice-involved individuals.

Once stakeholders are gathered, a variety of tools can be used within the collaborative group setting. Some tools are listed in this chapter in moderate detail, although, additional tools can be used to garner conversation within the collaborative group. Finally, a couple of successful collaborative models are listed as examples of successful collaborative group efforts in action. The tools and models section is meant to give ideas on how to implement actions in the collaborative group. Readers should keep this chapter in mind when reading through the subsequent sections of this guide. Each of the following sections in the Cascade of Care benefits from collaborative group efforts.

CHAPTER 2

OPIOID SERVICES CASCADE

Introduction

This chapter gives a brief overview of opioid use disorder and addiction. Background information is given to explain the importance of the opioid services cascade in addressing opioid use disorder. This chapter also delves into the opioid services cascade of care and each stage in the cascade framework. The information provided in this chapter will be a useful reference for the subsequent chapters on parts of the cascade of care.



Chapter Objectives

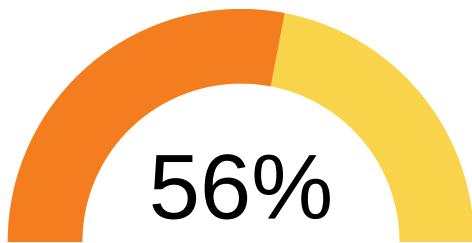
- Understand addiction as a chronic disease that requires long-term care
- Determine the gaps in service continuity for justice-involved individuals
- Learn about the Opioid Services Cascade of Care framework and each of its stages
- Learn about the Sequential Intercept Model
- Recognize the use of the Opioid Services Cascade of Care and the Sequential Intercept Model in developing the O-TLM Resource Guide

The Importance of Addressing Opioid Use Disorder

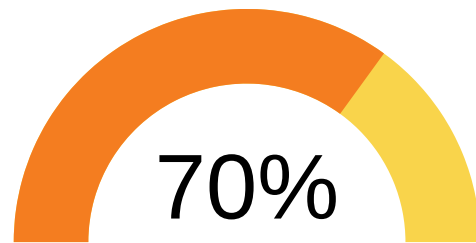
When reading through the O-TLM, keep in mind the information presented below on the prevalence and severity of opioid use disorder (OUD) among justice-involved individuals. It is important to know the following information on addiction when interacting with individuals with OUD. Understanding addiction as a disease will aid in combating the stigma associated with having an OUD.

Facts at a Glance

- Estimates suggest 63% of individuals incarcerated in local jails report substance use (SU) issues, and 58% of individuals in state-run CJ facilities report substance dependence (Bronson et al., 2021).
- More than half of all incarcerated individuals in the United States consumed alcohol at the time of the offense, while illicit drugs were involved in three-fourths of incarcerations (Maruschak et al., 2021).
- However, only 10% of all clients with a substance use disorder (SUD) received any treatment during their incarceration (Belenko & Peugh, 2005).



drank alcohol at the time of their offense



used drugs at the time of their offense

Substance use at the time of offense according to the Maruschak et al. (2021) study

Why is Addiction Considered a Disease?

Addictive substances cause the brain to release chemicals associated with pleasure and reward (Partnership to End Addiction, 2022). Continued use of addictive substances causes the brain to release these chemicals in order to make the person feel "normal" (Partnership to End Addiction, 2022). Although the continued use of substances is harmful and dangerous, the benefit of using substances to curtail intense desires ("cravings") is greater than the risks (Partnership to End Addiction, 2022). The reinforcement in the use of substances to feel better is a long-term change in the brain that will continue after the person has gone through treatment (Partnership to End Addiction, 2022).

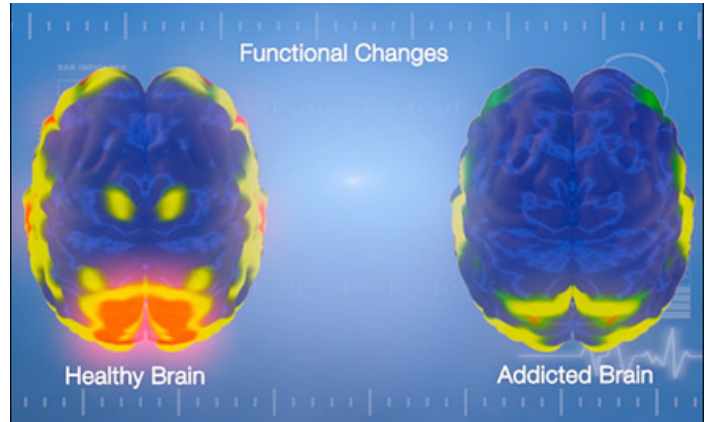


Key Term

A **chronic disease** is a long-lasting condition that can be controlled through medication and/or behavior change but not completely cured. Chronic diseases are clinically characterized as lasting for one year or longer and may impact someone's daily activities.

Although the changes in the brain remain long-term, substance use can be treated with medications, counseling, and support (Partnership to End Addiction, 2022).

Fortunately, a variety of effective and available treatments help people recover from addiction to lead normal, productive lives (American Psychiatric Association & Parekh, 2017).



PET scans show changes in activity within the brain. Image Source: Inspire Malibu, 2019

Development of Opioid Services Cascade of Care

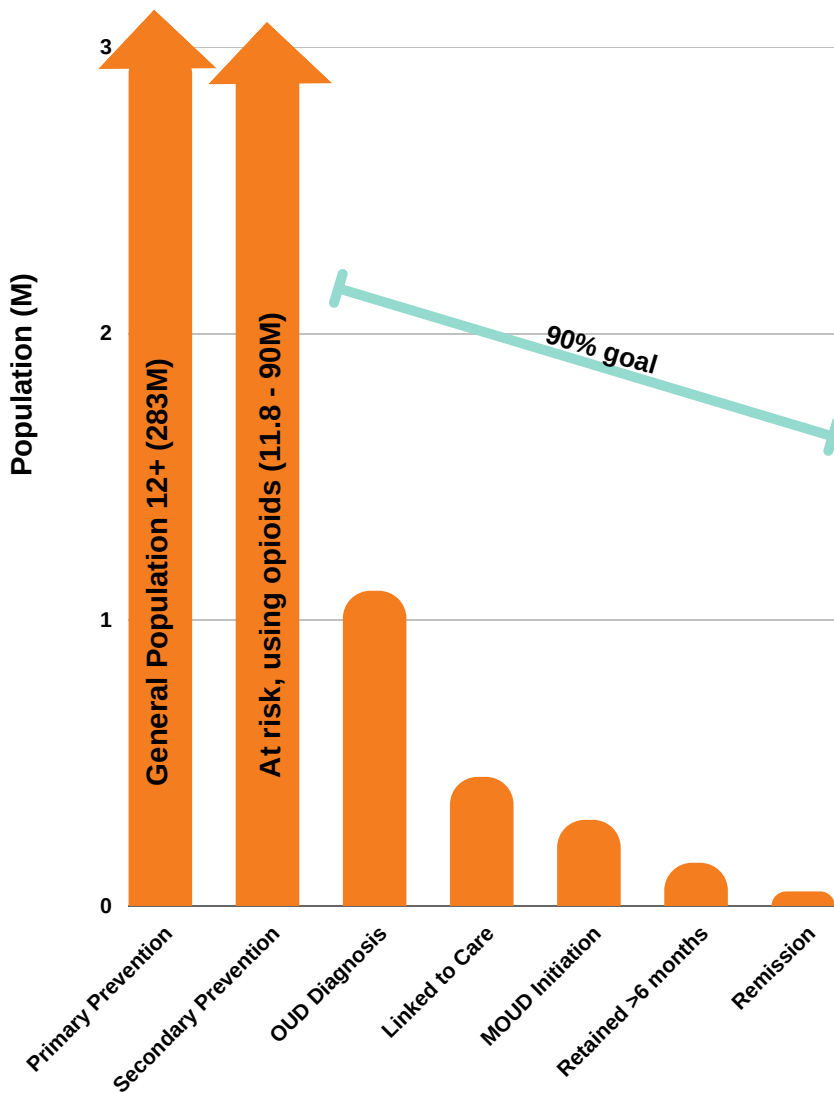


Figure 2.1. OUD Cascade of Care among reporting providers in 2016, based on Williams et al., 2019

The development of the Opioid Services Cascade of Care is based on the HIV cascade of care which has proved beneficial in identifying the gaps in screening, treatment initiation, and retention in care (Williams, Nunes, & Olfson, 2017; Williams et al., 2018). Successful identification, treatment, and retention benefits the patient as well as the community. This framework was then revised and used to address the opioid epidemic.

The target of each stage in the Cascade of Care is based on a 90% goal of the previous step (Williams, Nunes, & Olfson, 2017; Williams et al., 2019; Williams et al., 2022). For instance, this framework aims to diagnose 90% of the individuals screened for OUD. Of those who are diagnosed, the aim is to get 90% of those individuals connected to treatment. This trend continues down to the final stage of the cascade, remission.

Opioid Services Cascade of Care

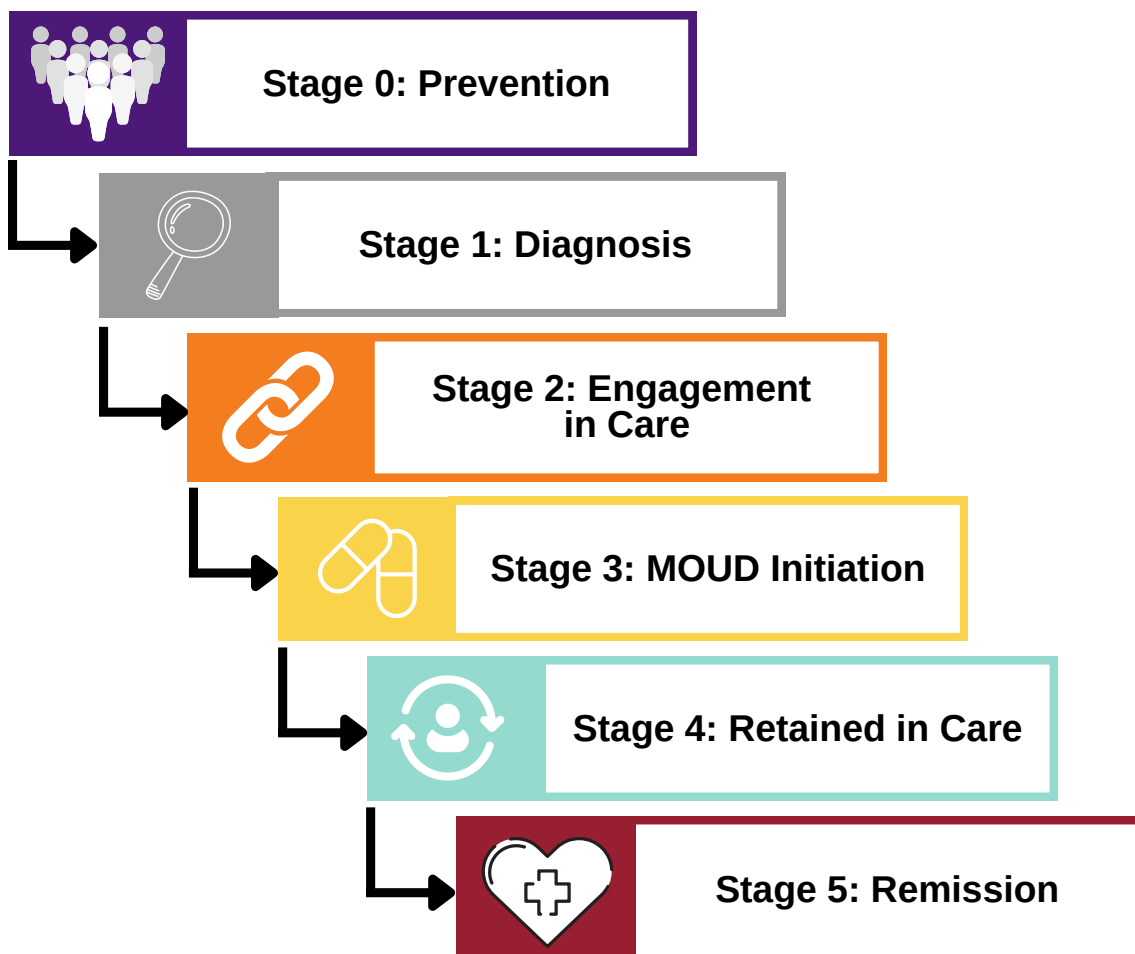
Stage 0: Prevention

This stage of the Cascade of Care is not mandatory and is more of a means to analyze populations at-risk of developing an OUD. We can split prevention into two helpful categories: primary prevention and secondary prevention.

Primary prevention includes attempts to educate the general public through campaigns to prevent opioid misuse (Williams et al., 2019). The target population for primary prevention is not specified but should include targeted responses to various demographics. For instance, educational efforts targeting secondary school students will not work for adults released from the CJ system.

Secondary prevention efforts include screening for early identification of those who are prescribed opioids, have a history of SU or OU or are currently misusing opioids (Williams et al., 2019). The use of secondary prevention efforts enables early diagnosis of opioid misuse and works to prevent an individual from developing OUD or SUD.

Figure 2.2 Steps of the Opioid Services Cascade of Care



Stage 1: Diagnosis

This stage in the Cascade of Care is important in identifying OUD (Williams et al., 2019). While secondary prevention efforts overlap this stage, screening and assessment tools are crucial to the success with this stage of the cascade. Positive results on a screening tool should lead to a more in-depth assessment. Assessments will aid in determining an OUD, which is characterized by specific criteria in the DSM-V. More information on screening and assessment can be found in Chapter 3 of this guide.

Stage 2: Engagement in Care

Should a client have a positive assessment and diagnosis of OUD, they should be linked to treatment. There are a variety of treatment types including but not limited to self-help groups, counseling, in-patient treatment, outpatient treatment, and medication-assisted treatment (MAT). Clients should be offered all available types of treatment and their input taken into consideration when choosing treatment types. For additional information on linkage to care, view Chapter 4 of this guide.

Stage 3: MAT Initiation

There has been an immense success in OUD treatment with the use of MAT. The use of medications to treat opioid use disorder (MOUD) is considered the gold standard of treatment by many organizations including NIDA (Williams et al., 2018; Williams et al., 2022). Therefore, in addition to treatment services, all clients should be educated on and offered MOUD. More information on MAT/MOUD can be found in Chapter 5 of this guide as well as relevant appendices.

Stage 4: Retention in Treatment

Ideal retention in treatment is consistent MOUD use over the course of 6 or more months. A range of assistance could be used in helping the client remain in treatment. For instance, if the client has transportation barriers that limit their ability to utilize treatment, resources and assistance could be given so the client can continue treatment. These barriers should be determined during treatment planning and revisited often to determine additional needs. Chapters 4 and 5 of this guide discuss additional service needs to help retain the client in treatment as well as encourage clients to stay in treatment.

Stage 5: Remission

Treatment for OUD is an ongoing process that may not always entail complete abstinence from OU. Therefore, while complete abstinence from opioids is ideal, this stage encourages the continued treatment of OUD while also recognizing that relapse is part of the recovery process. It may take some individuals years to get to the final stage of the Cascade of Care and stay there.

Using a Universal Service Cascade to Address System Gaps for Opioid Use Disorders

Targeting gaps in the criminal justice system where it intersects with community behavioral health (CBH) is crucial for improving the continuum of services for opioid users (Brinkley-Rubenstein et al., 2018; Williams et al., 2018). While the potential to intervene exists, justice-involved individuals with a history of (or at risk for) OU continue to reenter the community without receiving recommended MOUD and CBH services. Part of the challenge is the implementation and sustainment of innovative practices designed to provide an appropriate continuum of care. Further, recent health events (specifically COVID-19) have resulted in unprecedented challenges for serving recently released populations at risk for opioid use.

Benefits of Addressing OU Using Clinical and Medical Approaches

The use of psychotherapies and counseling seek to change behaviors, thoughts, emotions, and how people interpret situations (SAMHSA, 2022a). It is vital for people in treatment to also initiate MOUD. This is important to prevent relapse and withdrawal, reduce cravings, and protect against overdose (SAMHSA, 2018). The way MOUD interacts with the brain differs from the way opioids interact with the brain. MOUD blocks the cravings for opioids and suppresses opioid withdrawal. It does not feed the addiction. Instead, the medication stops the brain's abnormal mechanisms caused by addiction (Kosten & George, 2002).

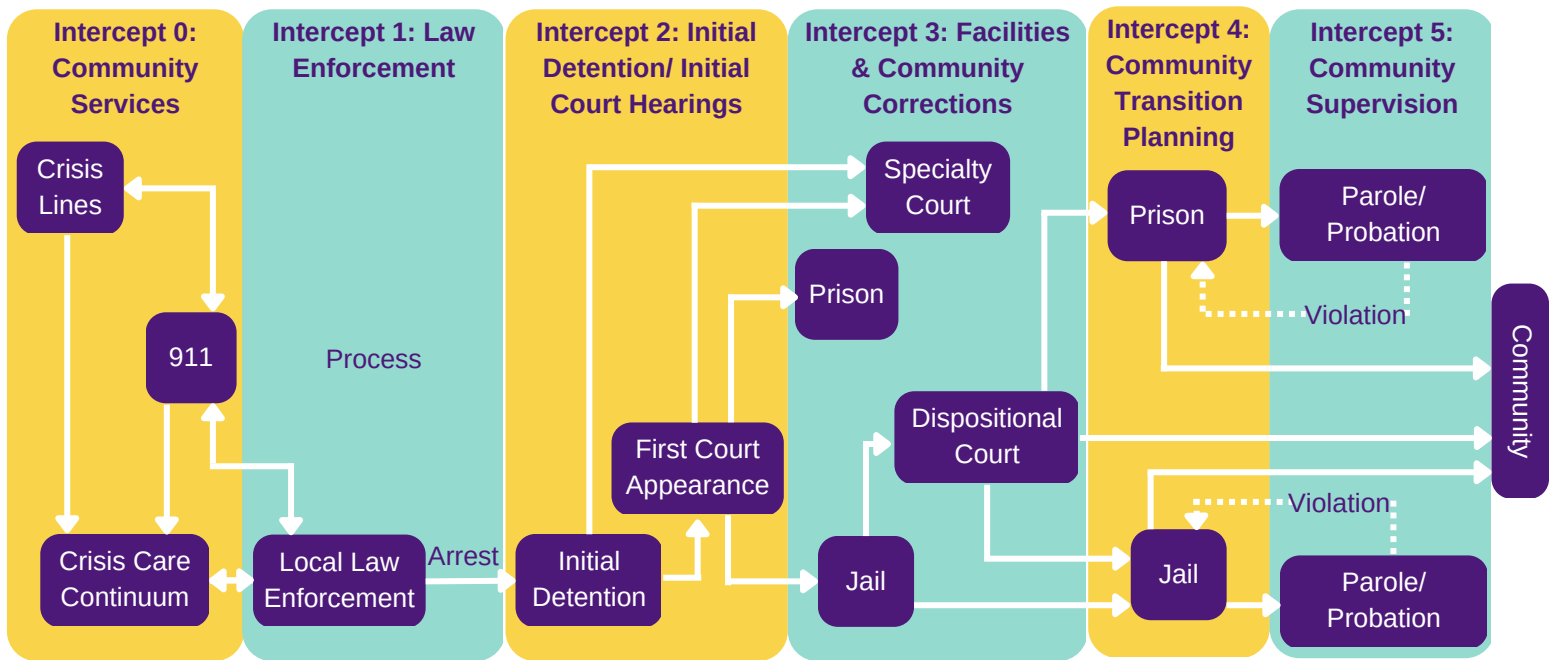
Opioid Use & Criminal Justice -- A Changing Landscape

The US opioid epidemic is having a profound impact on justice-involved populations. Among 50,000 overdose deaths in 2014, 60% involved illicit opioid use (Rudd et al., 2016). Justice-involved individuals reentering the community are among the highest at-risk group for misusing opioids, developing an OUD, experiencing adverse health-related outcomes, and criminal recidivism (Wakeman, 2017). Service gaps persist; for example, treatment plans do not include MOUD for 80% of people with an OUD (Hedegaard et al., 2018).

Adapted Sequential Intercept Model

The Sequential Intercept Model (**Figure 2.3**) illustrates the typical service flow and conceptual framework to assist communities in organizing strategies targeting justice-involved individuals with behavioral health disorders (Munetz & Griffin, 2006). Throughout the CJ system, there are numerous opportunities (e.g., intercept points) for linkage to services and prevention of further introduction into the CJ system (SAMHSA, 2021). The following flowchart was adapted from its original form to include additional contact points that people have with the CJ system and various services available at each intercept.

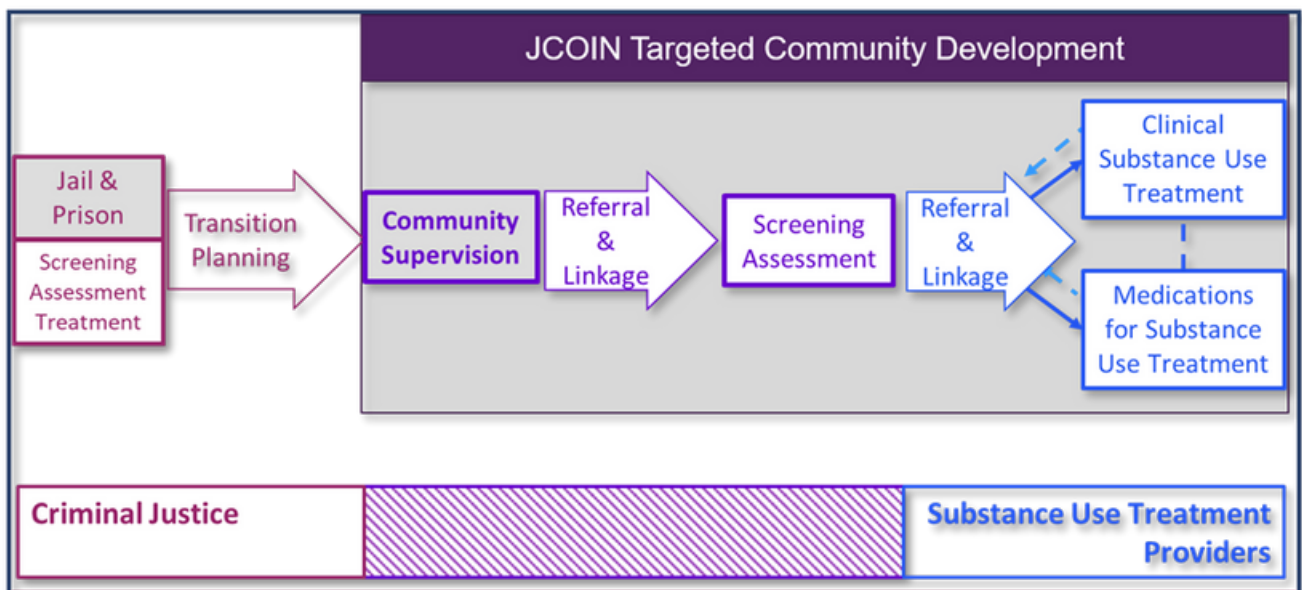
Figure 2.3 Adapted Sequential Intercept Model



Community Reentry Substance Use Services Cascade

The Continuity of Care Indicators Checklist includes checklists corresponding to each point in the Cascade of Care and tailored to available resources within the community to facilitate linkage to specific service providers (Knight et al., 2021). The Continuity of Care Indicators Checklist is informed by two best-practice frameworks: The Behavioral Health Services Cascade (Belenko et al., 2017) and the Opioid Services Cascade of Care (Williams et al., 2017, 2018). The cascades include universal services that branch across both care cascades, as well as discrete benchmarks for OUD as distinct from SU services more broadly.

Figure 2.4 Community Reentry Substance Use Services Cascade



Ideally, clients would receive the following services in a logical sequence across both cascades (**Figure 2.4**):

- Clients would receive a universal screening for OUD or other substances that raise OUD risk
- Clients who screen positive would receive a comprehensive clinical or diagnostic assessment for that problem
- Clients who have a positive assessment/diagnosis would be referred to a CBH provider and/or receive MOUD
- Clients referred to services would initiate treatment (show up for an initial appointment; receive the first dose).
- Clients would continue services long enough to achieve improvements in problem areas

Moving across the cascade is difficult for clients in CJ settings due to the fact that they are commonly screened in a community CJ setting but receive treatment services in behavioral health care sectors (Belenko et al., 2017). This system requires clients to navigate across two or more entities, which affirms the need of cross-system linkage for effective care (Belenko et al., 2017). This is further complicated for individuals who received SU services while incarcerated, adding another layer of service coordination.

Your community's model of the cascade may look a little different, either in the ordering of the steps or in the services offered within your community. The order of steps shown here (**Figure 2.4**) is what is likely to happen when CJ and clinical assessment services are co-located, so clients receive a referral after their clinical assessment. In other jurisdictions, instead, clients receive a referral to off-site behavioral health services for their assessment, after screening.



Tip

Just as it is crucial to consider universal services that overlap across both cascades, it is equally important to consider best practices that promote client improvement for OUD-specific problem areas. It is possible for a system to adequately address behavioral treatment for SU problems yet fall short on addressing OUD problems.

Considering measurable actions along a service cascade, as performed by either a client, justice agency, or health provider, can help communities identify unmet needs. This assessment may provide insight into how the screening, referral, and service transition activities are proceeding, and at which step in the cascade changes are necessary.

Noticing these actions can translate into a checklist of best practices along a continuum of care. Further, if we apply this process to a community's operations, from one time point to another, we can measure process improvement. Comparing one community's operations to practices in another community is also informative.

System Breakdowns in Service Delivery

Problems for Clients

When persons do not access the services they need, this breakdown can have negative consequences not only for the individual, but also for you and your agency. For the client, when behavioral health problems go untreated, they can become worse, making them more difficult to treat late and giving rise to other behavioral problems (Scientific American, 2012; Young, 2015).

Problems for Agencies

For you and your agency, a service breakdown (e.g., loss of funding, negative perceptions of treatment effectiveness) means you do not have all the resources needed to best serve this person. Service breakdowns can increase your workload and cause frustrations for the client and their family.

We know, however, that many people who should get to the next level of care do not. A bumpy transition between your agency and your health counterparts can arise because of what the client does (or does not do), but sometimes they result from practices in your agency or the health agency.

The cost of recidivism is greater than the cost of supplying effective MOUD treatment. A study in Australia found that offering MOUD was cost-effective 96.7% of the time, averaged half the cost to society as non-MOUD treatment (\$7,000 vs. \$14,000), and an investment of \$500 in MOUD attributed to one additional person-year (Gisev et al., 2015). This analysis looked at Australian justice-involved individuals from 1985-2012 and included over 16,000 individuals who were released from incarceration into the community or SU treatment providing MOUD. The study found that people connected with MOUD and retained on treatment at 6 months had lower overall costs to society, a difference of about \$1,400 per individual. It was found that the majority of the costs saved were in the criminal justice system, which included police labor forces, court proceedings, and prison stays.



Tip

Agencies can use information about the number of clients who reach each step in the cascade to track how well they are meeting their goals. This information can also show how your agency works, which you may not otherwise have time to do, as you manage your caseload.

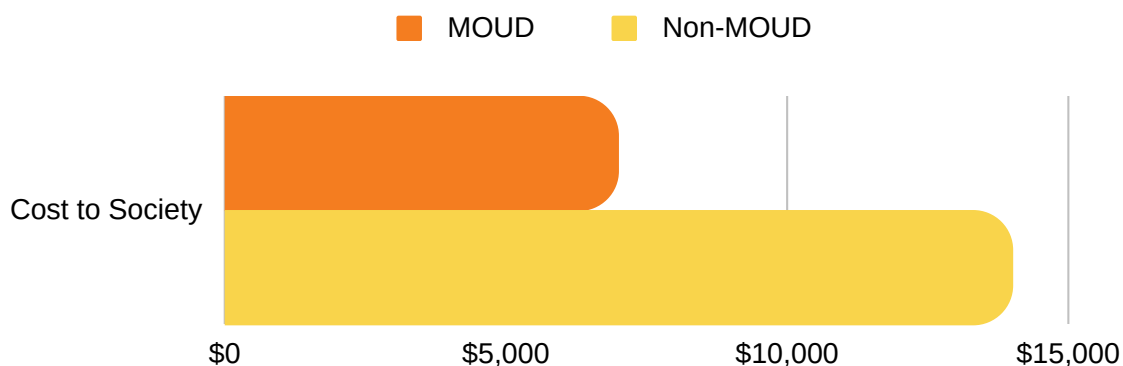


Figure 2.5 Average cost to society of individuals receiving MOUD versus not receiving MOUD according to the Gisev et al. (2015) study.

Common Challenges and Solutions for Agencies

Interagency Communication and Service Continuity

Providers and others working in SU treatment services for recently released individuals need to have education, understanding, shared language, respect, and mutually agreed upon goals at the national, state, agency, and local levels. However, there may be miscommunication between parole officers, case managers, facility-based treatment providers, and community-based treatment providers resulting in delayed, misinformed, or absence in service delivery. For instance, client tracking could be a problem because data is not shared between community agencies and community corrections, resulting in clients being lost to follow-up. For instance, community agencies and community corrections should share data between agencies to better help clients and retain them in treatment. Should data not be shared between entities, important actionable information that may help the client could be lost or the client themselves could be lost to follow-up.

The following chapters will detail a few options for enhancing service continuity, including: developing formal agreements with community-based treatment providers, identifying community-based providers with liaisons, utilizing recovery specialists who follow clients post-release, and ensuring close coordination with courts and community supervision officers (Ferguson et al., 2019).

Screening and Assessment

Aim to employ a screener for SU and OUD before community supervision referral for all new clients. The screeners should build upon screening and treatment records conducted while the client was incarcerated. However, gaps might exist when CJ offices have limited space for referral, which makes it non-conducive to conduct screening. The Screening and Assessment chapter will provide some innovative practices for assessment (e.g. providing incoming clients a self-administered screener with a tablet).

Service Referral

Agencies should aim to offer treatment to all individuals diagnosed with SUD and/or OUD unless treatment is not recommended due to medical considerations for that individual. Research on post-release opioid-related overdose risk shows that individuals reentering the community have a higher risk of opioid use and overdose due to many determinants (including chronic pain, disrupted social networks, poverty, etc.; Joudrey et al., 2019). Referrals can be disrupted due to lack of education among clients about MOUD treatment options or individuals' lack of access to post-release treatment as a result of transportation issues or insurance status at the time of release (Ferguson et al., 2019).

The Referral chapter will provide innovative options such as

- Tools to provide clients education at intake about available treatment programs
- Conducting focus groups to probe lack of interest in treatment
- Working with the state to suspend public insurance and reactivate it at the time of release
- Expanding state Medicaid enrollment
- Working with community providers to provide "bridge" services
- Ensuring there is an adequate release plan
- Having a warm handoff from the CJ sector to community providers

- Ensuring access to MOUD post-release with individuals having prescriptions for buprenorphine or equivalent in-hand when being released from a facility, if possible

Treatment Initiation and Continued Care

Upon release, all persons should receive an appointment for treatment and agencies should work together to ensure individuals attend the appointments. Gaps in service at the back end can come from many directions. Some examples include when a community provider engages an individual on community supervision in their first SU treatment appointments as if they've never received services; or when the supervision agent, post-release case manager, or the facility-based SUD treatment program provider lack coordination among their services; and in collaboration with the individual and the community provider.



Tip

The JCOIN O-TLM Resource Guide incorporates MOUD and SU indicators from several sources. **Continuity of Care Indicators Checklist (Appendix C)** compiles several performance measures into one universal set of benchmarks to help JCOIN participating communities (1) identify opportunities for improvement, (2) establish realistic targets for improvement, and (3) track improvement by monitoring the success of quality improvement initiatives.

Summary

There is value in using a universal service cascade to address system gaps among people using or at risk of using opioids. This chapter provided a cascade framework, along with discrete benchmarks as a checklist of quality indicators for MOUD/SU treatment. The following chapters will present innovative practices to address system breakdowns across the cascade, starting with a chapter on the importance of open communication across agencies serving individuals recently released from correctional facilities.

More information relating to the Opioid Services Cascade can be accessed using the links on the Useful Resources table on the following page.

Table 2.1 Useful Resources

Behavioral Health Services Cascade

This source illustrates an ideal set of sequential steps and measures along a cascade of services for youth on community supervision and in need of SU treatment. Benchmark sources include the National Commission on Quality Assurance, National Quality Forum, Office of National Coordinator of Healthcare Reform, and Office of Juvenile Justice and Delinquency Prevention.

Opioid Cascade of Care

This cascade has been utilized to develop national benchmarks to assess SAMHSA's State Targeted Response (STR) to the Opioid Crisis Grants using criteria documented in Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures designed to provide individuals with the information they need for comparison of health plans.

Substance Abuse and Mental Health Services Administration

This organization provides a variety of resources on the topics of substance use and mental health. In particular, this guide focuses on using MOUD in jails, prisons, and during reentry to the community (SAMHSA, 2019d). Additionally, there is an overview of policies and evidence-based practices that can be used to reduce the risk of overdose and relapse (SAMHSA, 2019d).

American Society of Addiction Medicine National Practice Guideline

This guideline, which is intended to inform and empower clinicians, health system professionals, CJ system executives, and policymakers who are interested in implementing evidence-based practices to improve outcomes for clients with OUD.

National Commission on Correctional Health Care

This organization, whose published guidelines introduce what has been learned from the sheriffs' and jail administrators' innovative use of MOUD, describes the essential components of these programs, and analyzes the latest research on how these programs are best implemented.

Office of the Assistant Secretary for Planning and Evaluation

The ASPE is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for activities in legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

CHAPTER 3

SCREENING AND ASSESSMENT

Introduction

The purpose of this chapter is to provide various best practice resources for screening and assessment of clients who have a substance use disorder (SUD) or opioid use disorder (OUD). The chapter describes screening and assessment procedures; important considerations that might be made prior to, during and shortly after admission to treatment; and assessment techniques and considerations that are important to ongoing medications to treat opioid use disorder (MOUD) (SAMHSA, 2005a).

The chapter concludes with critical factors that are important to assess during the screening and assessment process to help the criminal justice system and behavioral health providers advance their efforts to meet the outcomes they seek for the justice-involved population who struggle with SUDs and OUDs.

Chapter Objectives

- Why are best practices for screening and assessment important?
- General differences between screening and assessment
- Substance use screening and assessment tools
- Approaches to support screening and assessment practices
- Resources and best practices for specialized populations
- Screening and assessment in criminal justice facilities
- Screening and assessment in opioid treatment programs (OTP)
- Additional screening and assessment factors

Best Practices for Screening & Assessment

The prevalence of substance use among justice-involved populations puts them at an increased risk of mental health issues (Tapia et al., 2016), sexually transmitted infections (Donenberg et al., 2015), and criminal recidivism (Henggeler et al., 2002). The criminal justice system is in a position to prevent, identify, and treat SUDs among this vulnerable population (Wiese, 2020). Administration of an evidence-based screening instrument is the first step in identifying individuals with SUD as

indicated by the Behavioral Health Services Cascade (Belenko et al., 2017).

Screening is the first opportunity for criminal justice staff and treatment providers to establish an effective therapeutic collaborative among staff members, clients, and the client's family (SAMHSA, 2005a). Including new clients and their families in the planning process contributes to positive treatment outcomes (SAMHSA, 2005a). Using this process, staff members will be able to provide immediate, practical information to help clients make decisions about treatment, including the approximate length of time before admission, what to expect during the admission process, and the types of services offered (SAMHSA, 2005a). Exploration of clients' expectations and circumstances may reveal additional information the client needs for treatment consideration (SAMHSA, 2005a).



Helpful Tip from TIP 43

Initial screening can begin to identify other medical and psychosocial risk factors that could affect treatment, including factors related to mental disorders; legal difficulties; other substance use; and vocational, financial, transportation, and family concerns. Cultural, ethnic, and spiritual factors that affect communication and might affect treatment planning should be noted as early as possible. Staff members should obtain enough information from applicants to accommodate needs arising from any of these factors if necessary. (p. 44)

Reference

Substance Abuse and Mental Health Services Administration. (2005a). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: A Treatment Improvement Protocol (TIP) 43*. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK64164/>

Individuals given a screening tool and scoring above a certain threshold will receive a comprehensive assessment (Wiese, 2020). Assessments should be conducted before clients are given permanent placements (in correctional facilities) or referred to community behavioral health providers (Wiese, 2020). The assessment is instrumental in defining the nature of the problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis (SAMHSA, 2015b).

The important elements for assessing clients prior to receiving substance use and/or MOUD treatment are not currently captured in a single tool (SAMHSA, 2005a). For instance, the Addiction Severity Index (ASI; McLellan et al., 1992) can guide the collection of the basic information needed to objectively measure client conditions and progress (SAMHSA, 2005a). Assessments influence treatment planning, treatment intensity and services needed (e.g., treatment planning and matching), and reentry and continuing care plans (SAMHSA, 2005a). It is recommended that substance use treatment providers and opioid treatment programs (OTPs) develop tools and processes for more extensive assessment (SAMHSA, 2005a).

Screening and assessments are also pivotal in identifying legal issues that might interrupt treatment or have an impact on community supervision compliance (SAMHSA, 2005a). However, pending or unresolved charges should not impede SUD treatment (SAMHSA, 2005a). While screening and assessments are central in identifying various risks and needs, justice-involved individuals are often not screened or administered an assessment; consequently, many do not have their needs identified.

Differences Between Screening & Assessment

Criminal justice systems and behavioral health providers utilize the screening process to determine whether an individual needs treatment for SUD and/or OUD. Screening and assessment tools differ in many ways, discussed in detail below. The most significant difference is that screening tools are designed to be easily and quickly administered. Screening tools are intended to identify potential problems that warrant a deeper investigation and understanding, which is done via assessment tools. Assessment tools are more complex and require more time to administer.

The **screening** process involves asking questions designed to determine whether a more thorough evaluation of a problem or disorder is needed (SAMHSA, 2015b). Screening and the screening process should have the following characteristics:

- Efficiently (brief instrument) and reliably identifies problems that were previously not identified
- Can indicate a problem is possible, but not absolutely present (Marks et al., 2019)
- Should be administered to all clients being processed
- The screening process should begin when an individual is first placed under correctional custody or supervision, or enters a treatment program
- Little or no special training is needed to administer the tool (clinician review may sometimes be needed; SAMHSA, 2015b)
- Additional screening should be conducted when the individual is released into the community (either by the facility or at their first community supervision appointment), and again when the client is referred to a CBH provider
- The screening results generate clear decision-making rules (i.e., where and for what purposes a client is referred for additional clinical assessment; Belenko et al., 2017).



Helpful Tip from TIP 44: Collateral Information

In addition to administering an evidence-based instrument to screen for substance use problems, biological testing (e.g., urine) should also be used to screen for substance problems. Additional collateral sources of information should be obtained (e.g., drug test results, correctional records) and combined with client self-reported information to make referral decisions. This will help overcome the barrier of contradictory or incomplete substance use problem client information. For example, drug tests are used to flag treatment needs despite client denial of recent substance use. Similarly, criminal records may indicate a history of substance use problems, based on arrest history or pre-sentence investigation results.

Reference

Substance Abuse and Mental Health Services Administration. (2005b). Substance Abuse Treatment for Adults in the Criminal Justice System: A Treatment Improvement Protocol (TIP) 44. <https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4056.pdf>.

Assessments support diagnosis, placement, and treatment planning related to OUD or other SUDs and related problems.

- Comprehensive and multidimensional assessments should identify behavioral health symptoms and diagnoses, treatment history of behavioral health problems and opioid use problems, psychosocial history, and barriers to care. Some of these factors are discussed later in this chapter.

- Most clinical assessments should be conducted by a trained clinical professional.
- Information gathered from the assessment (and screening instrument) should be used to determine the frequency, intensity, and type of treatment services provided to the individual (SAMHSA, 2015b).

Assessment tools may include exploration of personal circumstances such as child custody and related obligations (SAMHSA, 2005a). Client avoidance of legal problems during periods of substance use may pose a serious threat to recovery (SAMHSA, 2005a). A client's CJ history should be clarified through the assessment process (SAMHSA, 2005a). Information on prior CJ involvement may include a client's arrest record, including age at first arrest, arrest frequency, nature of offenses, criminal involvement during childhood, and life involvement with the CJ system (SAMHSA, 2005a). The following areas should be assessed:

- Periods of abstinence from SU (e.g., number, duration, circumstances)
- Circumstances or events leading to relapse
- Effects of SU on physical, psychological, and emotional functioning
- Changing patterns of SU, withdrawal signs and symptoms, and medical problems that have been caused by a SUD or OUD (SAMHSA, 2005a).

Substance Use Screening & Assessment Tools

Table 3.1 - 3.2 provides a select number of screening and assessment tools that have been used in various clinical (e.g. ER admissions, outpatient services), community, and correctional settings. These validated tools vary in length, which could be appropriate to quickly screen and assess the needs of clients that are suspected to have an OUD and/or other SUDs. Links to the full tools included in this chapter have been published in peer-reviewed journals and have been approved for reproduction.

Table 3.1 SCREENING TOOLS

TAPS Tool

"The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool consists of a 4-item screening and brief assessment (a modified version of the ASSIST-Lite (Ali et al., 2013)). This instrument is used to assess primary care clients for tobacco, alcohol, prescription drug, and illicit substance use and problems related to their use, and is available for self-administration and interviewer-administration to detect substance use, sub-threshold SUD (i.e., at-risk, harmful, or hazardous use), and SUDs. The TAPS Tool was developed and validated so that health systems will have the option of using either a screen or a combined screen and brief assessment tool, as directed by the needs of their client populations and clinical settings (McNeely et al., 2016). The instrument is available for use in the public domain; research was supported by the National Institute on Drug Abuse" (McNeely et al., 2016; Instrument: TAPS Tool).

Opioid Risk Tool

"The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult clients in primary care settings to assess the risk for opioid abuse among individuals prescribed opioids for the treatment of chronic pain. Clients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female clients, but not in non-pain populations" (Webster & Webster, 2005).

Rapid Opioid
Dependency Screen
(RODS)

"The RODS is an 8-item measure of opioid dependence designed for quick, targeted screening in clinical and research settings. Based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria, the RODS has an average administration time of less than 2 minutes and can easily be administered as a stand-alone instrument or as part of a comprehensive interview" (Wickersham et al., 2015). **Note:** This instrument was validated among HIV+ individuals in the correctional intake process.

The Risk and Needs
Triage (RANT)

"The RANT® tool yields an immediate and easily understandable report that classifies offenders into one of four risk/needs quadrants, each with different implications for selecting suitable correctional decisions by judges, probation and parole officers, attorneys, and other decision-makers. RANT can be administered rapidly and easily: The 19-item instrument can be completed in less than 15 minutes. It can be completed by non-clinically trained probation officers or case managers with relatively minimal training. The user-interface consists of simple-to-read input screens that present each item one at a time. Clearly worded help menus describe the intent of each item" (Treatment Research Institute, 2015, p. 2).

Alcohol, Smoking, and
Substance Involvement
Screening Test (ASSIST)

The ASSIST (version 3.1) is an 8-item, pen and paper questionnaire designed by the World Health Organization. It is administered by a health worker to a client that takes about 5-10 minutes to complete. The ASSIST was designed to be culturally neutral and screens for: tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, sedatives, hallucinogens, inhalants, opioids, and other illicit drugs (Humeniuk, et al., 2010).

Simple Screening
Instrument for Substance
Abuse
(SSI-SA)

"The SSI-SA is a 16-item screening instrument that examines symptoms of both alcohol and drug dependence. An expert panel developed the SSI-SA as a tool for outreach workers. The SSI-SA, which can be administered without training, includes items related to alcohol and drug use, preoccupation and loss of control, adverse consequences of use, problem recognition, and tolerance and withdrawal effects" (SAMHSA, 2005b, p. 19).

CAGE-AID

The CAGE-AID is a modified version of the CAGE screening. CAGE stands for parts of each question in the tool: Cut down, Annoyed, Guilty, and Eye-opener. The CAGE screens solely for alcohol while CAGE-AID screens for alcohol and drugs (which is inclusive of a variety of substances). This tool is only four questions long and can be self-administered by clients. CAGE-AID can be administered electronically, by paper, or verbally by staff and has been used with both adolescents and adults.

Texas Christian University Drug Screen and Opioid Supplement (TCUDS 5)

The Texas Christian University Drug Screen and Opioid Supplement (v5) is a brief and free evidence-based screening instrument available for identifying SUDs among both adolescents (Knight, Becan, Landrum, Joe, & Flynn, 2014; Wiese, Blue, Knight, & Knight, 2019) and adults (Knight, Blue, Flynn, & Knight, 2019). The scoring guide is available [here](#). The TCUDS 5 is based on clinical diagnostic criteria established in the Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5).

Table 3.2 ASSESSMENT TOOLSTAPS Tool

The TAPS Tool includes both a screening instrument and a brief assessment tool.

Addiction Severity Index (ASI)

"The ASI is most useful as a general intake screening tool. It effectively assesses a client's status in several areas, and the composite score measures how a client's need for treatment changes over time. The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or treatment systems are available. Designed for adults of both sexes who are not intoxicated (drugs or alcohol) when interviewed. Also available in Spanish. The ASI has been used with males and females with drug and alcohol disorders in both inpatient and outpatient settings" (SAMHSA, 2005b, p.303).

RIOSORD Risk Index

Risk Index for Overdose and Serious Opioid-Induced Respiratory Depression (RIOSORD) is a risk-stratification tool developed and validated within the veteran population. The 17-item assessment should be administered by a health care professional due to specific questions on the client's maximum opioid and morphine tolerance. The index score is presented with the calculated risk for opioid overdose.

Structured Clinical
Interview for DSM-5
(SCID-5).

The SCID-5 covers the DSM-5 diagnoses most commonly seen in clinical settings: depressive and bipolar disorders; schizophrenia spectrum and other psychotic disorders; substance use disorders; anxiety disorders (panic disorder, agoraphobia, social anxiety disorder, generalized anxiety disorder); obsessive-compulsive disorder; posttraumatic stress disorder; attention-deficit/hyperactivity disorder; and adjustment disorder. It also screens for 17 additional DSM-5 disorders.

Global Appraisal of
Individual Needs -- Initial
(GAIN-I).

The GAIN-I is a comprehensive bio-psychosocial assessment designed to support clinical diagnosis, placement, treatment planning, performance monitoring, program planning and economic analysis. It is designed to be used primarily in clinical settings.

Resources to Support Screening & Assessment Practices

This section provides evidence-based screening and assessment resources that could assist CJ and BH treatment providers.

Table 3.3. APPROACHES TO SUPPORT SCREENING AND ASSESSMENT

Treatment Improvement
Protocol (TIP) Series,
No. 43

(See Chapter 4)

Chapter 4: Initial Screening, Admission Procedures, and Assessment Techniques - This chapter provides information on Initial Screening; Admission Procedures and Initial Evaluation; Medical Assessment; Induction Assessment and Comprehensive Assessment on establishing a client's readiness for medication treatment for OUD (MOUD) and admission to an opioid treatment program (OTP).

TIP Series, No. 43

(See Chapter 12)

Chapter 12: Treatment of Co-occurring Disorders – This chapter summarizes current thinking and consensus panel recommendations on screening, diagnosing, and treating clients in OTPs. This chapter expands on a number of screening and assessment factors including but not limited to specific screening procedures; screening for cognitive impairment; screening tools; and the making and confirming of psychiatric diagnoses.

TIP Series, No. 43

(See Chapter 9)

Chapter 9: Drug Testing as a Tool – This chapter provides an analysis of drug testing as it relates to providing guidance for its use in OTPs. The chapter expands on the following topic areas: the Purposes of Drug Testing in OTPs; Benefits and Limitations of Drug Tests; Drug-Testing Components and Methods; Development of Written Procedures; Other Considerations in Drug-Testing Procedures; Interpreting and Using Drug Test Results; Reliability, Validity, and Accuracy of Drug Test Results.

Police Assisted and
Addiction Recovery
Initiative (PAARI)

This is a website for law enforcement agencies to develop non-arrest pathways to treatment and recovery. This may be useful for developing programs where individuals are taken to treatment environments rather than being arrested.

NarxCare

A SUD platform for prescribers and dispensers. Data is obtained from a PDMP and analyzed against medical history to provide a risk score. Prescribers can also review usage patterns and share information with other providers to coordinate care. Provider-prompted screening (i.e., not triggered by automated protocol or EHR prompt).

Prescription Drug
Monitoring Program
(PDMP) Systems

PDMPs are state-run and can be useful in monitoring individuals with suspected SUD/ODU and can also highlight additional risk factors.

Providers Clinical
Support System (PCSS)
SUD 101 Core
Curriculum

PCSS is a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) created in response to the opioid overdose epidemic to train primary care providers in the evidence-based prevention and treatment of OUDs and treatment of chronic pain. The PCSS curriculum is for healthcare providers spanning prevention, assessment, and treatment of SUDs and co-occurring mental health disorders. The curriculum includes 22 modules (approximately 1 hour each) and offers free inter-professional continuing education credits.

Assessing Opioid
Withdrawals

(Leavitt et al., 2000)

"Validated clinical scales that measure withdrawal symptoms may be used to assist in the evaluation of clients with opioid use disorder... Assessment of a client undergoing opioid withdrawal management should include a thorough medical history and physical examination, focusing on signs and symptoms associated with opioid withdrawal. Opioid withdrawal can be diagnosed with client-reported subjective symptoms" (Cunningham, et al., 2020).

HRSA Home Visiting
Program

HRSA resource describes how to support families who are affected by OUD and neonatal abstinence syndrome through home visiting programs. Provides a description of how to assess postpartum women and families.

[SAMHSA "Now What? The Role of Prevention Following a Nonfatal Opioid Overdose"](#)

This is a 9-page document that describes Emergency Department screening and the use of non-fatal overdose as a way to identify individuals for intervention.

[State of Ohio Board of Pharmacy Guidance for Law Enforcement](#)

This site includes links to the Ohio Law Enforcement Gateway (OHLEG), which is an electronic information network that allows Law Enforcement to share criminal justice data.

[Screening for at-risk alcohol and drug use in an emergency department](#)

(Johnson et al., 2013)

Electronic Health Record (EHR)-Prompted Screening and Automated Algorithms

- Three single-item screening questions were programmed into the triage EHR tool.

Clients who answered positively had their information automatically forwarded to education specialists who then provided the intervention and referrals.

For additional tools and resources available for providers and clients who offer or use MOUD services, see [this page](#) or [this guide](#) by the Agency for Healthcare Research and Quality (AHRQ).

[SAMHSA](#) provides several sources for communities, clinicians, policymakers, and others to find information and tools to incorporate evidence-based practices into their communities or clinical settings.

Resources and Best Practices for Specialized Populations

Risk and needs assessments can be used as a tool for more effective and fairer criminal-legal system processing. These assessments lead to more effective sentences by helping to tailor services to the risk and needs of justice-involved individuals in ways that will reduce their likelihood of recidivism while increasing their likelihood of living socially productive lives (Bonnie et al., 2013). Additionally, research suggests that when discretion is guided by tools that structure court actors' discretion, inequality decreases (King & Light, 2019; Skeem & Lowenkamp, 2016).

There has been a recent renewed emphasis on meeting the therapeutic needs of those in the custody of the CJ system. This has placed the CJ system in a position of struggling to provide effective services, with limited resources, to a large number of clients in the system. In response to the recent rise of opioid use cases, the CJ system seeks best practices to assist in its efforts to address this need (National Institute of Corrections, 2020). **Table 3.4** of this section provides a list of best practices and resources that have proven effective in assisting justice-involved populations who suffer from

SUDs or OUDs. This section also provides resources that can be utilized to train staff working with justice-involved clients with SUD or OUD. Clicking on the various links below will guide you to the full resource documents, video-clips, or reports.

Table 3.4. RESOURCES AND BEST PRACTICES FOR SPECIALIZED POPULATIONS

[Guide for Probation and Parole: Motivating Offenders to Change](#)

This guide provides CJ professionals with a solid foundation in the principles behind Motivational Interviewing (MI) as well as a practical guide for applying MI principles in their everyday interactions with clients. Through numerous examples and exercises, this guide presents techniques for interacting with clients at all stages of supervision. In addition, this publication recognizes that deception, resistance to change, and relapse into criminal behaviors are realities for many clients. Therefore, strategies are set forth for dealing with those issues that lead to unproductive confrontations with the client (Walters, et al., 2007).

[Offender Risk & Needs Assessment Instruments: A Primer for Courts](#)

This publication explains: what risk and needs assessment (RNA) instruments are and reasons for using them; examples of six RNA instruments and how they differ; what the qualities of good RNA instruments are; the practices which support the sound implementation of RNA instruments; and the practical considerations in selecting and using RNA instruments. An appendix provides profiles of RNA instruments. "Practitioners use risk assessment information to inform decisions at various points in the criminal justice system. The Primer is written for judges, policy-makers, and other practitioners interested in the use of RNA information at sentencing for the purpose of informing community corrections-related decisions regarding the management and reduction of offender recidivism risk. It focuses on RNA instruments designed specifically to inform these community corrections-related decisions" (Casey et al., 2014, p.2).

[Successful Parole and Probation Practices](#)

This video shows an interview with four directors of state parole and probation agencies who attended a conference at the National Institute of Corrections (NIC) in Washington, DC. These directors shared what worked to complete cases successfully while also working toward protecting public safety.

["Opioid Addiction Screening and Assessment for People in the Criminal Justice System"](#)

During this webinar, Dr. Roger Peters of the University of South Florida reviews screening and assessment instruments as well as discusses instrument selection and specific considerations for identifying and assessing people who have opioid use disorder.

Risk and Needs
Assessment in the
Criminal Justice System

Sections of this report include a summary of the following:

- an overview of risk and needs assessment
- RNR principles
- critiques of risk and needs assessments—making a judgment about individuals based on group averages, the separation of assessment of risk from assessment of needs, and the potential for discriminatory effects

Additionally, there are select issues for congress regarding:

- the use of risk and needs assessment in federal prisons
- the exclusion of certain inmates from earning additional time credits, whether priority should be given to high-risk offenders
- the use of assessment in sentencing
- whether the emphasis on punishment should be decreased.

Treatment Improvement
Protocol (TIP) Series,
No. 44

Substance Abuse Treatment for Adults in the Criminal Justice System: This TIP provides tools and resources to increase availability and improve the quality of substance use treatment for justice-involved individuals. This publication should assist the CJ system in meeting the challenges of working with clients with substance use disorders and encourage the implementation of evidence-based approaches to treatment, such as best practices in the screening and assessing of justice-involved individuals.

Prescription Drugs of
Abuse and Misuse: An
introduction for the
correctional environment

This presentation helps in identifying the typical drugs used within the correctional setting; provides the justice system information to assist in predicting the likelihood of substance use; and recommends drug use and misuse mitigation strategies for correctional environments.

Screening & Assessment in Specialized Facilities

Criminal Justice Facilities

Every individual entering or released from incarceration should be administered a substance use screening in a timely manner using an evidence-based screening tool that provides clinically meaningful results to indicate the severity of OUD and other SU problems. Screening should be conducted as early as possible after the individual's placement under correctional custody or supervision. The screening should be used to flag the justice-involved client for further intervention and a referral to treatment.

Once a client is referred for substance use treatment, a comprehensive assessment will be administered. Conducting an assessment may be delayed due to the individual's sentence length, anticipated date of enrollment in substance use treatment services, and other factors (SAMHSA, 2005b). For example, most prison treatment programs provide services for justice-involved individuals

serving the last 24 months of their sentence. In this sense, a comprehensive assessment is delayed until the offender is nearing the enrollment date for treatment services (SAMHSA, 2005b). While staff do not need formal training to conduct screenings, clinical staff with appropriate training should administer assessments and provide related diagnoses and treatment plan recommendations (SAMHSA, 2005b).

Opioid Treatment Programs (OTP)

SAMHSA regulations require that clients accepted for treatment at an OTP should receive an initial assessment and periodical assessments by qualified staff to determine the most appropriate treatment services (SAMHSA, 2005a; SAMHSA & HHS, 2012). An OTP is a program or practitioner engaged in the treatment of individuals with an OUD registered under 21 U.S.C. 823(g)(1). OTPs must be certified through a means by which SAMHSA determines that an OTP is qualified to provide opioid treatment under the Federal opioid treatment standards described in §8.12. To learn more about OTP services, see the Treatment chapter of this manual.

The results of a client's screening and intake help determine a client's eligibility and readiness for MOUD and admission to an OTP. Periodic assessment should begin once a client is admitted to an OTP. This provides a basis for individualized treatment planning and increases the likelihood of positive outcomes (SAMHSA, 2005a). The following goals for initial screening are recommended:

- **Crisis intervention.** The identification and immediate assistance with crisis and emergency situations
- **Eligibility verification.** Determining that the client meets the Federal and State regulations and program criteria for admission to an OTP
- **Clarification of the treatment alliance.** Explanation of client and program responsibilities
- **Education.** Communication of essential information about MOUD and OTP operations and discussion of MOUD to help clients make informed decisions about treatment
- **Identification of treatment barriers.** Determining factors that might prevent a client to meet treatment requirements. For example, lack of childcare or transportation.

Referrals for urgent medical or psychiatric problem(s) - including drug-related impairment or overdose - should be given clinical priority (Cunningham et al., 2020). Criminal justice agencies and community treatment providers should work to create medically, legally, and ethically sound policies and procedures to address client emergencies (SAMHSA, 2005a). Emergencies can occur at any time but are most common during induction to MOUD and the acute treatment phase (SAMHSA, 2005a). Clients who could jeopardize the safety of themselves or others should be referred for inpatient or psychiatric care (SAMHSA, 2005a). If possible, the same staff members who conduct initial screening and assessment should make additional referrals before clients are admitted to an OTP (SAMHSA, 2005a). Staff should be familiar with components of a mental health status examination in cases of identifying and assessing emergencies (SAMHSA, 2005a).

Cases of Uncertainty: When an incomplete account of treatment history or withdrawal symptoms creates uncertainty about a client's eligibility, OTP staff should ask clients for additional means of verification, such as criminal records involving the use or possession of opioids or their probation or parole officer's knowledge of the client's substance use (SAMHSA, 2005a). Community supervision officers should reach out to OTP staff after a referral is made to ensure they have all relevant information regarding the client's criminal and substance use histories. A formal statement from the client's family or clergy member who can attest to an individual's opioid abuse might also be advantageous (SAMHSA, 2005a).



Note: Naloxone

A naloxone (Narcan®) challenge test (SAMHSA, 2005a) is not recommended for use in cases of uncertainty. The naloxone challenge test as indicated by SAMHSA (2005a) is a "test in which naloxone is administered to verify an applicant's current opioid dependence and eligibility for admission to an OTP" (p. 289). Using the naloxone challenge test causes the individual to almost immediately experience severe withdrawal symptoms, which is unnecessary (SAMHSA, 2005a). It also requires invasive injection, and the effects can disrupt or jeopardize prospects for a sound therapeutic relationship with the client. It is recommended that naloxone be reserved to treat opioid overdose emergencies.

Physical dependence on opioids can be demonstrated by less drastic measures. For example, a client can be observed for the effects of withdrawal after he or she has not used a short-acting opioid for 6 to 8 hours. Administering a low dose of methadone and then observing the client is also appropriate.

Reference

Substance Abuse and Mental Health Services Administration. (2005a). Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: A Treatment Improvement Protocol (TIP) 43. <https://www.ncbi.nlm.nih.gov/books/NBK64164/>

Additional Screening & Assessment Factors

When utilizing screening and assessments in either venue (institutional corrections or community) to identify the treatment needs of the client, the process should fully screen and assess additional factors that may be critical to the client's success in treatment because these client-specific characteristics may contribute to relapse or criminal recidivism after treatment (SAMHSA, 2005b). Gathering information regarding these critical factors and others could be instrumental for community supervision officers and treatment providers to better serve their clients. This section lists some of the factors; later chapters will provide tools and resources to help address client needs at the point of referral and treatment.

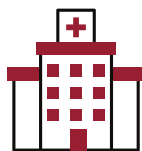
Social Determinants of Health

The CDC defines the social determinants of health as "the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes" (CDC, 2022b). The social determinants of health can be split into a few different categories: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.



Economic Stability:

job opportunities, income, socioeconomic status, and credit status



Healthcare Access:

Availability of health care specialists, quality of health care, and the proximity of hospitals



Education Access:

literacy and school curriculum



Neighborhood & Built Environment:

housing, air and water quality, safe neighborhoods, and proximity to grocery stores



Social & Community Context:

discrimination, racism, sexism, and social support

Reference

Centers for Disease Control and Prevention. (2022b). Social determinants of health at CDC. *About CDC*. <https://www.cdc.gov/about/sdoh/index.html>

Note that some factors are more important to address early on than others. Clients should not be expected to tackle all these factors immediately upon release. Start by addressing the most critical barriers affecting recovery, and less urgent factors can be addressed later in the treatment process. Communication and collaboration between community supervision officers and community behavioral health providers are essential to ensure consistency for the client in overcoming these barriers.

Factor 1: CULTURAL BACKGROUND AND ETHNICITY DIFFERENCES

Tools for screening and assessment have primarily been evaluated for validity and reliability with two populations—Caucasians and African Americans (SAMHSA, 2015b). Although these instruments may have been translated for non-English-speaking populations, they are often not further tested for validity. Furthermore, questions about personal habits can be considered invasive in some cultures (SAMHSA, 2015b; Paniagua, 1998). Taking a perspective of cultural relevance and strengths will help to better understand how a client's culture may influence screening and assessment results and processes (SAMHSA, 2015b). Acceptance and acknowledgement of a client's cultural influence on health beliefs, illness behaviors, and attitude towards treatment types will provide a firm foundation for successful treatment planning (2015b).

Some racial and ethnic groups differ dramatically on most of the factors discussed below, and racial and ethnic minorities face more barriers to successful treatment. Additionally, there are other differences that can impact treatment, such as trust in institutions, such as the legal system. Addressing these barriers can increase treatment access and success and reduce inequality.

Factor 2: FAMILY, RELATIONSHIPS, AND SUPPORTS

Substance use effects more than just the client themselves; these effects extend to the client's family as well (SAMHSA, 2005a). Therefore, there should be some expectation of family problems for clients entering treatment (SAMHSA, 2005a). SAMHSA (2005a, p.56) suggests, "The comprehensive assessment should include questions about family relationships and problems, including any history of domestic violence, sexual abuse, and mental disorders." These questions regarding a history of family problems are meant to determine adverse childhood experiences, ACEs. ACEs are potentially traumatic events that occur in childhood (0-17 years), such as witnessing violence or substance misuse in the home (CDC, 2022a). The long term effects of ACEs include chronic health problems, mental illness, and substance misuse in adulthood, and early death (CDC, 2022a).

If possible, family members and significant others should be included or asked for input in the assessment process (SAMHSA, 2005a). It is beneficial to have at least one staff member trained in family therapy as part of this family assessment process (SAMHSA, 2005a). This will be helpful when emotions arise relating to the client's substance use. Additionally, the trained staff member will be able to refer the client for more specialized assistance for this family intervention (SAMHSA, 2005a).



A Note from TIP 43

Family types and structures differ for each client and the situation in which they grew up and currently live. Staff members administering assessments should be conscious of varying family types during this process (SAMHSA, 2005a). For example, programs with a large single parent population could consider onsite childcare assistance while the client is being helped (SAMHSA, 2005a). These structured childcare services also give staff the opportunity to observe and assess a client's family functioning, which can be used in the treatment planning process (SAMHSA, 2005a).

References

Substance Abuse and Mental Health Services Administration. (2005a). Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: A Treatment Improvement Protocol (TIP) 43. <https://www.ncbi.nlm.nih.gov/books/NBK64164/>

Factor 3: HOUSING STATUS AND SAFETY CONCERNS

A study in Boston (Baggett et al., 2013) showed that drug overdose was the leading cause of death among homeless adults, surpassing the number of deaths caused by HIV. Of those drug overdose deaths, opioids were responsible for 80%. Homeless adults (aged 25-44) were nine times more likely to die from an overdose than adults with stable housing (Baggett et al., 2013).

Clients in MAT who are not homeless sometimes live with people who use substances or in areas where SU is common (SAMHSA, 2005a). A client's housing needs should be determined early on in the screening and assessment process and lead to an arrangement of safe, permanent housing to assist in the treatment process (SAMHSA, 2005a). Collaboration and formal agreements between CJ staff, the OTPs they work with, housing agencies, and other housing programs in the community would be beneficial in connecting clients to housing (SAMHSA, 2005a).

Factor 4: SOCIOECONOMIC STATUS AND RESOURCES

The screening and assessment process should help in determining the client's ability to cover treatment costs and which treatment types may be covered by insurance, if any (SAMHSA, 2005a). Clients may be uninsured or have no knowledge of payment assistance available to them (SAMHSA, 2005a). CJ staff and OTPs should assist clients in determining various payment options so the client may have access to a variety of treatment services while also ensuring payment to the OTP (SAMHSA, 2005a). Should public assistance be available, CJ staff and OTP staff may assist the client in applying for funds (SAMHSA, 2005a). The same is true for assisting the client in determining insurance reimbursement for MOUD costs (SAMHSA, 2005a). Overall, OTP staff can help the client weigh the benefits and drawbacks of involving their insurance company as well as address the client's fears of their substance use being outed to employers or denial of health care benefits by their insurance (SAMHSA, 2005a).

Factor 5: EMPLOYMENT HISTORY

In 2015, prescription painkiller abuse was nearly twice as high among unemployed Americans compared to full-time workers (Medicaid and CHIP Payment and Access Commission, 2017). Unemployment rates are strongly related to rates of OUD. In 2017, the National Bureau of Economic Research found that opioid death rates increased by 3.6% for every 1% increase in county unemployment rates (Hollingsworth et al., 2017). Employed clients may report substance-related difficulties in the workplace before becoming stabilized on MOUD (SAMHSA, 2005a). Some of these difficulties include lack of concentration, tardiness, difficulty cooperating with coworkers, workplace accidents, and increased claims for workers' compensation (SAMHSA, 2005a). Identification of these difficulties during the assessment process may help staff and clients enable more successful treatment planning (SAMHSA, 2005a).

Employed clients should be encouraged to treat their substance use similarly to other clinical illnesses (SAMHSA, 2005a). These clients may be reluctant to utilize residential treatment or take time for the effects of medication to stabilize (SAMHSA, 2005a). Clients should be encouraged to take leave time as necessary for residential treatment and/or medication stabilization (SAMHSA, 2005a).

Factor 6: CLIENT'S ABILITY TO MANAGE MONEY

Clients should be assessed for socioeconomic status and money management skills to help them determine areas of strengths and improvements (SAMHSA, 2005a). Clients looking to turn their lives around may experience a loss of income caused by reduced criminal activity (SAMHSA, 2005a). Though this may be hard for the client to experience, CJ and BH staff can encourage clients to develop skills to increase their earning power (SAMHSA, 2005a). Clients may feel more financially prepared once they have worked with CJ and BH staff to recognize and strategize for their financial goals (SAMHSA, 2005a).

Factor 7: RECREATIONAL AND LEISURE ACTIVITIES

Recreational and leisure activities are opportunities for clients to create positive friendships and lead to a more successful recovery (SAMHSA, 2005a). The assessment process should determine which

activities, if any, the client is involved in or interested in being involved (SAMHSA, 2005a). Encouraging and fostering hobbies with others can be significant in living a recovery-oriented lifestyle (SAMHSA, 2005a).

Factor 8: RISK FOR RELAPSE AND OVERDOSE

Clients are particularly vulnerable to relapse in the weeks following release from CJ settings (Cunningham, 2020). Staff should work with clients to assist and identify barriers a client may face after incarceration. This individualized, pre-release planning may help clients sustain their recovery efforts while also utilizing resources available in the community (Cunningham, 2020).

Factor 9: TRANSPORTATION

In a study conducted by the National Reentry Resource Center (2018), transportation is noted as a key screening target, particularly for the justice-involved population. Many justice-involved clients live in rural areas that are often not equipped with the necessary treatment providers. Identifying this need at the onset is imperative to the continuum of treatment after incarceration. This factor has become a driving force for community and criminal justice providers to explore technology-assisted treatment methods to ensure successful outcomes long-term.

Factor 10: GENDER DIFFERENCES

When utilizing screening and assessment tools that have been validated with the male population, these tools should also be examined for their appropriateness for use with the female population. Screening and assessment tools should be equipped to gather information on factors such as child custody history, trauma, and physical and sexual abuse history (SAMHSA, 2005b).

Summary

Screenings are easy and quick and should be administered to everyone; many of these are free and immediately accessible with little training required.

SUD and/or OUD assessments are more time-consuming and require unique interviewing skills and clinical knowledge; however, these do not need to be administered to everyone, only those who exhibit a high level of potential need based on the screening results. The assessment process is an ongoing evaluation of the client's needs and changing circumstances and drives the treatment process. Information and collaboration between all parties involved with the client are essential for maximum effectiveness in the SUD/ODU treatment process.

Between the Risk & Needs Assessment done by community corrections officers and institutional corrections staff, and SUD/ODU assessment done by treatment providers, there are a lot of common factors that contribute both to success under supervision and success in treatment. Recognition of this, and collaboration to address the factors/barriers that may reduce success in both areas, is critical to improving outcomes. The ability to effectively communicate between these two service systems (probation/parole and treatment) using some shared language and shared information creates a synergy that can support client success in both realms.

CHAPTER 4

REFERRALS

Introduction

This chapter aims to provide resources to assist communities in building capacity for promoting justice-involved individuals' linkages to substance use treatment services. Based on system needs, these resources may be useful for corrections staff, community behavioral health (CBH) providers, and medications for opioid use disorder (MOUD) clinicians.

Criminal justice (CJ) systems and CBH providers share a responsibility to ensure justice-involved individuals are positioned to achieve success, sustain recovery, and maintain a drug- and crime-free lifestyle. To this end, CJ staff and behavioral health (BH) staff should identify the factors that impact these areas and offer guidance to maximize the referral process. Making referrals that will sufficiently support justice-involved individuals starts with agency staff possessing a working knowledge of the resources available for CJ systems and BH organizations. This level of understanding can enhance an organization's ability to provide evidence-based services and establish a foundation based on best practices for connecting clients to services.

Chapter Objectives

1. Discuss primary indicators associated with promoting the justice-involved individuals' linkage to community-based substance use services. This chapter presents three primary indicators as essential elements of the referral process that ideally would be present to ensure continuity of care. Primary indicators include:
 - Refer the justice-involved individual with a substance problem to treatment services.
 - Select a treatment option that addresses the justice-involved individual's specific level and type of need.
 - Encourage the justice-involved individual to access treatment after a referral is made using active referral practices.
2. Discuss secondary indicators as quality indicators for each primary indicator to promote treatment referral.
3. Discuss practical applications for each primary indicator to provide the CJ system and CBH organizations with a quick review of processes that can augment current services or be implemented as new practices to better support the SUD/OD justice-involved individuals.
4. Provide a resource appendix by category that can be used by CJ, BH, and other community organizations to enhance efficacy, build skill sets, and improve outcomes for the justice-involved SUD/OD individual.

Refer the Justice-Involved Individual with a SUD to Treatment Services

Within this indicator, it is imperative to align the decision to refer a justice-involved individual to treatment with information gathered during the screening and assessment process to ensure an accurate and timely referral is made.

Supporting secondary indicators include:

- Initiating referrals as soon as possible after justice-involved individual needs have been identified.
- Continuing the treatment of substance use disorders at the time of community reentry.
- Continuing treatment of opioid use disorders at the time of community reentry.
- Referring justice-involved individuals to treatment providers that are accredited by the state or a national accreditation agency.
- Referring justice-involved individuals to treatment providers that use evidence-based practices.
- Providing the justice-involved individual with the treatment provider's contact information (phone number, address).

Practical Applications of the Indicators:

- Develop Memorandums of Understanding (MOUs) or contracts among collaborating agencies that strengthen the referral process among the CJ staff and BH providers.
- Implement referral teams that are inclusive of key stakeholders, including case management, clinical (CJ and BH), and supervision staff.
- Create a multidisciplinary oversight team composed of CBH staff and CJ staff, to review, develop, and implement policies around service delivery.

Select a Treatment Option that Addresses the Justice-Involved Individual's Specific Need

This indicator focuses on decisions made after the determination of the justice-involved individual's need for treatment services has been established. Referring systems should ensure the justice-involved individual is referred to the right type and level of treatment to meet the justice-involved individual's particular needs. As an example, justice-involved individuals may have similar drugs of choice, but the dynamics that lead to their use may differ, in which case, making an informed decision of what level of treatment will best benefit the justice-involved individual becomes key. In addition to establishing the justice-involved individual's level of treatment, it is important to evaluate their ability to access the services they are being referred to and their willingness to pursue the treatment option.

Supporting secondary indicators include:

- A justice-involved individual's referral to treatment should consider provider location, and client accessibility (for example, hours, transportation, and distance).
- Physicians should consider the justice-involved individual's preferences, past treatment history, current state of illness, and treatment setting when determining medication options.
- Do not impose time limits on pharmacological treatment when extended treatment is warranted.
- Couple MOUD with counseling and other treatment services when the treatment is for individuals with an OUD.
- Consider the wide range of justice-involved individual's other needs, such as the need for mental health services when determining which treatment setting is most appropriate.
- If appropriate, initiate treatment with methadone or buprenorphine (rather than withdrawal management or psychosocial treatment alone) as early as possible during pregnancy.

Practical Applications of the Indicators:

- Integrate various methods of treatment as part of the initial program structure or add to existing structure (i.e., MAT, Telehealth)
- Consider expanding contractual services to include vendors who offer technology-assisted treatment and/or opioid treatment programs to expand the justice-involved individual's access to treatment services.
- Incorporate treatment protocols that allow the flexibility to individualize treatment timeframes.

There has been a need to use seemingly unconventional treatment options that CJ and BH providers may not be accustomed to. A treatment option that is moving to the forefront of care for the justice-involved population, is medication-assisted treatment (MAT). In the process of including the CJ system as a path to MAT, states may see an increase in access to and retention in treatment and a decrease in overdoses, re-offending, and re-incarcerations (SAMHSA, 2019b). This treatment option is addressed in detail in the Treatment chapter of this manual.



Key Term: Medication Assisted Treatment (MAT)

MAT is an evidence-based treatment for opioid use disorders that SAMHSA defines as "The use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a 'whole-patient' approach to the treatment of substance use disorders" (SAMHSA, 2022b).

Reference

Substance Abuse and Mental Health Services Administration. (2022b). Medication-assisted treatment (MAT). SAMHSA. <https://www.samhsa.gov/medication-assisted-treatment>

Encourage Justice-Involved Individuals to Access Treatment After a Referral is Made by Using Active Referral Processes

Case management is key in this indicator in that it provides a holistic approach to addressing the justice-involved individual's basic needs and can assist the justice-involved individual in re-establishing or establishing support systems. The National Association of State Mental Health Program Directors (NASMHPD) defines case management as a "range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other essential services and supports" (Martone et al., 2022, p. 6).

Supporting secondary indicators include:

- Confirm that the justice-involved individual has the means to pay for treatment (either through Medicaid, private health insurance, or some other means).
- Assist the justice-involved individual in making the initial contact/appointment with the service agency.
- Assist with arranging transportation to the initial appointment.
- When possible, accompany the justice-involved individual to the initial appointment.
- Follow-up with the treatment provider after a referral is made to ensure the justice-involved individual attended the first appointment and collect any other necessary information. Follow-up with the justice-involved individual if the appointment was missed.

Practical Applications of the Indicators:

- Partnering or employing peer recovery coaches/specialists and connecting them with the justice-involved individual during treatment and after. For more information on peer recovery coaches, see this [infographic from SAMHSA](#).
- Pair case managers with supervision officers to create teams to conduct needs assessments and follow-up with the SUD/ODJ justice-involved individuals.
- Incorporate motivational interviewing training as a required training for community supervision staff. For more information on MI, see [this page](#) and associated resources from Case Western Reserve University.
- Utilize Recovery Oriented Systems of Care (ROSC) organizations as part of the treatment and aftercare services. For more information on ROSC, see [this guide](#) from SAMHSA.

One of the most important indicators of a successful transition to community-based SUD/ODJ treatment for the justice-involved individual is attendance at the first SUD/ODJ treatment appointment. Research has shown that if the justice-involved individual makes their first appointment, the likelihood of them continuing in treatment increases exponentially. Evidence-based practices around advocating, supporting, and referring the justice-involved individual to the appropriate behavioral health treatment provider identify the importance of a "warm hand-off"- in other words the justice-involved individual is supported in person by a recovery coach, a CJ professional, a family member, or significant other. The justice-involved individual knows where they are going, has the

address, time of appointment, the name of the counselor that is seeing them, and is physically supported to get to the appointment. In addition, the physical presence of the CJ professional at the initial SUD/ODU appointment, helps create a bridge of transition for the justice-involved individual. The CJ professional will/should be able to address any questions/concerns the SUD/ODU professional might have regarding the justice-involved individual's prior facility-based treatment, the monitoring and reporting requirements that the justice-involved individual might be operating under, the expectations regarding sharing information regarding the justice-involved individual's progress in treatment, or other collaborative needs.



Key Term: Warm Hand-Off

Warm hand-offs are a more personal transition of one clinician or service provider to another. The Agency for Healthcare Research and Quality (2017) suggests this process be done in-person while the client is present. This enables the client to be part of the transition of healthcare information, ask questions, and correct information if needed. Warm hand-offs ensure accurate information is given to clinicians and service providers to determine the best course of treatment and patient care.

Reference

Agency for Healthcare Research and Quality. (2017). Warm handoff: Intervention. AHRQ. <https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html>

Primary/Secondary Indicator guided questions for the active referral/warm hand-off:

- Does the CJ staff ensure the SUD/ODU justice-involved individual continues his/her treatment in the community as they transition to parole/probation?
- Is there collaboration with the corrections-based SUD, BH treatment staff, case management staff, and other community providers?
- Is there a multi-disciplinary team working with the justice-involved individual and their family?
- Does the CJ professional encourage the justice-involved individual's treatment participation?

Elements of an active referral/warm handoff:

- The CJ system should work to develop a multi-disciplinary team inclusive of community and facility-based resources, and peer and family support services that meet at least once a month to review the justice-involved individual's status.
- CJ staff and BH providers should develop an extensive community resources referral guide in conjunction with the community, faith-based, educational/vocational, and service-oriented agencies.
- CJ staff and BH providers should develop cross-training opportunities in the community to ensure that all entities involved with the SUD/ODU justice-involved individual are educated regarding roles, expectations, EBPs, and commonalities.

- The CJ system and BH providers should possess a general understanding of the processes of treatment, transition, progression, recovery process, and the importance of collaboration.
- The CJ system and BH providers should develop systems that promote collaboration and the sharing of information about the justice-involved individual.
- The CJ system and BH providers should attend training specific to the concepts of relapse, MAT, and the stages of recovery.
- The CJ system and BH provider should foster a true attitude of collaboration and coordination through the use of a Multi-disciplinary Advisory Board.
- Conduct multi-disciplinary team staffing prior to the justice-involved individual's release to ensure a smooth transition and access to needed services.
- Collaboration and communication between the family, the justice-involved individual, and the service providers should be fostered.

Case Management and the Referral Process

Case management is an integral part of the referral process and encompasses a variety of activities necessary for successful treatment engagement. In most jurisdictions, supportive services are fragmented and unable to meet the needs of the SUD/ODJ justice-involved population; therefore, case management would be beneficial (SAMHSA, 2015a). One of the principal goals of case management is to keep justice-involved individuals engaged in treatment and on the path to recovery (SAMHSA, 2015a). Treatment retention leads to better outcomes; therefore treatment is more likely to succeed when a justice-involved individual's other needs are addressed simultaneously with the SUD/ODJ (SAMHSA, 2015a).

It is essential that the justice-involved individual identify their programming needs and work with the parties to prioritize the goals and services identified. Referrals are not generic and should be individualized based on the justice-involved individual's circumstances. This section discusses the principles of case management, services planning, and the coordination of care that are inherent to integrating case management into the referral process.

Principles of Case Management

Adhering to the case management principles ensures the transition from facility to community-based services is a seamless process, and that the justice-involved individual maximizes their recovery potential and is successful on community supervision.

These principles are as follows:

- Case management involves advocacy
- Case management is community-based
- Case management is anticipatory
- Case management is culturally sensitive
- Case management must be flexible
- Case management is pragmatic (SAMHSA, 2015a)

Service Planning

Service planning across agencies is grounded in three major tasks: 1) making the initial referral; 2) calling to confirm service access; and 3) communicating with BH, CJ, and other service providers about progress. This section provides a list of strategies for these tasks and explains why they are an important part of the case management process.

Task 1: Making the Referral

- A referral form is recommended:
 - It creates a paper trail
 - It gathers important information about the justice-involved individual in one concise form
- Make the call
 - What to ask during the call:
 - Who should you call in the future?
 - Who will be the therapist or case manager? This should be recorded in your records or on the referral form.
 - Let BH/CJ and other service providers know that you will be calling to confirm access and review progress
 - Discuss how your agencies should accomplish this

Task 2: Confirming Service Access

- Must complete a release form
 - Under HIPAA, all personal health information (PHI) is confidential.
 - To communicate health needs and treatment plans, both the BH provider and CJ agency must have the consent of the justice-involved individual to disclose PHI.
 - Let justice-involved individual know what information will be released by both parties.
- Call the BH/CJ provider directly and in a timely manner
- Ask if the justice-involved individual made the initial appointment
- Ask if the justice-involved individual was referred for further services and get contact information for those agencies.



Key Term:

Personal Health Information

Sometimes called protected health information, this is information protected under HIPAA. Examples of this information include name, address, age, phone number, social security number, and any other personal identifying information (Office for Civil Rights, 2013). This information must be kept private and confidential, except for clinicians and those individuals/agencies listed on the Release of Information (ROI) who are granted access to the medical records.

Reference

Office for Civil Rights. (2013). Summary of the HIPAA privacy rule. HHS.gov. Retrieved March 15, 2022, from <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>

Task 3: Ongoing Communication with BH, CJ, and other Service Providers

- Communication will occur throughout all points in the timeline

- What BH and other service providers need to know from CJ:
 - Is the justice-involved individual violent?
 - Is there a risk to the provider's staff?
 - Is the justice-involved individual a risk to themselves?
 - Is the justice-involved individual involved in a gang, or do peers mostly include those known to CJ?
 - What are the justice-involved individual's strengths?
 - Is the justice-involved individual interested in treatment?
 - Does the justice-involved individual return phone calls?
 - Does the justice-involved individual have a history of domestic violence?
 - What is the current condition of probation/parole?
 - What other conditions must be met?
 - Is CJ doing drug testing?
 - Does the justice-involved individual have a known treatment history?
- What BH and other service providers should provide to CJ:
 - What does BH see as the current problem?
 - What are the goals of BH treatment?
 - What services is the justice-involved individual being offered?
 - Current medications
 - Compliance with treatment plan (barriers)
 - Will BH be referring for other services?
 - Psychosocial stressors (deaths, divorce, abuse, etc.)
 - Progress and attendance
 - Who is the BH case manager?
 - Liaison or contact person between CJ and BH for follow-up (if not BH case manager)
 - Do other service providers provide case management services?
 - Any cognitive limitations that may impact CJ compliance?

Coordination of Care

Coordination of care ensures all parties involved are working collaboratively, sharing information, pooling resources, and maximizing treatment efficacy. Coordination of care is the road map for pre and post-service delivery.

Active referral/warm hand-off encompasses:

1. Contracts: may specify which agencies you most commonly work with
2. Agreement on information-sharing practices
3. Referral forms
4. Release forms
5. Confirming service access
6. Ongoing communication with BH providers
7. Expectations checklist.

Unstructured hand-offs may result in:

1. Delay in treatment
2. Inappropriate treatment
3. New or worsening BH problems (due to delayed/inappropriate treatment)
4. No treatment
5. Increased costs (to justice-involved individuals, CJ agency, and BH agency)
6. Inefficient due to replication of screen/assessment/further referrals

Multi-disciplinary Team Staffing/Team Meetings

Many SUD/ODD individuals receive screenings, assessments, and treatment while incarcerated; although research has shown that the demand for SU treatment far exceeds the capacity for those services. As the justice-involved individual transitions from incarceration back into the community, the continuity and need for ongoing SUD/ODD treatment (as well as other services) is extremely important. "To reduce the risk of relapse to illicit drugs and criminal recidivism, criminal justice agencies may need to establish collaborations with substance use treatment and other community-based providers" (Fletcher et al., 2009, p. S54). To strengthen the referral process, collaborative partnerships are essential for the effectiveness of the continuity of care. Community supervision staff and community-based case managers should be working with the local community SUD/ODD treatment providers, community mental health, community health departments, local clinics, community organizations, support and self-help groups, churches, community leaders, and family support members. Development of these multiple-entity coalitions improves outcomes, increases effective communication, decreases the chance of duplication of services, and spreads a wider safety net for the justice-involved individual. Below are some of the key responsibilities to consider as part of the multi-disciplinary process.

Table 4.1 MULTI-DISCIPLINARY STAFFING/TEAM RESPONSIBILITIES

Team Staffing/Team Meetings	<ul style="list-style-type: none"> • The purpose of this meeting is to begin the transition process from facility to community-based services and familiarize the justice-involved individual, his/her family, and the community service providers with the needs, goals, and plans for reentry. • Members include, but are not limited to: facility-based treatment staff, on-site corrections facility staff (educators, vocational training staff, mental health, medical, counselors, pastoral), as well as the designated community-based "team" (parole, case management, treatment, family support members). • Information is shared with all partners regarding the justice-involved individual's ongoing treatment goals, their diagnostic impression, and other additional service needs.
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Collaborative Comprehensive Care Plans

- Pooling a team that includes CJ and BH staff, as well as the participant and their support system. "The Criminogenic Risk and Behavioral Health Needs framework introduced state leaders and policy makers to the concept of prioritizing supervision and treatment resources for people based on their criminogenic risk and needs, as well as their behavioral health needs. Since then, the framework has been used as a foundational tool by federal grantees of the Second Chance Act (SCA) and the Justice and Mental Health Collaboration Program (JMHCPC)" (NRRC, 2017; Osher et al., 2012).
- The plan must be based on the justice-involved individual's strengths and identified service needs. It is the justice-involved individual who identifies and prioritizes the services needed.
- The plan needs to include comprehensive information from BH (SUD/ODU and mental health), criminogenic risk, and psychosocial, educational, and vocational assessments.
- "Lead case planners must identify the appropriate people from the agencies who will comprise the case management team for the participants....and should include representatives from criminal justice, behavioral health, and social service agencies..." (NRRC, 2017).
- Community transition and reentry need to begin immediately once an offender enters a facility-based Licensed Treatment Facility.
- The facility-based treatment provider works individually and in group sessions to ensure that offenders understand the importance of continuing treatment and programming upon release into the community.

Information Sharing

- Copies of the substance use assessment, treatment plan, discharge summary, and reentry plan should be shared with the appropriate community-based service providers.
- Additional reports for other service needs should also be forwarded to involved service providers.
- Signed consent for release of information (ROI) forms (see Sample 1 and Sample 2) should be completed by facility-based treatment program staff (or contractual case manager), for identified community-based programs for each justice-involved individual and include releases for parole, and other community-based programs (i.e. community mental health, county health department, domestic violence or anger management programs) as needed.

Individual Service Needs: Responding to Justice-Involved Individual Needs that may Impact Active Referral Approach

The following section highlights the individual needs that often impact whether a justice-involved individual will successfully connect with and start treatment. These needs are typically identified during the justice-involved individual's screening and assessment and may be imperative to their recovery and lifestyle success. Changes in the service needs of justice-involved individuals may occur at any point within the treatment and reentry process. Therefore, continuous review of where the justice-involved individuals are in their treatment and recovery is imperative.

Referral decisions that could lead to better outcomes for the justice-involved individual should focus on applying the indicators to the service needs that drive the justice-involved individual's referral. The practical application for the various service needs can then be addressed through primary and secondary indicator-guided questions to better focus the referral decision. A common need of most justice-involved individuals (that is not always evaluated or assessed) is the justice-involved individual's ability to access the treatment services to which they are referred. The questions in this section can serve as a starting point for CJ and BH providers, but it is not all-inclusive of the questions that can be asked to better individualize the justice-involved individual's referral needs.

Appendix E provides links to the various resource categories within this chapter that can assist CJ and BH providers in identifying solutions to the indicator-guided questions below. These resources may be needed to accommodate the justice-involved individual's treatment and reentry needs.

Primary/Secondary Indicator-Guided Questions for a Justice-Involved Individual's Focused Referral

The guided questions below refer to specific resources to consider for each question section. Some example resources can be found in **Appendix E**, grouped by resource type. Alternatively, you can click the resource type that follows the questions to be taken to the appropriate section of **Appendix E**.

Access to Treatment

- Does the justice-involved individual live in a rural area or a location with limited or no treatment providers?
- Does the justice-involved individual have employment obligations that may interfere with their ability to attend on-site treatment services?
- Does the justice-involved individual have an alternative means (i.e., computer, smart phone, internet) to participate in technology-assisted treatment services?
- Does the justice-involved individual have social support that would assist in gaining access to treatment (e.g. friends/family that could drive the justice-involved individual to appointments)?
- Is the justice-involved individual willing to engage in treatment? If not, what are the barriers to their willingness?
- Would the high cost of programming decrease the likelihood of program participation and completion?

Resources to Consider:

- [Tele-Behavioral Health Resources](#)
- [Transportation Resources](#)
- [Employment Resources](#)

Family, Relationships, and Support

- Does the justice-involved individual have a support system?
- Is the justice-involved individual's support system equipped with the information and resources needed to assist the justice-involved individual?
- Does the justice-involved individual's family participate (or are they willing to participate) in services that connect them to the justice-involved individual during treatment?
- Does the justice-involved individual's support system know how to respond to the justice-involved individual's needs in a crisis (i.e., opioid overdose, etc.)?
- Are the justice-involved individual and their family members familiar with the types of support groups available?
- Is the justice-involved individual informed on practices for minimizing contact with social network members who may hinder recovery?

Resources to Consider:

- [Case Management Resources](#)
- [Family Support Resources](#)
- [Peer Support/Peer Navigation and Social Networking Resources](#)

Housing Status and Safety Concerns

- Does the justice-involved individual have a drug-free environment to live in?
- Can the justice-involved individual afford alternative housing?
- Are there Oxford Houses or Sober Living Environments that can be accessed?
- Do justice-involved individuals have access to information about the various alternative housing options available to them?

Resources to Consider:

- [Housing Resources](#)
- [Transition Resources](#)
- [Peer Support/Peer Navigation and Social Networking Resources](#)

Socioeconomic

- Does the justice-involved individual have the economic resources to pay for treatment?
- What are the available financial resources (i.e., Medicaid, veteran benefits, etc.) available to the justice-involved individual upon release?
- How can CJ staff and BH providers help the justice-involved individual prioritize their financial resources to obtain or sustain their treatment and reentry needs?

Resources to Consider:

- [Community-Based Financial Resources](#)
- [Case Management Resources](#)

Cultural Background, Race/Ethnicity

- How are language barriers addressed for the justice-involved individual?
- Is cultural diversity training conducted for CJ staff, BH staff, and justice-involved individuals?
- Are there recovery resources specific for the justice-involved individual in his/her community that match in terms of race, ethnicity, or culture?
- Is there training in place that discusses how policies and program practices can inadvertently contribute to racial/ethnic inequality in treatment access, participation, and completion?

Resources to Consider:

- [Cultural Competency Resources](#)

Employment History:

- Does the justice-involved individual have an employment history?
- Are programs or components of the program offered to the justice-involved individual that enhances employment skills?
- Are justice-involved individuals offered services that include job fairs to assist and educate the justice-involved individual about the available employment opportunities?

Resources to Consider:

- [Employment Resources](#)

Justice-Involved Individuals' Ability to Manage Money

- Does the justice-involved individual have life skills training?
- Are there community resources for life skills training available to the justice-involved individual?
- Are the justice-involved individuals required to participate in life skills groups as a part of their supervision requirements?

Resources to Consider:

- [Financial Resources](#)

Recreational and Leisure Activities

- Are recreational and leisure activities addressed with the justice-involved individual as a part of their post-treatment plans?
- Are justice-involved individuals educated on different types of activities that can positively or negatively impact their recovery?
- Are the justice-involved individual's post-treatment recreational and leisure activities discussed as a part of their supervision follow-up?
- Are there support groups that offer recreational and leisure activities available to the justice-involved individual?

Resources to Consider:

- [Mutual Help and Support Group Resources](#)
- [Case Management Resources](#)

Transportation:

- Is the justice-involved individual's access to transportation evaluated prior to referrals?
- Do the justice-involved individuals in rural areas have access to technology that can be utilized to provide community-based services?
- Is the justice-involved individual provided information about various transportation resources (i.e., bus passes)?
- Is there a one-stop shop that offers a myriad of services in one location to maximize referrals for justice-involved individuals with limited transportation options?

Resources to Consider:

- [Transportation Resources](#)
- [Tele-Behavioral Health Resources](#)

Gender Appropriateness:

- Are referrals for programs centered around gender-sensitive issues (i.e., gender identity, gender-based, and those justice-involved individuals who identify as non-binary) available?
- Is there an attitude of non-judgment and gender acceptance present in the referral process?
- Is there training in gender inclusivity available to CJ and BH staff working with the SUD/ODD population?
- Are there anti-discrimination policies in place addressing gender bias, gender shaming, and gender-appropriate language?

Resources to Consider:

- [Gender Specific Resources](#)
- [Cultural Competency Resources](#)

Domestic Violence:

- Do the justice-involved individual's treatment services provide a domestic violence intervention component?
- Does the screening and assessment process include tools that explore the need for domestic violence services?
- Does the justice-involved individual's treatment and release plan include objectives and resources for domestic violence assistance?

Resources to Consider:

- [Trauma Informed Care Resources](#)
- [Family and Support Resources](#)

Child Care/Child Custody/Child Rearing:

- Are family reunification programs provided to justice-involved individuals with children?
- Does the justice-involved individual have a history of child protective service involvement?
- Are children included in the treatment approach?
- Are parenting skills classes required as a part of the justice-involved individual's treatment and release planning?

Resources to Consider:

- [Family and Support Resources](#)

Medical Services:

- Are justice-involved individuals educated on how to access medical services?
- Are justice-involved individuals provided assistance with applying for programs (i.e., Medicaid, insurance) that will help with their medical needs?
- Are justice-involved individuals informed of the types of medical programs available in their communities?

Resources to Consider:

- [Case Management Resources](#)
- [Tele-Behavioral Health Resources](#)

Co-Occurring Mental Health Services:

- Are justice-involved individuals who are dually diagnosed informed of special services available to them in their communities, and how to access those services?
- Are justice-involved individuals connected to mental health services prior to completing SUD/OD treatment programs?
- Are justice-involved individuals connected to self-groups that are knowledgeable in supporting justice-involved individuals who are dually diagnosed?

Resources to Consider:

- [Case Management Resources](#)
- [Tele-Behavioral Health Resources](#)

Trauma Informed Care

- Are treatment services provided in an environment that is safe for the justice-involved individual?
- Are the justice-involved individuals periodically screened to identify potential barriers to their engagement because of past trauma?
- Are the justice-involved individuals educated on how to connect to services in the community that are sensitive to working with justice-involved individuals who have experienced a traumatic event?

Resources to Consider:

- [Trauma Informed Care Resources](#)
- [Case Management Resources](#)

Summary

This chapter was structured around the appropriate care indicators found in **Appendix C**. The chapter also notes the importance of utilizing all information about the justice-involved individual when making referrals to needed resources. Using all of the screening and assessment information provided should help CJ staff and treatment providers determine the appropriate treatment for the client.

Once the client is referred to treatment, CJ staff and treatment providers should determine if additional referrals may be needed to overcome barriers to treatment. The chapter then concludes with a series of questions to address and screen for treatment barriers. Should a client express that they are in need of services, a list of treatment resources can be found in **Appendix E**.

CHAPTER 5

TREATMENT

Introduction

Treatment is an essential element of the recovery process for justice-involved individuals who have SUD and/or other challenges. There has been much research conducted regarding the prevalence of SUD among justice-involved individuals and the nexus between crime and substance use.

To effectively address the multiple needs of the SUD/ODJ justice-involved individual, SUD treatment (as well as other BH, educational, vocational, financial, and family services) needs to be readily available and individualized for each situation, including refocusing how opioid treatment needs are addressed for the justice-involved population. There are numerous evidence-based treatment approaches that have proven effective with the justice-involved population. The intent of this chapter is to review those approaches (e.g., MOUD, Telehealth) that are often viewed as difficult to use with the justice-involved population.

This chapter utilizes primary and supporting indicators complemented by practical applications to guide the focus on treatment initiation, engagement, and continuity for the justice-involved individual. The practical applications are expanded to provide recommendations that may serve as a guide to the CJ system and BH providers, who are finding the impact of opioid use among the justice-involved population to be just as significant as other drugs. Additionally, the treatment chapter addresses the ancillary or supportive services that help the individuals move into and sustain their recovery.

Objectives

1. Discuss **primary indicators** associated with treatment initiation and engagement. This chapter presents five primary indicators as essential elements of the treatment process that, ideally, would be present to ensure continuity of care. Primary indicators are essential to organizational practices in that they serve as guides to enhance the treatment initiation and engagement processes for CJ and BH staff involved in the management of SUD/ODJ justice-involved individuals.
2. Primary indicators include
 - Encourage the client with a substance use disorder to initiate treatment services.
 - Ensure service continuity around treatment initiation practices
 - Encourage clients with substance use problems to stay in services
 - Initiate contact with a service provider to obtain information about a client's progress in treatment
 - Ensure continuity around treatment engagement practices
3. Discuss **secondary indicators** as quality indicators for each primary indicator to promote treatment adherence.
4. Discuss **practical applications** for each primary indicator to provide the CJ staff and CBH organizations with a quick review of processes that can augment current services or be implemented as new practices to better support the SUD/ODJ justice-involved individuals.

Encourage Clients with a Substance Use Disorder to Initiate Treatment Services

Within this indicator, it is imperative to encourage treatment participation from the standpoint of rehabilitation rather than punishment. Assisting the justice-involved individual in understanding the significance of participating in treatment after a diagnosis is key to ensuring they capitalize on the benefits. Additionally, this indicator establishes the foundation to explore treatment options that will meet their needs, while advancing the CJ system and BH providers' efforts to incorporate new approaches that will better serve the justice-involved individual.

Supporting secondary indicators include:

- Encourage the client to initiate treatment soon after the referral
- Contact the service provider to confirm the first treatment session
- Encourage services with an accredited treatment provider
- Encourage the use of MAT services in conjunction with psychotherapy
- Encourage continuation of treatment for OUDs after clients are released from corrections facilities

Practical Applications of the Indicators:

- Work in conjunction with the justice-involved individual in determining the services they need to succeed in treatment and maintain success after treatment
- Identifying and understanding non-traditional treatment approaches to address the justice-involved individuals' diagnosis
- Examine and expand current treatment options by determining ways to incorporate MAT and/or Telehealth approaches for the justice-involved individual

Formulating Practical Application of the Indicator into Action

Medications for Opioid Use Disorder: A Quick Overview

There are three FDA approved medications to treat OUD: Methadone, Naltrexone, and Buprenorphine. Each of these three medications acts in different ways to block receptors in the brain to assist in the treatment of SUD/OUD. Therefore, it is important for all staff to know the basic information on how each of the three medications works so the client has all the necessary information to inform their treatment decision. The client should discuss with their BH and clinical provider which of the three medications would be most beneficial to them.



Note

You may hear the terms MAT and MOUD interchangeably. MAT is Medication-Assisted Treatment, which incorporates the use of MOUD in an individual's treatment plan. MOUD is Medications for Opioid Use Disorder, which references pharmacological treatment exclusively. These medications are methadone, naltrexone, and buprenorphine.

Methadone. Methadone as a treatment for OUD can only be attained through certified Opioid Treatment Programs (OTPs) or in a hospital setting (SAMHSA, 2021a). Clients who are given methadone must go to the OTP every day to receive the medication. Over time, the dosage of methadone the client receives may be lowered. Methadone may be used during the process of medically supervised withdrawal from opioids by reducing and sometimes eliminating withdrawal symptoms (SAMHSA, 2021a). Methadone may also be used to reduce cravings and block the effects of opioid use (SAMHSA, 2021a).

Naltrexone. Not as restrictive as Methadone, Naltrexone does require a prescription for the client which may be obtained at substance use treatment facilities including OTPs, clinical offices, and specialty treatment settings (SAMHSA, 2021a). Naltrexone can be taken orally or there is an extended-release intramuscular form. Unlike Methadone, Naltrexone does not work to reduce or eliminate withdrawal symptoms. Therefore, a client must have already gone through medically supervised withdrawal before being prescribed this medication (SAMHSA, 2021a). Naltrexone does reduce cravings and block the effects of opioid use (SAMHSA, 2021a).

Buprenorphine. Lastly, Buprenorphine can be obtained in a variety of settings. Until legislation was passed in 2023, physicians needed an X-Waiver to prescribe Buprenorphine. This limited access to a crucial medication to treat OUD. Now, physicians do not need to have an X-Waiver to prescribe Buprenorphine, which makes it most available to all clients. There are several routes to administer Buprenorphine including sublingual (placing a tablet under the tongue), buccal (between the cheek and gum at the back of the mouth), a subdermal implant (a small rod inserted under the skin of the arm), and an extended-release injection (SAMHSA, 2021a). It is recommended that clients be clinically stable in their recovery process before receiving the Buprenorphine implant (SAMHSA, 2021a). As for the extended-release injection, it is recommended that clients have received Buprenorphine either sublingually or buccally for at least one week before switching to the monthly injection (SAMHSA, 2021a). Like Methadone, Buprenorphine can be used during medically supervised withdrawal to reduce or eliminate withdrawal symptoms (SAMHSA, 2021a). It also works to reduce cravings and block the effects of opioid use during treatment maintenance (SAMHSA, 2021a).

To learn additional information on MOUD or to compare the medications, you can read through [SAMHSA's TIP 63: Medications for Opioid Use Disorder](#). However, as of Spring 2023, this text has not been updated to reflect the abolition of the X-Waiver Buprenorphine requirement.

Addressing Challenges to Incorporating MAT in Criminal Justice Settings

Incorporating MAT in criminal justice settings first requires states to address a number of potential challenges, such as misunderstandings staff may have regarding MAT, medication diversion, the cost of MAT, and a lack of community-based partnerships with MAT providers.

Criminal justice staff may perceive MAT treatment as "substituting one drug for another," which often leads to underutilization of this evidence-based treatment. To address this, staff should be trained on how MAT promotes recovery among individuals with OUDs. Previous research has shown that MAT reduces drug use, disease rates, and overdose events (SAMHSA, 2019b). Further, within the CJ system, MAT is associated with reductions in criminal activity, arrests, probation revocations, and re-

incarcerations (SAMHSA, 2019b).

Within CJ facilities, changes may need to be implemented to ensure OUD medications are administered in a way that reduces medication diversion. SAMHSA (2019b) provides several strategies that may address this issue, including:

- Assign dedicated staff who participate in multidisciplinary teams of medical and correctional staff
- Monitor dispensing of medication
- Conduct drug testing
- Implement spot audits and incident reports
- Ensure the safe and secure storage of the medications (SAMHSA, 2019b, p. 2)

MAT medications are often not covered in correctional facilities' insurance plans. As such, CJ programs may assume they cannot afford to provide MAT due to the costs of medications and other additional resources needed (SAMHSA, 2019b). Further, in states that did not expand Medicaid coverage, it is likely that CJ facilities serve many individuals that do not qualify for Medicaid (SAMHSA, 2019b). This is important to consider when deciding whether to implement MAT, since these individuals may face problems continuing treatment upon release. Financial resources should be set aside to provide comprehensive MAT programming across CJ systems (SAMHSA, 2019b). Depending on the state, some CJ agencies can choose to be part of group purchasing organizations in order to negotiate for more affordable OUD medication rates (SAMHSA, 2019b).

The availability of community-based providers able to provide services to justice-involved individuals may be minimal in some areas (SAMHSA, 2019b). However, having providers able to deliver medications for opioid use disorder (MOUD) is essential for this population (SAMHSA, 2019b). Some CJ agencies have created partnerships with community-based agencies to make an easier transition for treatment (SAMHSA, 2019b). Furthermore, a few CJ programs are considering residential settings where clients can receive primary health care and SU treatment in order to provide support for the client's needs (SAMHSA, 2019b).

Preparing to provide services to justice-involved clients may require a plethora of planning for community-based providers. Given this, some community-based providers may be unable to provide MOUD services within the correctional setting (SAMHSA, 2019b). This is especially true for those clients the provider cannot bill for reimbursements (SAMHSA, 2019b). Despite the possible inability of providers to come to the correctional settings to provide MOUD, CJ agencies can choose to provide MOUD in-house or through referring out to community-based providers for treatment (SAMHSA, 2019b). Working with community-based providers is critical for continuity of care as individuals transition in and out of the CJ system (SAMHSA, 2019b).

Making Decisions About Treatment Through Engagement

As with any treatment approach, informing the justice-involved individuals about their screening and assessment outcomes can be pivotal in the efforts to assist them in gaining a level of ownership in the treatment decisions that may sustain their recovery long-term (SAMHSA, 2021a). In many cases, justice-involved individuals do not have the freedom of having a treatment preference due to various

legal requirements. However, taking an inclusive approach can have an impact on how the justice-involved individual responds to the treatment they are required to attend. Although the justice-involved individual may not have the latitude to select the type of treatment to participate in, particularly if they are ordered to treatment, it is still imperative to find ways to include them in the decision process. As an example, a counselor or supervision officer may consider the following:

Recommendation to Consider: Treatment providers and/or CJ staff should share the OUD diagnosis with the justice-involved individual (SAMHSA, 2021a). Additionally, clients should be educated on the different types of OUD treatment. This should be an opportunity for justice-involved clients to develop an idea of specific treatment types that may be the best option. Treatment providers and CJ staff will collaborate with the client and use their feedback when developing a treatment plan (SAMHSA, 2021a). Refer to **Figure 5.1** below for SAMHSA's (2021a) recommended topics to be discussed.

Figure 5.1 Recommended Topics for Treatment Discussions

Client's should have information to make decisions about:	Topics for treatment providers/CJ staff to discuss with clients:	Ways to encourage the client in treatment planning:
<ul style="list-style-type: none"> • Treatment type <ul style="list-style-type: none"> ◦ Which OUD medications to begin -- buprenorphine, methadone, naltrexone ◦ Supervised withdrawal • Locations where the client can access their chosen treatment type • Whether the client should access support services regardless of their choice to use OUD medications or not <ul style="list-style-type: none"> ◦ These can include recovery support (e.g. AA, NA), ancillary services (e.g. behavioral health services, telehealth services, socioeconomic needs), and mental health treatment 	<ul style="list-style-type: none"> • A comparison of OUD medications <ul style="list-style-type: none"> ◦ This should include benefits, risk, and possible barriers • Recognition of socioeconomic barriers to treatment <ul style="list-style-type: none"> ◦ Some examples include transportation, cost, and insurance status • Treatment types without the use of medication <ul style="list-style-type: none"> ◦ Supervised withdrawal • Parole board requirements of the client's treatment plan 	<ul style="list-style-type: none"> • CJ staff express their willingness to collaborate with clients to find the best course of treatment • Incorporate important individuals to the client (family members, peers, etc.) in the treatment planning process <ul style="list-style-type: none"> ◦ Remember to get consent from the client before including these individuals • Listening to and answering questions clients may have about treatment <ul style="list-style-type: none"> ◦ This may also include resolving misperceptions and myths the client may have heard ◦ In addition to answering questions, staff should offer information such as the requirements of the treatment options, risks, benefits, barriers, side effects, etc.

Information in this table was adapted from SAMHSA TIP 63.

Stigma

The stigma associated with SU may subject individuals who struggle with addiction to prejudice and discrimination by others. Stigma can come in three forms: structural stigma within the CJ system may result in disparities in treatment, policy support, and resources for justice-involved individuals. Professional education is one way to combat these disparities. Public stigma among the general population can lead to feelings of isolation and rejection. Self-stigma is characterized by shame and low self-esteem. It is especially salient among justice-involved populations, often resulting in a "why-try" cycle wherein they feel it is pointless to try to seek or engage in treatment.



Barriers

Structural Stigma can be experienced through the institutions of society in which we live such as the healthcare system, employers, the criminal justice system, etc. It is created by discriminatory and/or prejudicial actions towards actions that do not align with institutional norms (i.e. shared attitudes, beliefs, behaviors, etc.). Typically, structural stigma is embedded within larger structures that require restructuring of the institutional culture.

Public Stigma is similarly influenced by shared community norms. However, with public stigma, perpetrators of discriminatory and/or prejudicial actions are members of the general public rather than institutions. While shared community norms are embedded in local culture, the laws, policies, and rules in the community often lead to public stigma for those who do not conform to the shared community norms.

Self-Stigma is an internalized negative attitude toward the stereotypes created by public stigma. This leads to ambivalence in seeking treatment due to being characterized by the stereotype given to them.

Reference

Committee on the Science of Changing Behavioral Health Social Norms, Board on Behavioral, Cognitive, and Sensory Sciences and Education, Division of Behavioral and Social Sciences and Education, & National Academies of Sciences, Engineering, and Medicine. (2016). *Understanding Stigma of Mental and Substance Use Disorders*. In *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*. essay, National Academies Press. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK384923/>.

Addressing Legal Cynicism

Addressing legal cynicism may increase the likelihood of justice-involved individuals wanting to participate in treatment. Legal cynicism could lead to clients who may not consent to communication among providers if they:

- Do not trust the justice professional or MOUD service provider
- Feel that their concerns and wishes are not being heard or addressed
- Are not provided the information needed to make an informed decision in a language they can comprehend
- Are not included in the treatment process

Justice professionals can address these concerns by developing a therapeutic alliance with their justice-involved clients. In developing a relationship based on honest communication and acknowledgement of the client's desires and wishes, the justice professional can be perceived as

honest, trustworthy, and sincerely interested in the well-being of his/her client. Acknowledging that the justice-involved client plays an active part in the decisions that are made in terms of his/her OUD treatment and actively supporting the justice-involved client's efficacy, are also techniques that the justice professional can utilize.

Procedural justice enables others to support views of laws and legal actors as reasonable and appropriate (Kirk, 2016). Upholding procedural justice, involves working to ensure the system's processes are fair and just. Keep in mind that procedural justice is dependent on the individual's perception of the system's fairness. Research has shown that individuals will adhere to laws when they do perceive those laws to be fair (Sunshine and Tyler, 2003; Tyler, 1990; Tyler and Fagan, 2008). We can use this idea to infer that individuals will adhere to MOUD if they perceive they can trust CJ staff.



Key Term: Legal Cynicism

Legal cynicism is a social theory that helps understand reactions to criminal behavior. Sampson and Bartusch (1998) coined this term during their research in understanding the perception of law enforcement in neighborhoods with racial minorities. Legal cynicism refers to the "cultural frame in which people perceive the laws illegitimate, unresponsive, and ill equipped to ensure public safety" (Kirk & Papachristos, 2011).

Reference

Kirk, D.S., & Papachristos, A.V. (2011). Cultural mechanisms and the persistence of neighborhood violence. *American Journal of Sociology* 116(4), 1190-1233. Retrieved May 4, 2022, from <https://doi.org/10.1086/655754>

Sampson, R. J., & Bartusch, D. J. (1998). Legal cynicism and (subcultural?) tolerance of deviance: The neighborhood context of racial differences. *Law & Society Review*, 32(4), 777–804. Retrieved March 16, 2022, from https://scholar.harvard.edu/files/sampson/files/1998_lsr_bartusch.pdf.



Key Term: Procedural Justice

Procedural justice is a theory in which an individual's perceptions of the justice system are influenced by their experience of fairness. However, perceptions are not based on the result of an interaction (e.g. receiving a ticket for a law violation) rather these perceptions are based on the thoughts and feelings during interactions with the justice system. The four pillars of procedural justice can be found in the graphic below. For more information on procedural justice, view [this guide](#) or visit the [Community Oriented Policing Services \(COPS\)](#) website.



VOICE

Everyone is given a chance to tell their side of the story



NEUTRALITY

Unbiased decisions with transparent reasoning



RESPECT

Everyone is treated with respect and dignity



TRUST

Decision-makers have trustworthy motives and concern about the well-being of others

Reference

United States Department of Justice. (n.d.). Procedural justice. *PROCEDURAL JUSTICE | COPS OFFICE*. Retrieved March 17, 2022, from <https://cops.usdoj.gov/procdceduraljustice#:~:text=Procedural%20justice%20refers%20to%20the,change%20and%20bolsters%20better%20relationships>

Yale Law School. (n.d.). Procedural justice. *The Justice Collaboratory*. Retrieved March 17, 2022, from <https://law.yale.edu/justice-collaboratory/procdcedural-justice>

Understanding Treatment Settings and Approaches

Criminal Justice Setting. As opioid use becomes more prevalent among the justice-involved population, a key component in promoting the initiation of treatment is understanding which treatment approach better addresses their needs (SAMHSA, 2019a). The individuals involved with the justice system are often offered treatment services in the various traditional methods (i.e., therapeutic community (TC) and cognitive behavioral therapy (CBT)). As the concerns of opioid use continue to grow within this population it has become even more imperative for the CJ system and BH providers to understand how to incorporate many newer or less familiar methods, such as MOUD and Telehealth approaches into their practices for the justice-involved individuals.

When considering incorporating MOUD as an approach for use with the justice-involved population during incarceration, state and local entities possess the latitude to determine the parameters of OUD medication provisions (SAMHSA, 2019b). For example, the treatment process can be dictated by sentencing length (SAMHSA, 2019b). Justice-involved individuals with sentences of one year or less could receive ongoing MAT. Those with sentences over one year could utilize medical withdrawal and MAT.

In addition to expanding or restructuring treatment approaches, state governments can provide support for community-based agencies by determining billing methods for services provided to justice-involved individuals during incarceration (SAMHSA, 2019b). For those states with Medicaid-expansion, a reimbursement will be given for services provided to the justice-involved individual (SAMHSA, 2019b). These funds will be given by Medicaid after the client is released.

Therapeutic Programming. Most criminal justice systems utilize the Therapeutic Community (TC) and/or CBT approach to provide services to the justice-involved population within their SUD programs (Feucht & Holt, 2016; NIDA, 2015). The rise of opioid use among justice-involved populations is causing CJ agencies to consider if MAT services can or should be offered during incarceration. One consideration may include expanding on the SUD programs' therapeutic process by adding OUD medications, either in the same setting or by establishing a partnership with community agencies. As an example, TCs are residential communities with a very structured treatment modality for SUD (Texas Administrative Code, 2022). Treatment activities in this setting include individual counseling, group counseling sessions, CBT, and MAT (Texas Administrative Code, 2022). It is thought TCs for justice-involved individuals will reduce criminal behaviors and teach appropriate morals and values (Texas Administrative Code, 2022).

In cases where TCs may not be in use or considered a preferred method, CJ systems may consider incorporating MAT into their CBT, which is another common approach utilized with the justice-involved population. Trauma-focused CBT is especially useful for clients with a history of trauma, which encompasses a large share of individuals involved with the justice system.



Key Term: Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) is a therapeutic treatment that has been used to treat a variety of mental health disorders. CBT is focused on the connection between thoughts, feelings, and behavior. Therefore, using CBT requires time to change negative thoughts, unhealthy behaviors, and the feelings associated with those negative thoughts and unhealthy behaviors. CBT treatment strategies include methods in changing thinking patterns and behavioral patterns to more positive thoughts and behaviors.

Reference

American Psychological Association. (2017). What is cognitive behavioral therapy? PTSD Clinical Practice Guideline. Retrieved March 17, 2022, from <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>

Institute for Quality and Efficiency in Health Care. (2016, September 8). Cognitive behavioral therapy. InformedHealth.org. Retrieved March 17, 2022, from <https://www.ncbi.nlm.nih.gov/books/NBK279297/>

Behavioral Health Setting. The community-based level of treatment the justice-involved individual receives is even more critical than that received during incarceration and can have a significant impact on the level of engagement and continuity of care. It is important to note that justice professionals understand that decisions regarding the level of care are primarily the responsibility of the MOUD service provider. The justice professional may consult with the MOUD clinician regarding the level of care, but it ultimately is a clinical decision utilizing ASAM and DSMV criteria. Community-based services for justice-involved individuals with SUDs may include the following types of services:

- **Halfway Houses/Recovery Homes:** A halfway house or sober house, is a place where people recovering from SUDs begin the process of reintegration with society, while still monitored and supported.
- **Residential Treatment:** A specialized residential treatment program for behavior disorders including SUDs. It may include therapeutically planned group living and learning situations including the teaching of adaptive skills to help patients function in the community.
- **Supportive/Intensive Outpatient:** Outpatient SUD treatment is less restrictive than inpatient programs. Outpatient recovery programs usually require 10 to 12 hours a week spent visiting a local treatment center. These sessions focus on SUD education, individual and group counseling, and teaching clients how to cope with their life situations without the use of substances. Treatment may include treatment:
 - **Opioid Treatment Program (OTP):** OTPs provide daily methadone dosing and outpatient-level counseling.
 - **Buprenorphine Waivered Doctors** prescribe Buprenorphine but are not required to have any counseling for the client. This is likely insufficient to successfully transition a justice-involved individual to the community while on parole.
- Any doctor can prescribe Vivitrol. Again, no counseling is required. This is likely insufficient clinical support for justice-involved individuals making the transition from prison to the community.

A similar understanding of the traditional approaches is also warranted for the non-traditional treatment approaches to maintain a seamless transition from an incarcerated setting to a community-based one. Depending on the setting, the BH provider may have slightly more latitude to adjust the services for the justice-involved individual, provided the channels of communication remain fluent among all parties beginning from the initiation through release.

Working with the justice-involved individual outside of confinement may further enable the BH provider to listen to and support the decisions patients make about their treatment (SAMHSA, 2021a). To avoid stigma, some patients may choose to receive MOUD from physician offices rather than OTPs (SAMHSA, 2021a). Other clients may prefer to receive medically supervised withdrawal in an OTP (SAMHSA, 2021a).



Key Term: Opioid Receptor Agonist Treatment

Opioid receptor agonist treatment involves using methadone or buprenorphine to prevent withdrawal and reduce cravings. This treatment works by preventing withdrawal for 24 to 36 hours. For a quick overview of opioid agonist therapy, visit the fact sheet by the Centre for Addiction and Mental Health.

Reference

Centre for Addiction and Mental Health. (2016). Opioid agonist therapy. CAMH. Retrieved March 17, 2022, from <https://www.camh.ca/-/media/files/oat-info-for-clients.pdf>

It is important to give clients information about the risks and benefits of all treatment types, even if the client has an initial preference for a specific type of treatment (SAMHSA, 2021a). While it is sufficient to give information, it is even more important for the client to be able to comprehend the risks and benefits of treatment and use this information to provide true informed consent for treatment (SAMHSA, 2021a).

Provided below are other recommendations that BH providers can take into consideration for the justice-involved individual when determining an appropriate setting for those dealing with OUD. These include but are not limited to outpatient OUD treatment settings, outpatient medical settings, and residential drug treatment settings.

Outpatient OUD Treatment Settings. Recommendation to Consider: *CJ staff should ensure clients initiate treatment in an OTP (if this course of treatment is chosen) by making an intake appointment while the client is in the office with staff (SAMHSA, 2021a).* This will eliminate the barrier of an inability to contact the OTP intake (SAMHSA, 2021a). In the case of no openings at the OTP, buprenorphine can be initiated before acceptance into the OTP (SAMHSA, 2021a). However, if CJ staff refers clients to an OTP for methadone or buprenorphine they should explain:

- The client will have to visit the OTP 6-7 times per week to start
- Methadone take-home doses are a possibility for the client with demonstrated progress
 - These take-home doses are 90 days of medication
- Required parts of OTP treatment include counseling and drug testing; however, some locations also offer services such as case management, peer support, medical services, and mental disorder treatment

Recommendation to Consider: *Treatment can be given at different intensity levels; therefore, staff should use appropriate information to determine the treatment intensity level for clients seeking treatment for OUD in settings other than OTPs (SAMHSA, 2021a).*

Low-intensity treatment takes place a few times per week while high-intensity treatment is several days per week for at least two hours each session. Information used to determine treatment intensity may include:

- The client's socioeconomic needs
- Substance use severity
- The client's treatment preferences
- Mental and behavioral health needs
- Cost of treatment and the client's ability to pay for treatment

Outpatient Medical Settings. Recommendation to Consider: Physicians may also prescribe naltrexone or buprenorphine but are not able to provide methadone in their healthcare clinics. Methadone can only be accessed at OTPs. If no treatment plan is already determined, the medical professional should assist in creating a treatment plan and determine locations a patient can receive the preferred form of treatment (SAMHSA, 2021a). It should be considered that referring the patient to another location may delay treatment, therefore buprenorphine should be offered as a temporary treatment until the patient is able to seek treatment at the preferred location (SAMHSA, 2021a). Since medical professionals are also able to prescribe naltrexone, the physician should provide naltrexone for continuing treatment that was initiated elsewhere.

Residential Drug Treatment Settings. Recommendation to Consider: *Clients who are eligible for residential treatment should be referred for treatment at locations providing residential treatment (SAMHSA, 2021a).* Several factors should be taken into consideration such as the client's housing status, concurrent SU problems, and concurrent BH problems (SAMHSA, 2021a). CJ staff should inform the client of the requirements in the length of stay, services received, and cost of treatment (SAMHSA, 2021a).

Recommendation to Consider: *Clients already taking opioid agonist treatment may have concurrent other SU issues (i.e. alcohol use disorder [AUD], cocaine use disorder, etc.) and could profit off of residential treatment (SAMHSA, 2021a).*

Important Note

Legislation passed in 2023 has removed the X-Waiver requirement needed for physicians to prescribe buprenorphine.

Additionally, the FDA has approved the sale of Narcan (Naloxone) over the counter.

If this is the right course of treatment for the client, staff should look into the admission requirements of the residential treatment program to determine if the client could continue receiving opioid receptor agonist medications (SAMHSA, 2021a). Residential treatment programs provide:

- Housing
- Support services
- Counseling

Residential treatment programs will sometimes provide:

- Case management
- medically supervised withdrawal
- opioid agonist medication initiation
- mental health services
- Buprenorphine or methadone continuation



Note

Doctors cannot provide methadone in their clinics. Any healthcare professional with a license can provide naltrexone. As of January 2023, physicians are no longer required to have a waiver to prescribe buprenorphine. This went into effect as part of the Consolidated Appropriations Act, 2023.

Recommendation to Consider: *Treatment planning should take place when transitioning out of residential treatment (SAMHSA, 2021a).* The treatment plan should incorporate continuity of care after discharge from the residential treatment setting as well as plans to minimize overdose risk (SAMHSA, 2021a). Continuing MOUD after discharge will help clients maintain sobriety after discharge (SAMHSA, 2021a). All clients should also receive a Naloxone prescription to further overdose prevention (SAMHSA, 2021a).

Telehealth/Telemedicine and the Justice-Involved Individual

As with many services impacted by the COVID-19 pandemic, SUD services felt the effects and have experienced the need to shift the practices in the field. This shift has included exploring new methods to deliver SUD services, such as Telehealth. Although it is not a new approach, Telehealth is not typically utilized with justice-involved individuals. However, current research explains that to improve access to care for justice-involved individuals, and to negate geographic barriers, technology-based methods are essential (Young & Badowski, 2017).

Telehealth/telemedicine can be utilized in both a synchronous, live videoconferencing format as well as an asynchronous format (SAMHSA, 2019a). The synchronous format enables providers and patients to engage in direct care delivery at present time (SAMHSA, 2019a). The asynchronous format allows



Note: Differences Between Telehealth and Telemedicine

Within this chapter, Telehealth and Telemedicine are used synonymously. As explained by Young and Badowski (2017), the terms are often used interchangeably, but there is a minor difference. Telehealth is inclusive of telemedicine and utilizes telecommunication to provide services, education, and data. Telemedicine on the other hand focuses on utilizing a two-way interaction between the client and provider to improve health outcomes.

Reference

Young, J. D., & Badowski, M. E. (2017). Telehealth: Increasing Access to High Quality Care by Expanding the Role of Technology in Correctional Medicine. *Journal of Clinical Medicine*, 6(2), 20. <https://doi.org/10.3390/jcm6020020>

the transmission of information between provider and patient (SAMHSA, 2019a). Synchronous telehealth services are more often reimbursed than asynchronous telehealth services. Although helpful in maintaining communication between provider and patient, phone, text, and web-based interventions are not included as a telehealth modality (SAMHSA, 2019a). It is important to note that telehealth outcomes for OUD are similar to that of in-person outcomes. Therefore, telemedicine may be helpful when in-person care is not available.

Things to consider for OUD:

- Initiating and maintaining client treatment
- Logistics of patient drug testing, delivering and administering medications while not meeting with the client in person
- Arranging for client counseling that can be utilized concurrently with medication
- Staff understanding of telemedicine and comfort with using this modality to meet with clients and provider sites
- Following federal, state, and local laws on prescribing medication for clients met through telehealth
- Some clients may have more complex needs and require in-person care rather than care through telehealth

What is needed to prescribe MAT through Telehealth/Telemedicine?

- DEA-waivered providers
- Nursing/clinical staff
- Prescription Drug Monitoring Programs
- Reliable pharmacies
- Laboratory testing
- Ability to refer to a higher level of care
- Compliance with federal tele-prescribing laws (Ryan Haight Act*)
- Compliance with state tele-prescribing laws (Shore, n.d.).

*The Ryan Haight Act was passed in 2008 to regulate online prescriptions, particularly for controlled substances. This has an implication for telehealth in that in-person evaluations are needed to prescribe controlled substances.

Reference

Shore, J. (n.d.). Ryan Haight online pharmacy consumer protection act of 2008. Ryan Haight Act. Retrieved March 17, 2022, from <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/ryan-haight-act>

Ensure Service Continuity Around Treatment Initiation Practices

Service continuity is key within this indicator in that it supports the importance of collecting treatment data and the sharing of that data among CJ and BH providers to ensure the justice-involved individual's needs are identified and addressed at the start of treatment. Developing training

curriculums designed to educate the CJ and BH staff about collaboration among all parties advances current practices, establishes an inclusive approach that provides a variety of services that strengthen the continuity of treatment, and enhances collaboration.

Supporting secondary indicators include:

- Document client-level treatment initiation in a data system to better capture treatment initiation data
- Develop an MOU across agencies/programs for more streamlined treatment initiation practices or sharing of data
- Train staff on treatment initiation services/practices

Practical Applications of the Indicators:

- Establish protocols that will enable the entity to share information with the various treatment providers that are pertinent to the justice-involved individual's treatment
- Develop training curriculums that will educate the relevant staff about the significance of information sharing to support the justice-involved individual's success during and after treatment
- Develop and implement transition teams designed to increase the ability of CJ staff and community providers to communicate about the need for more intensive levels of care based on increased drug use

Formulating Practical Application of the Indicator into Action

Data and Information Sharing

CJ agencies should have the ability to store and share data regarding clients receiving MAT with other stakeholders and partners (SAMHSA, 2019b). A State Medicaid Director letter issued by Tim Hill (2018) petitions for the use of Medicaid-supported technology to aid in information sharing between agencies to combat the opioid epidemic. However, when using this technology, it is important to adhere to HIPAA and 42 CFR Part 2 legislation when sharing information about individuals with OUD (SAMHSA, 2019b). Legislators should review the privacy laws in their state to ensure laws are not prohibitive of information sharing leading to a delay in treatment services (SAMHSA, 2019b).

Data and information sharing can occur in several ways among CJ staff and BH providers. Recommendations to consider include but are not limited to:

- Conducting Multi-Disciplinary Team Staffing that brings together the community treatment “team”-inclusive of recovery coaches, family members, community support networks, as well as the SUD/BH and CJ system staff.
- Developing a process for the transition of information regarding the justice-involved individual's assessment, diagnosis, treatment plan, and discharge plan from the facility-based treatment provider to the community treatment provider, to ensure a seamless treatment transition.
- Developing training for community-based providers as well as CJ system staff to ensure that there is a better understanding of roles, rules, and goals.

- Conducting Multi-Disciplinary Team Staffing prior to the justice-involved individual's release from the facility-based treatment program including the community-based SUD treatment provider, support team, CJ staff, and BH staff.
- Implementing protocols to improve information sharing across agencies
- Scheduling meetings for the myriad of agency staff on a regular basis to review the justice-involved individual's progress in treatment.
- Sharing information on a regular and standardized basis to ensure that all parties involved are aware of any changes, issues, and successes.
- Developing an MOU with all agencies involved with the justice-involved individual to establish a formal commitment for data and information sharing.

Improving Collaboration Between Agencies

Collaboration methods like cross-training, coordinated and comprehensive planning, and follow-up multidisciplinary meetings can all aid in developing a shared responsibility with all partners (SAMHSA, 2005b). The CJ system is increasingly adopting public health approaches and increasingly focusing on offender needs and rehabilitation at sentencing (Painter-Davis & Ulmer, 2020), and that to better reach these goals the CJ system would do well to borrow insights from and collaborate with the treatment system. Both of these systems have focal concerns with some overlap. These focal concerns include assessments of risk, assessments of practical constraints and consequences (funding), and client needs and rehabilitation.

Table 5.1 *Paradigm of Collaboration*

Goals of Treatment System	Goals of Supervision System	Shared Goals
Increase recovery and promote healthy lifestyles	Reduce recidivism	Minimize risk to public
Provide evaluation and treatment services	Maximize the use of databases for the justice-involved individual	Obtain adherence to treatment plans and abstain from substance use
Practice social skills	Enhance supervision	Alleviate symptoms of illness
Develop a working alliance	Rely on third party expertise	Promote successful community reintegration with the goal of abstinence
Prevent secondary pathology	Focus on public safety	Encourage family/social support
Collaborate/consult with other providers	Respond to court mandates	Support employment efforts

Minimally edited: SAMHSA Treatment Improvement Protocol (TIP) 44, Figure 10-2.

Encourage Clients with Substance Use Problems to Stay in Services

The justice-involved individual's length of stay and commitment to treatment can be directly tied to successful recovery. Utilizing techniques that will help motivate and engage the justice-involved individual to stay in structured SUD/ODD services, obtain and accept community support, and take ownership of their recovery, the more likely that the justice-involved individual will be to sustain their recovery long term. Because the justice-involved individual may experience multiple needs and deal with co-morbid concerns, ongoing services and support are necessary.

Supporting secondary indicators include:

- Talking with the client about their progress in treatment
- Utilizing motivational interviewing (MI) and/or contingency management (CM) to support treatment engagement or to change behaviors when treatment is not available

Practical Applications of the Indicators:

- Train supervision and clinical staff working with the justice-involved individual in MI and CM techniques
- Incorporate CM and MI into the supervision visits to assist in reinforcing the justice-involved individual's treatment participation
- Implement a comprehensive relapse prevention plan that is designed to provide information about the justice-involved individual that is inclusive of data from each phase of treatment (initiation, engagement, and continuity)

Formulating Practical Application of the Indicator into Action

Supporting Engagement Through Contingency Management

The UCLA Integrated Substance Abuse Programs (ISAP) published a treatment manual for implementing contingency management (Pendergast & Hall, 2011) that included seven principles of motivational incentives. These seven core issues that all behavior modification or contingency management systems need to address include:

1. **Target Behavior:** In selecting a target behavior typically choose something that is problematic and in need of change. It is vital that the behavior be observable and measurable. The target behavior is the centerpiece of the behavioral contract, which, in turn, provides the framework within which incentives can be successfully used (Petry, 2000; Pendergast & Hall, 2011).
2. **Choice of the Target Population:** While it might be ideal to provide reinforcements for all clients in a program, this may not be feasible or even necessary. This means that choices will need to be made regarding which group or subpopulation to target with reinforcement-based interventions (Pendergast & Hall, 2011).
3. **Choice of the Reinforcer:** The choice of reinforcer(s) is a crucial element in the design of a motivational incentives program. Incentives that are perceived as desirable are likely to have a

much greater impact on behavior than those that are perceived as being of less value or use (Pendergast & Hall, 2011).

4. **Incentive Magnitude:** Interwoven within the discussion as to which reinforcer to use is the question of how much reinforcement to provide. This is because the magnitude of reinforcement needed to sustain change may differ for different behavior targets (Pendergast & Hall, 2011).
5. **Frequency of Incentive Distribution:** Another factor that is intertwined with the choice and magnitude of the incentive is the frequency of its distribution (Pendergast & Hall, 2011).
6. **Timing of the Incentive:** The core principle here is that the reinforcement needs to follow the exhibition of the target behavior as closely as possible (Pendergast & Hall, 2011).
7. **Duration of the Intervention:** The last factor that must be considered is how long to continue to provide incentives for desirable behavior (Pendergast & Hall, 2011).

Supporting Engagement Through Motivational Interviewing

The initial contact with a client should assess the client's motivation to engage in MAT/MOUD as a form of treatment (SAMHSA, 2005a). A client's motivation for treatment is correlated with a variety of positive outcomes such as increased participation, improved social adjustment, and successful treatment referrals (SAMHSA, 2005a). Community supervision officers and OTP staff can use methods of motivating clients to focus on a fresh start by moving beyond past experiences (e.g., negative relationships with staff, inadequate dosing; SAMHSA, 2005a). Some ideas on what to focus on in the present situation are identifying current realities, working through ambivalence about change, and identifying goals for the future (SAMHSA, 2005a). The use of peer specialists or others with lived experiences may be helpful in motivational enhancement activities (SAMHSA, 2005a).

For more information on motivational interviewing and additional concepts relating to motivation to change, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (SAMHSA, 2019c). The sample Motivational Interviewing Script in **Appendix J** provides an example of how motivational interviewing can be utilized to explore client strengths and barriers to treatment.

Motivational Interviewing and OUD. Below are recommendations to consider when working with justice-involved individuals who have an OUD and lack the motivation to engage in the treatment needed to obtain sobriety for a healthy lifestyle.

Recommendation to Consider: *Staff should help clients reluctant to begin OUD treatment be safer (i.e. harm prevention techniques) in their continued use and lead them to approach readiness for treatment (SAMHSA, 2021a).* Nonjudgmental attitudes by staff will help clients overcome shame and help them be more willing to discuss concerns with staff (SAMHSA, 2021a). Motivational interviewing techniques and using trauma-informed techniques will help clients become more trusting of staff and therefore more willing to discuss the possibility of treatment. Staff should utilize each visit with a client to discuss making changes and moving toward recovery (SAMHSA, 2021a). It should be kept in mind that clients may relapse several times in the course of treatment for SUD. This is part of the recovery process and should not be looked down upon.

Recommendation to Consider: *CJ staff should educate their clients about OUD-related risks and stigma (SAMHSA, 2021a).* Clients have likely received similar information in other settings, but

education is still valuable in the client determining they are ready to initiate treatment. Clients with OUDs have a higher risk of contracting infectious diseases such as HIV and Hepatitis C, as well as skin and soft tissue infections at injection sites (SAMHSA, 2021a). CJ staff can educate clients about:

- Harm reduction strategies
 - Not reusing syringes
 - Avoid sharing syringes and other supplies
 - Cleaning syringes
- Preventing opioid overdose
 - Obtaining Naloxone
 - Training for use of Naloxone
 - Obtaining opioid overdose prevention resources

Initiate Contact with Service Providers to Obtain Information About a Client's Progress in Treatment

Information sharing serves as the focal point of ensuring the justice-involved individual's transition from facility-based to community-based treatment is inclusive of all areas of their needs. These needs can be identified through comprehensive relapse prevention planning and collaboration among the serving entities and the justice-involved individual.

Supporting secondary indicators include:

- On a regular basis, informally share information between CJ supervision and treatment provider staff regarding client participation in services (phone calls, emails)
- Developing mutually agreed upon client relapse prevention plan of care between CJ staff and community treatment providers
- Sharing information between CJ staff and treatment provider on urine screen results to monitor the client's use of alcohol as well as illicit and controlled substances
- Sharing information between CJ staff and treatment provider on the client's adherence to prescribed medications

Practical Applications of the Indicators:

- Restructure current data-sharing mechanisms to allow the sharing of data through systems utilized to track and document the treatment progress of the justice-involved individual.
- Implement data-sharing processes that allow MAT providers the avenue to collaborate with qualified behavioral healthcare providers in order to determine the optimal type and intensity of psychosocial treatment. These data-sharing processes can additionally be used to renegotiate the treatment plan for circumstances in which the justice-involved individual does not adhere to recommended plans for, or referral to, psychosocial treatment.
- Incorporate information about consent protocols for the justice-involved individual into the training of CJ and BH staff to help enhance information-sharing practices.

Formulating Practical Application of the Indicators in Action

Improving Communications

Patients should concurrently have counseling sessions as well as MOUD as part of their SU treatment (SAMHSA, 2021a). Communication and collaboration between MOUD prescribers and counselors enable supportive work for the patient (SAMHSA, 2021a). Although not able to prescribe MOUD, a counselor has frequent visits with the patient. Typically, a counselor will:

- See clients more frequently than doctors
- Have a more complete sense of the client's issues
- Offer providers valuable context and perspective
- Help clients take medications appropriately
- Ensure that clients receive high-quality care from their other providers (SAMHSA, 2021a).

Obtaining the Justice-Involved Individual's Consent

Counselors should have patients sign a consent form (i.e. Release of Information [ROI], Appendix M) which will allow the provider to communicate personal health information directly to other providers, unless the counselor and providers work in the same treatment organization (SAMHSA, 2021a). The consent form should be specific in the information that is allowed to be shared between providers, particularly in relation to substance-use-related issues, as well as which specific providers are allowed to share and receive the information. The consent forms should comply with all federal and state laws governing patient confidentiality for clients with SUDs (SAMHSA, 2021a).

The patient's PHI, medical care, and treatment information should be protected. Information should not be sent through secure channels, such as:

- Text messaging
- Unsecure, unencrypted emails
- Faxes to unsecured machines (SAMHSA, 2021a).

Keep in mind that phone calls are the most secure way to discuss patient information (SAMHSA, 2021a). However, it may be more convenient to reach out to other professionals by email to schedule a phone call (SAMHSA, 2021a).

Addressing Collaboration Barriers Between Community Behavioral Health (CBH) and MAT Prescribers

Unless the client's providers work for the same agency, clients must sign ROIs for the providers to have collaborative conversations about the client's care (Confidentiality of Substance Use Disorder Patient Records, 2020; SAMHSA, 2021a). This follows federal regulations on the confidentiality of medical records. When a client does not consent to collaborative communication, the providers must decide whether to continue treatment (SAMHSA, 2021a). The providers should use their judgment and review client information to determine whether treatment will continue despite the inability to collaborate.

Collaboration between providers is the standard of care for OUD treatment and recovery (SAMHSA, 2021a). While deviation away from this standard should rarely occur, the client's circumstances, preferences, and needs should dictate the intensity of collaborative communication among providers (SAMHSA, 2021a). It should be explained that collaborative care for the client is mutually beneficial to all involved and the only information shared is determined by client approval.

Ensure Continuity Around Treatment Engagement Practices

Within this indicator, continuity focuses on sustaining long-term recovery through support that can assist the justice-involved individual in maximizing their treatment. The use of collaborative approaches among servicing entities can engage the justice-involved individual and promote self-directed and person-centered care. Further, these approaches can help the justice-involved client change their lifestyle, thinking, and health by connecting the client with mutual help/support groups during and after treatment to form a foundation for sustainable recovery.

Supporting secondary indicators include:

- Documenting client-level engagement or continuing care in data systems to better capture client-level engagement or continuing care data
- Training staff on engagement and continuing care services/practices
- Having an MOU between collaborating agencies for improved engagement, continuing care practices, and data sharing

Practical Applications of the Indicators:

- Incorporate mutual help/support groups as a core component of treatment practices for the justice-involved individual during incarceration and continued through community-based treatment.
- Collaborate with mutual help groups to establish opioid-use-specific support groups for the justice-involved individuals identified with OUDs.
- Develop a training curriculum that will educate CJ system staff and BH staff on how to identify and utilize the various support groups available for the justice-involved individual to participate in during and after treatment to sustain engagement at each level of service. Participation in support groups, mutual aid, AA, NA, etc., should not require information sharing or consent. These are intended for the personal, confidential use of the client.

Formulating Practical Application of the Indicators into Action

Accessing services in the community that help a justice-involved individual transition from a facility-based treatment program to on-going treatment in the community requires collaboration, communication, and commitment on behalf of all parties. The continuity of care allows the justice-involved individual to continue their recovery progress using community resources, family support, peer support, and advocacy and support from the CJ professional. In many cases, this is made possible by utilizing mutual help groups.

This section addresses the challenges the justice-involved individual may face, the steps that can be taken to assist with the mutual help experience, and the mutual help group options for individuals with OUD.

Challenges MAT Clients May Encounter

Clients can take advantage of 12-step groups to aid in abstinence while also learning skills to support recovery (SAMHSA, 2021a). Spirituality/religion is an important aspect of 12-step groups. Therefore, it is important to relay to clients that being open to spirituality/religion is vital to participating in these groups. The client's involvement in the 12-step group is indicative of the benefits gained and greater attendance at meetings has been linked to greater success in abstinence (SAMHSA, 2021a).

Despite the usefulness of attending mutual-help groups, there are some barriers that prevent clients from utilizing these groups (SAMHSA, 2021a). For example:

- Narcotics Anonymous (NA) does not differentiate illicit opioid use and OUD medication when considering abstinence from substances. Therefore, NA does not deem participants sober if they are taking MOUD and may not allow them to attend meetings or have hostile attitudes towards clients taking MOUD.
- AA is more accepting of clients taking MOUD, which may also be used to treat AUD. Clients taking MOUD may face similar barriers as those in NA, but not to the same extent.
- Other support groups may also face barriers to MOUD use through group policies. These groups include:
 - SMART Recovery
 - LifeRing
 - Secular Recovery
 - Religious mutual-help groups

Preparing MOUD Clients to Attend Mutual-Help Meetings. Treatment providers and CJ staff can ensure the justice-involved individual will find mutual-help groups (SAMHSA, 2021a) if:

- Staff can gauge the mutual-help group's attitudes toward MOUD use
- Staff have a document on-hand with a list of all mutual-help groups and options in the client's geographical area

- Members from mutual-help groups can be utilized to introduce the client to groups in the area
- Meeting attendance is recommended but not mandated
- Staff aid justice-involved individuals in starting a mutual-help group
- There is a discussion surrounding the client's perception of mutual-help groups

Facilitating Positive Mutual-Help Group Experiences. In addition to preparing clients for mutual-help group attendance, CJ staff and treatment providers can take measures in creating a positive experience for the client's participation in a mutual-help group. Education is a large part of the process of developing a positive experience. CJ staff and treatment providers should discuss the different group types with the client including the risks and benefits of participation, addressing the client's prior experience with mutual-help groups, and the group's views on the use of MOUD (SAMHSA, 2021a). To create a more positive experience for the client, a "buddy" person who also takes MOUD is an option for the client (SAMHSA, 2021a). This buddy may have knowledge of certain groups that are more open and accepting to group members that take MOUD (SAMHSA, 2021a).

Clients should keep in mind they are not required to disclose their use of MOUD (SAMHSA, 2021a). If a client is considering disclosing their use of MOUD, some methods that can prepare clients for the disclosure of MOUD use to the mutual-help group include:

- Developing a script of how to answer certain questions that may be asked
- Role-playing scenarios of questions the client may be asked
- Creating a plan for disclosing the use of MOUD (either to an individual or small group rather than the large group)

Although participation in mutual-help groups may be mandated, CJ staff and treatment providers must keep in mind that the client will be unable to share what occurs during the group meetings (SAMHSA, 2021a). Clients should not be pressured to share information and staff should respect the privacy of group participation (SAMHSA, 2021a).

Online Mutual-Help Groups. CJ staff and treatment providers should vet online mutual-help groups to determine whether they are supportive of individuals using MOUD (SAMHSA, 2021a). Online groups are helpful for clients who live in rural areas, have transportation issues, or have other barriers. These online mutual-help groups can utilize discussion boards, chat rooms, and even teleconferencing software (SAMHSA, 2021a). Despite the format of the online groups, it is highly recommended that the client takes part in moderated online groups versus unmoderated groups (SAMHSA, 2021a).

Mutual-Help Groups Specific to Opioid Treatment Providers (OTP). Briefly mentioned earlier in this chapter, an alternative to finding a mutual-help group is to create a group on the premises of OTPs and/or associated with OTPs. This would ensure that all group members are open to the use of MOUD in treating SUD (SAMHSA, 2021a). Clients would not experience the stigma they may endure at NA meetings if they disclosed their use of MOUD (SAMHSA, 2021a). A new movement of variations on the 12-step model exists for clients to utilize. Some of these groups include Methadone Anonymous (MA), Medication-Assisted Recovery Services (MARS), and Medication-Assisted Recovery Anonymous.

Client Self-Directions and Person-Centered Care

Client Self-Direction. Clients who attend consistent counseling sessions learn valuable techniques to help them with long-term recovery (SAMHSA, 2021a). The clients who seek this type of counseling will develop skills such as:

- Healthy and positive ways to interact with others
- Problem solving
- Incentivizing abstinence
- Methods to prevent future SU or an increase in SU
- Replacing SU with other activities

Treatment plans should be individualized for each client (SAMHSA, 2021a). While some may use MOUD for a short time, other clients may not use MOUD, and, still, others may use MOUD for life (SAMHSA, 2021a). Sustained outpatient MOUD for clients has proved to be more beneficial for clients than not utilizing MOUD (SAMHSA, 2021a). Other clients are able to cease OU on their own, without the assistance of MOUD. Input from clients on what they believe may help their recovery should be used when planning OUD treatment. Still, FDA-approved medication should be considered and offered to clients with OUD as part of their treatment (SAMHSA, 2021a).

Although clients should be offered MOUD as part of their treatment plan, clients should also be offered psychosocial support (SAMHSA, 2021a). These additional supports are offered in a variety of settings and encompass a broad range of services. The addition of these support services can be determined in the screening and assessment stage when analyzing the client's treatment barriers, as well as discussions in the treatment planning phase (SAMHSA, 2021a).

There is no specified period of time a client should be taking MOUD (SAMHSA, 2021a). Generally, clients who stop taking their MOUD before being advised will resume their SU (SAMHSA, 2021a). Although clients have previously worked towards recovery, SUD changes the release of chemicals in the brain and leads the client to return to illicit OU (SAMHSA, 2021a). The collaboration between the treatment provider, CJ staff, and client should discuss a treatment plan, and if the topic arises, discontinuation of MOUD (SAMHSA, 2021a).

Person-Centered Care. The client's self-efficacy is important to consider when creating a treatment plan. It is important to encourage clients' positive thinking and confidence in refraining from SU. Keeping the client at the forefront and being a major part of treatment planning is one large piece of person-centered care, sometimes known as patient-centered care (SAMHSA, 2021a; SAMHSA, 2022c). In this model, the client has control over their care by deciding details such as the healthcare and treatment professionals they visit with, the duration of treatment, and the type of services received (SAMHSA, 2021a; SAMHSA, 2022c). The healthcare and treatment professionals chosen must be aware of the model they will be interacting within, as well as respect the preferences of the client in treatment planning (SAMHSA, 2021a). Most importantly, all professionals within the model should communicate and collaborate on the client's treatment plan.

The previous model of SUD treatment in the past may harm the recovery process (SAMHSA, 2021a). This confrontational/expert model is characterized by using aggressive means to break down the client's defensive structure (White & Miller, 2007). The treatment provider in this model would give direct feedback and confrontation about the client's SU in hopes to ridicule them into ceasing the behavior (White & Miller, 2007).

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Utilization of collaboration methods and recognition of the Stages of Change improve the client's outcomes of the recovery process (SAMHSA, 2021a). The Stages of Change, or the Transtheoretical Model, recognizes the client's movement from one stage to the next in the recovery process (SAMHSA, 2021a; SAMHSA, 2019c). Relapse is part of the process and not looked down upon; rather, the events leading to relapse give the client the opportunity to plan and prevent relapse in the future (SAMHSA, 2019c). For a greater explanation of each stage of the model, see the **following page**.

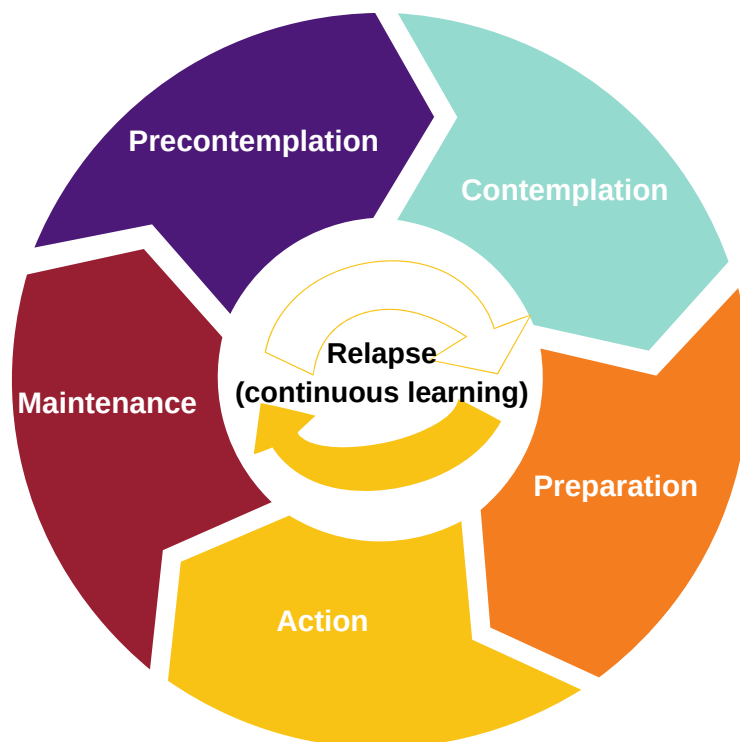
Summary

Treatment may cause anxiety, worry, and stress for some clients either based on past experiences or for fear of the unknown. The practical applications in this chapter give CJ staff and treatment providers ideas and recommendations on how to better encourage clients to initiate and remain engaged in treatment. All options for treatment should be explored including MOUD and telehealth. Further, input from clients on which treatment option is preferred and which would be better for their personal situation should be given great importance when developing a treatment plan. It is through collaboration between CJ staff, the client, and treatment providers that a personalized treatment plan will address the client's SU and other additional needs related to treatment success.

Stages of Change/Transtheoretical Model

The Stages of Change framework is used to determine a client's readiness to change unhealthy behaviors. There are several stages in this model and the client does not necessarily start at the first stage of the model. Each stage of the model is listed in more detail below:

- **Precontemplation** is defined as the client not recognizing their behavior as being unhealthy or destructive. The client does not intend to change their behavior within the next six months.
- Once the client is aware of the cons of their unhealthy or destructive behavior, they have moved into the **contemplation** stage. The client wants to make a change and intends to do so within the next six months. The contemplation stage is often marked with ambivalence to change behavior, therefore motivational interviewing is a useful tool in helping the client become more motivated to make a change.
- When the client is intending to make a change within the near future (about 30 days), they have entered the **preparation** stage. This stage may be marked with the participant planning steps in making the change to their behavior and acknowledging the benefits of making the change.
- When the client has changed or modified their behavior within the last six months or so, they have entered the **action** stage. The client intends to stay with the behavior change and wants to continue making this improvement.
- Once the client has maintained this behavior change for the last six months, they are categorized in the **maintenance** stage. Rather than focusing only on behavior change, clients in the maintenance change may work toward preventing relapse into their unhealthy behaviors.



For more information on the Stages of Change/Transtheoretical Model and its use in treating substance use, see [SAMHSA TIP 35](#).

APPENDICES

APPENDIX A	Sample Memorandum of Understanding
APPENDIX B	Logic Model Example
APPENDIX C	Continuity of Care Indicators Checklist
APPENDIX D	Sample Referral Forms
APPENDIX E	Referral Resources
APPENDIX F	Treatment Definitions and Terms
APPENDIX G	Treatment Planning
APPENDIX H	Stages of MAT in an Opioid Treatment Program
APPENDIX I	Phases of MAT
APPENDIX J	Motivational Interviewing Sample Script
APPENDIX K	Consent for Release of Information Sample Form

SAMPLE MEMORANDUM OF UNDERSTANDING

The Memorandum of Understanding (hereafter referred to as “MOU”) shall serve as a basis for agreement between the _____ [INSERT Criminal Justice System] and _____ [name of treatment provider].

Purpose:

The purpose of this MOU is to establish a collaborative relationship between the parties to build a partnership based on:

- (1) understanding both _____ [INSERT Criminal Justice System] and _____ [name of treatment provider] expectations, including corrective action, incentives, supervision, and treatment program rules;
- (2) sharing information as outlined below; and
- (3) helping participants successfully graduate from the [INSERT Name] program.

The MOU covers but is not limited to, the efforts of both parties to gather and share information that will benefit the needs of the justice-involved individuals during and after their participation in all levels of treatment.

Terms:

The term of this Memorandum of Understanding (MOU) is legally effective for the calendar year from _____ [date] to _____ [date], or until a subsequent MOU is properly executed, whichever is later. All terms and conditions of, and modifications to the MOU remain effective during the calendar years listed above or until a subsequent MOU becomes legally effective.

Modifications:

Any party wishing to modify this MOU must notify the other parties in writing of its desire to do so. All the parties will review the requested modification(s) and decide whether to modify the MOU. If modifications are made, the revised document will be submitted to the parties for signatures.

Termination:

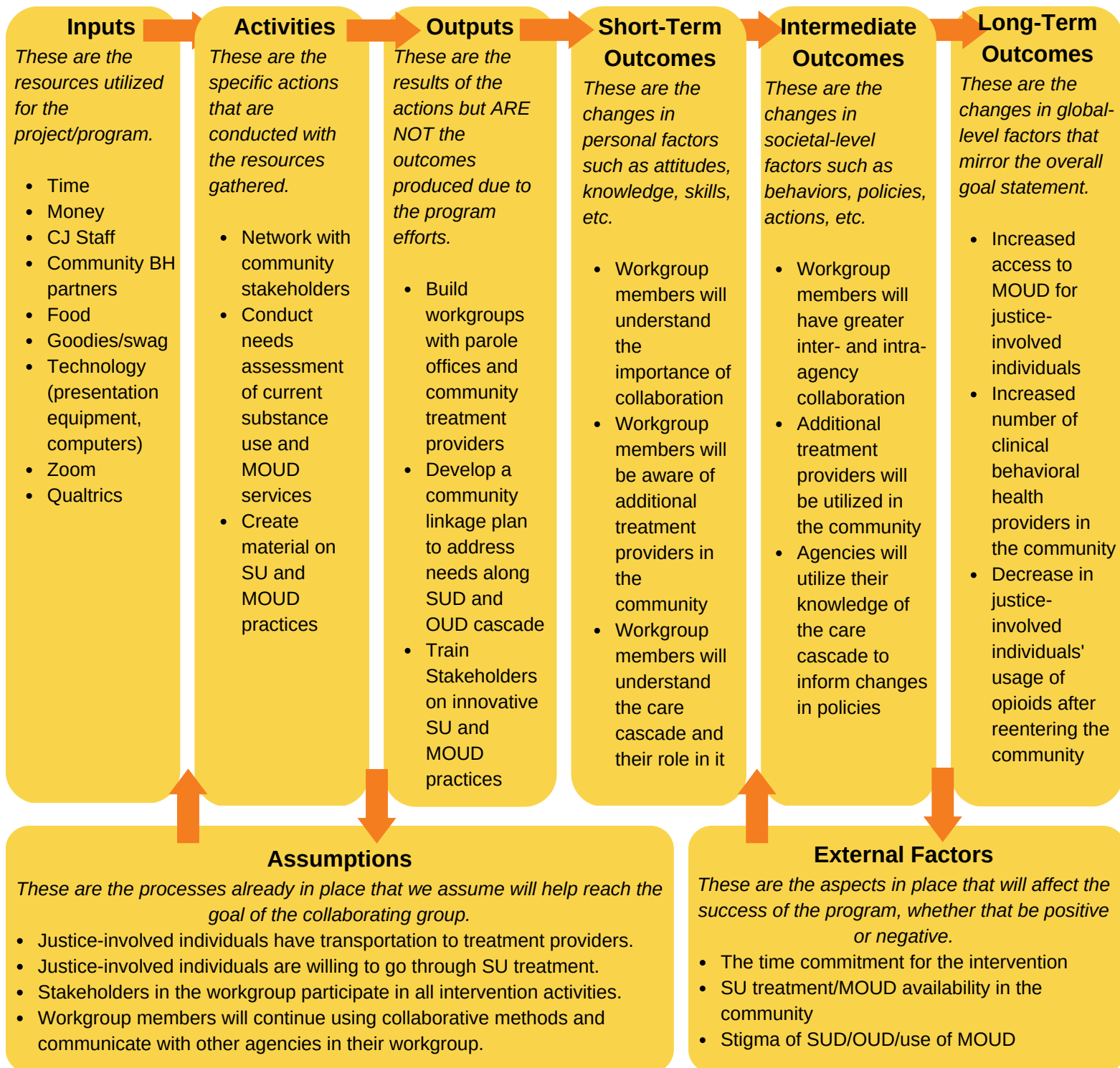
Any party wishing to terminate its participation in this MOU must notify the other parties in writing of its intent and reason for termination. All parties will review the request, discuss the reasons for the requested termination, and try to resolve the matter to continue the party’s participation. The party may still decide to terminate its participation.

LOGIC MODEL EXAMPLE

Goal Statement

This is the overall goal the collaborative is trying to achieve.

Increase access to and retention in clinical behavioral health and MOUD services for reentering justice-involved individuals who use or are at-risk of using opioids.



CONTINUITY OF CARE INDICATORS CHECKLIST

Screening and Assessment Indicators

Conduct a clinical screener for substance problems

- Use a scored, standardized evidence-based instrument to screen for substance problems
- Use biological testing (e.g., urine) to screen for substance problems
- Supplement the use of at least one validated screening tool with another source of information (e.g., another screening tool, biological testing, criminal records)
- Use a screener for drug-related impairment or overdose, and make an appropriate referral for any urgent or emergency medical or psychiatric problem(s)
- Administer a screening instrument as early as possible after the client's entrance into the criminal justice system
- Screen for withdrawal severity, monitoring, and medical management of symptoms
- Use results from screening instruments to recommend a more comprehensive assessment

Ensure service continuity around screening practices

- Train staff on screening services/practices
- Document client-level screening data in data records system to better capture client-level screening data
- Have an MOU across agencies/programs for screening practices or sharing of data (i.e., formal terms of agreement on how and what data or receipt of practices will be communicated between agencies)

Conduct a comprehensive assessment of substance use and related problems

- Use a scored, standardized evidence-based assessment instrument to identify substance problems
- Use a clinical assessment that generates a substance use disorder diagnosis
- Use an assessment that includes relevant history and a physical examination to diagnose opioid use disorder
- Use an assessment that includes relevant history and a physical examination to diagnose opioid use disorder
- Use an assessment that collects a detailed history of past and current polysubstance use
- Use a multidimensional assessment that includes an assessment of social and environmental factors to identify facilitators and barriers to recovery
- Use Screening and assessment results to make substance use treatment referrals
- Provide opioid overdose reversal drugs, along with training in how to administer
- Have licensed clinicians conduct comprehensive assessments

Ensure service continuity around assessment practices

- Train staff on assessment services/practices
- Document client-level assessment data in the data records system to better capture client-level assessment data
- Have an MOU across agencies/programs for assessment practices or sharing of data (i.e., formal terms of an agreement on how and what data or receipt of practices will be communicated between agencies)

Treatment Referral Indicators

Refer the client with a substance use problem to treatment services

- Initiate referrals as soon as possible after client needs have been identified
- Continue the treatment of substance use disorders at the time of community reentry
- Continue treatment of opioid use disorders at the time of community reentry
- Refer the client to treatment providers that are accredited
- Refer the client to treatment providers that use evidence-based practices
- Provide the client with the treatment provider's contact information (phone number, address)

Select a treatment option that addresses the client's specific need

- Refer the client to treatment providers based on location, convenience, or accessibility (for example, hours, transportation, and distance)
- Consider the client's preferences, past treatment history, current state of illness, and treatment setting when deciding which medication is best
- Couple MOUD with counseling for maximum benefits in the treatment of opioid use disorders
- Consider the client's psychosocial situation, co-occurring disorders, and risk of diversion when determining which treatment setting is most appropriate
- Initiate treatment with methadone or buprenorphine (rather than withdrawal management or psychosocial treatment alone) as early as possible during pregnancy

Encourage client's access to treatment after the referral is made using active referral practices

- Confirm that the client has the means to pay for treatment (either through Medicaid, private health insurance, or some other means)
- Make the initial contact/appointment with the service agency for the client
- Provide transportation to the initial appointment
- Accompany the client to the initial appointment
- Follow up with the treatment provider after a referral is made to ensure the client attended the first appointment and collect any other necessary information
- Utilize motivational interviewing (MI) and/or contingency management to support treatment initiation or change behaviors when treatment is not available.

Ensure service continuity around referral practices

- Use standardized procedures for referrals (for example, completing a referral form)
- Train staff on treatment referral services/practices
- Document client-level treatment referral data in data systems to better capture client-level treatment referral data
- Have an MOU across agencies/programs for treatment referral practices or sharing of data, i.e., formal terms of an agreement on how and what data or receipt of practices will be communicated between agencies.

Treatment Initiation Indicators

Encourage a client with a substance use problem to initiate treatment services

- Encourage the client to initiate treatment soon after a referral is made
- Contact the service provider to confirm the first treatment session
- Encourage services with an accredited treatment provider
- Encourage the use of MOUD services in conjunction with psychotherapy
- Encourage continuation of treatment for opioid use disorders after clients are released from corrections facilities

Ensure services continuity around treatment initiation practices

- Document client-level treatment initiation in data systems to better capture client-level treatment initiation data
- Have an MOU across agencies/programs for better treatment initiation practices or sharing of data (i.e., formal terms of an agreement on how and what data or receipt of practices will be communicated between agencies)
- Train staff on treatment initiation services/practices

Treatment Engagement Indicators

Encourage clients with substance use problems to stay in services

- Talk with the client about their progress in treatment
- Utilize motivational interviewing and/or contingency management to support treatment engagement or to change behaviors when treatment is not available

Initiate contact with service provider to obtain information about a client's progress in treatment

- On a regular basis, informally share information between CJ supervision and treatment provider staff regarding client participation in services (phone calls, emails)
- Develop mutually agreed upon client relapse prevention plan of care between CJ staff and community providers
- Share information between CJ staff and provider on urine screen results to monitor the use of alcohol, illicit, and controlled substances
- Share information between CJ staff and provider on adherence to prescribed medications

Ensure continuity around treatment engagement practices

- Document client-level engagement or continuing care in data systems to better capture client-level engagement or continuing care data
- Train staff on engagement and continuing care services/practices
- Have an MOU across agencies/programs for better engagement or continuing care practices or sharing of data (i.e., formal terms of an agreement on how and what data or receipt practices will be communicated between agencies)

SAMPLE REFERRAL FORMS

Referring Agency Information

Referring Agency: _____ Date: _____

Contact Name: _____ Email: _____

Phone Number: _____ Fax: _____

Receiving Agency Information

Receiving Agency: _____ Date: _____

Contact Name: _____ Email: _____

Phone Number: _____ Fax: _____

Client Information

Name: _____ Phone: _____

Address: _____ Age: _____

Gender: _____ DOB: _____

Services Requested

- | | | |
|--|---|---|
| <input type="checkbox"/> Substance Use Treatment | <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Legal Assistance | <input type="checkbox"/> Employment | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Food Assistance | <input type="checkbox"/> Primary Healthcare | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Housing | |

Consent to Release of Referral Information

I, _____ (individual), understand that the purpose of the referral and disclosure of information to _____ (receiving agency) is to ensure the continuity of care among service providers. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.

Signature: _____

Date: _____

[Agency letterhead goes here]

Client Name:

DOB:

Age:

Address:

Gender:

Email:

Phone

Referral Agency Information

Referral Agency:

Date:

Contact Name:

Email:

Phone Number:

Fax:

Consent to Referral

I, _____ (individual), understand that the information on this form will be released to _____ (receiving agency). The referring provider, _____ (referring agency), has listed the exact information to be disclosed. I understand that additional information may need to be requested, in which case I will have the opportunity to sign a Release of Information form. By signing this form, I authorize this exchange of information through my referral.

Signature:

Date:

Print Name:

REFERRAL RESOURCES

Case Management Resources

[Comprehensive Case Management for Substance Abuse Treatment](#)
(TIP 27)

This guide is targeted to substance use treatment providers. Throughout this guide there is an overview of case management best practices as well as information on managed care issues, referral and service requirements, working with clients with special needs and a variety of other useful information.

[Case Management in the Criminal Justice System](#)

This document discusses the use of case management with justice-involved individuals and the different techniques, strategies, and practices that can be used to provide services to this population.

NOTE: The below examples are resources specific to their state. Case management resources vary by state and city availability.

[Citywide Case Management](#)
(California)

This program in California encompasses 5 intensive case management programs, as well as recovery support services. The case management programs treat adults with serious mental illness and co-occurring substance use in an outpatient setting to support recovery and reduce hospitalizations, incarcerations, and houselessness.

[The Fortune Society](#)
(New York)

This organization employs a holistic "one-stop shop" model of services, offering a variety of in-house social services including housing, employment, education, mental health and SU treatment, health services, family services, transitional services, care management, food, and nutrition.

Cultural Competency Resources

[Planning a Reentry Program: A Toolkit for Tribal Communities](#)

Although primarily targeting tribal justice system practitioners, this toolkit is designed to assist American Indians and Alaska Natives with reentry into the community. This toolkit also offers guidance for practitioners who are wanting to create or enhance reentry programs currently in place.

Improving Cultural
Competence
TIP 59

This guide is targeted to professional care providers in the delivery of mental health and substance use services to culturally diverse clients.

NAADAC Cultural
Humility Webinar Series

This webinar series discusses SU and SUD disparities among several different cultural groups including LGBTQIA, Latinx, and low-income clients.

Engagement in the
Black Community: A
Virtual NAADAC
Summit

This webinar series discusses SU and SUD disparities among the Black community. Some topics discussed include health equity, policy reform, and innovative ideas to incorporate into treatment.

Behavioral Health
Services for American
Indians and Alaska
Natives
TIP 61

This TIP provides historical and cultural perspectives on American Indian and Alaska Native clients so that behavioral health professionals may better be able to serve this population.

Treating Substance
Use Disorder in Older
Adults
TIP 26

This TIP is designed to help providers and others better understand how to identify, manage, and prevent substance misuse in older adults.

The Opioid Crisis and
the Black/African
American Population:
An Urgent Issue

This brief presents recent data on opioid misuse and opioid overdose death rates in the Black/African American population. Some information covered includes factors and barriers to prevention and treatment, innovative strategies for outreach and engagement, and the importance of using and listening to community voice.

Get Connected: Linking
Older Adults with
Resources on
Medication, Alcohol,
and Mental Health

This toolkit offers information and materials to help understand the issues associated with substance misuse and mental illness in older adults.

The Opioid Crisis and
the Hispanic/Latino
Population: An Urgent
Issue

This brief presents data on opioid misuse and opioid overdose death rates in the Hispanic/Latino population. Some information covered includes factors and barriers to prevention and treatment, innovative strategies for outreach and engagement, and the importance of using and listening to community voices.

Employment Resources

Career One Stop

This site is managed by the US Department of Labor. On this site, individuals can find information on careers, find job training, look for jobs, and even find an American Job Center that provides various job readiness and job search services.

Substance Use Disorders Recovery with a Focus on Employment

This guide helps healthcare providers, systems, and communities support substance use recovery through employment mechanisms. It examines emerging and best practices, identifies knowledge gaps and implementation challenges, and offers resources.

Integrating Substance Abuse Treatment and Vocational Services TIP 38

Similarly to employment services, vocational services may aid clients with substance use treatment. This TIP targets a wide range of providers by helping them become familiar with integrating vocational services in the treatment process.

NOTE: *The below examples are resources specific to their state. Employment resources vary by state and city availability.*

First Step Job Training Program

(New York)

First Step helps by providing skills training, experience, and confidence-building to homeless and low-income women in order to help them find living-wage jobs.

Family Support Resources

Implementing the Family Support Approach for Community Supervision

This report introduces the Family Support Approach for Community Supervision, which engages families and social supports by creating a formalized partnership for successful supervision.

Substance Use Disorder Treatment and Family Therapy (TIP 39)

This guide features ideas for integrating substance use disorder treatment and family therapy in order to support clients and their families during the recovery process.

Why Ask About Family?: By Looking Beyond the Individual to Families and Social Supports, Corrections Officers can Help Improve Public Safety and Other Outcomes

This guide is targeted to a myriad of corrections personnel including case managers, reentry and discharge planners, transition coordinators, probation and parole officers, and others working in correctional institutions. Overall, this guide presents a strength-based, family-focused approach for use in corrections policy and reentry planning.

Financial Resources

My Money

This federally-based program provides information and resources on money management. Clients may also find information about loans and home buying.

Mint Personal Finance Software

This personal finance software that keeps track of your account balances, creates personal budgets, and provides tips for saving money. This software, meant to keep one's finances organized, is available free of charge on Mint's website.

Smart About Money

This program, funded by the National Endowment for Financial Education, offers information on a variety of financial topics to educate the public about setting and achieving financial goals.

Your Money, Your Goals - Focus on Reentry: Criminal Justice

This guide is designed to help frontline staff working with individuals in jails and prisons, pretrial diversion programs like drug courts, community reentry groups, and other social services groups address the unique financial challenges of individuals involved in the criminal justice system.

Helping People Achieve Financial Stability After Incarceration

During this webinar, participants learn about how to use the **Your Money, Your Goals** toolkit and the **Focus on Reentry** guide to help people returning to their communities after incarceration achieve their financial goals.

NOTE: *The below examples are resources specific to their state. Financial resources vary by state and city availability.*

[Better Texas Family Budgets Calculator](#)

This website provides Texas families with an estimate about what they need to earn in order to cover all their living expenses. The website calculates costs based on the metro area showing how much the family needs to make on a full-time hourly basis to cover family expenses. The website also provides information about the industries that are likely to provide that hourly wage and the percentage of workers who are employed in those industries in that metro area.

Gender Specific Resources

[After Incarceration: A Guide to Helping Women Reenter the Community](#)

This guide was created for individuals who provide or coordinate reentry services for women involved in the criminal justice system.

[Reentry Considerations for Justice-Involved Women](#)

This report identifies distinctive reentry needs for justice-involved women, and proposes ways to address these needs. Of note are the six “operating principles” for the management of justice-involved women.

[Adopting a Gender-Responsive Approach for Women in the Justice System: A Resource Guide](#)

These resources are designed to assist criminal justice program planners in designing trauma-informed policies, practices, and programs tailored to women’s distinctive gender-related histories, offending causes, and experiences in the criminal justice system.

[Reentry Tip Sheets for Women](#)

The tip sheets are an important resource for staff to use during the reentry planning process with women and a reminder of discussions and plans that were identified during their incarceration. The tip sheets cover each topic generally and provide links to national resources.

[Substance Abuse Treatment: Addressing the Specific Needs of Women](#)

This guide assists providers in offering treatment to women living with substance use disorders.

[Advancing Awareness in LGBTQ Care Webinar Series](#)

This webinar series explores topics of SU and SUD among LGBTQ+ clients.

[A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals](#)

This manual informs clinical providers about substance use disorder treatment approaches for patients in the lesbian, gay, bisexual, and transgender (LGBT) community. The manual discusses alliance building as well as cultural, clinical, health, administrative, and legal issues the clients may face.

[Addressing the Specific Behavioral Health Needs of Men \(TIP 56\)](#)

This TIP addresses the treatment needs of men living with substance use disorders. The guide reviews best practices such as patterns of substance use, specific treatment barriers, and strategies.

[Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants](#)

This guide provides national guidance for management of pregnant and parenting women with opioid use disorder and their infants. The Clinical Guide helps clinical providers and patients determine the best strategies for a particular situation and informs treatment decisions.

Housing Resources

[Assessing Housing Needs and Risks: A Screening Questionnaire](#)

This screening tool is intended to help reentry professionals better assess an individual's housing needs and risk of homelessness upon reentering the community.

[Helping People Released from Prisons and Jails Find Housing: A State by State Resource Guide](#)

This resource provides state-by-state COVID-19 emergency housing information for persons reentering the community needing safe shelter and housing.

[Homeless Shelter Directory](#)

This site provides a directory of homeless shelters in each state.

[Transitional Housing Directory](#)

This directory has a list of transitional housing and sober housing.

[National Coalition for the Homeless](#)

This resource has a directory of shelters and homeless assistance programs online. While this directory is extensive, it does not list every program in the country, so people should check for local programs in their area.

Recovery Housing:
Best Practices and
Suggested Guidelines

This report identifies guiding principles that will assist states and federal policymakers in understanding what constitutes safe, effective, and legal recovery housing. The guiding principles are meant to provide a framework that builds on the policy that guided the development of current recovery housing.

Shelter Listing Directory

This directory has a list of housing resources including homeless shelters, supportive housing, housing for low-income, halfway housing, transitional housing, day shelters, and low-cost housing.

Behavioral Health
Services for People
Who are Homeless
(TIP 55)

This manual offers skills and resources to providers working with people who are homeless or at risk of becoming homeless.

Medication Assisted Treatment Resources

MAT Course for
Prosecutors:
Understanding
Overdose Risk and
Medication Efficacy

This webinar is designed for prosecutors and their staff to better understand the treatment of substance use disorders, including FDA-approved medications to treat opioid use disorder and their effectiveness for people involved with the criminal justice system.

Use of Medication-
Assisted Treatment for
Opioid Use Disorder in
Criminal Justice
Settings

This guide focuses on using MAT for opioid use disorders in correctional settings and during the reentry process. The guide provides an overview of evidence-based practices and policies that reduce the risk of overdose and relapse when the justice-involved individual is back in the community.

Providers Clinical
Support System

This website serves as a training center for professionals working with clients who are in recovery. This resource is geared more towards clinical professionals to increase knowledge on SUD/ODU identification, screening, assessment, treatment, and supporting patients' long-term recovery.

NOTE: *The below examples are resources specific to their state. Medication Assisted Treatment resources vary by state and city availability.*

Directory of Opioid Treatment Program and Methadone Providers

(New York)

This directory by the New York State Office of Addiction Services and Supports has information on treatment in hospitals and ERs, opioid treatment programs, and an overview of how medications assist treatment.

Adult Substance Use Medication-Assisted Treatment

(Texas)

This site gives a brief overview of MAT services; links to find substance use providers in the client's area; and outreach, screening, assessment, and referral (OSAR) contact information for each region in Texas.

Mutual Help & Support Group Resources

Medication Assisted Recovery Anonymous

This website offers information on groups that welcome individuals using MAT. The website has a locator service to find local groups nearby.

SMART Recovery

Self-Management And Recovery Training (SMART) is a community of mutual support groups around the world. At meetings, participants help one another resolve problems with any form of addiction. This form of recovery is different in that participants develop their personal will to change and lead balanced lives. Meetings take place virtually and in person.

Narcotics Anonymous World Services

This website is a database to find local NA meetings, helplines, and websites. To find virtual meetings, individuals can choose "web" as the country in their NA meeting search.

Online Intergroup of Alcoholics Anonymous

This website provides virtual AA groups at a variety of times, in several different languages, to meet the needs of any individual.

In The Rooms

In The Rooms is a free online recovery tool that offers weekly online meetings. This program embraces multiple pathways to recovery, including all 12 Step, Non-12 Step, Wellness, and Mental Health modalities.

Substance Abuse Treatment: Group Therapy
(TIP 41)

This guide, targeted to counselors, lists innovative ideas on improving the skills to lead group therapy sessions for substance use treatment.

Opioid Specific Resources

[Opioid Overdose Prevention Toolkit](#)

This toolkit offers strategies for healthcare providers, communities, and local governments to develop practices and policies to prevent opioid-related overdoses and deaths. Additionally, there are reports for community members, prescribers, patients and families, and those recovering from an opioid overdose.

[Providers Clinical Support System](#)

This website serves as a training center for professionals working with clients who are in recovery. This resource is geared more towards clinical professionals to increase knowledge on SUD/OD identification, screening, assessment, treatment, and supporting patients' long-term recovery.

[Opioid Response Network](#)

This site provides free training and resources to all professionals who work with clients with a substance use disorder. Additionally, there is at least one consultant in each US state that can provide specialized information to individuals, communities, and organizations.

NOTE: *The below examples are resources specific to their state. Medication Assisted Treatment resources vary by state and city availability.*

[Support for Hospital Opioid Use Treatment - California Bridge](#)

This program provides clinical professionals with the tools to start and maintain patients on buprenorphine or methadone during hospitalizations for any condition.

[Texas Targeted Opioid Response](#)

Texas Targeted Opioid Response strategies fund prevention activities, treatment and recovery services, as well as integrated projects. Texas Health and Human Services Commission plans to expand current contracts and partner with entities such as academic institutions and local mental health authorities that provide outreach, screening, assessment, and referral functions.

Peer Support/Peer Navigation & Social Networking Resources

[Core Competencies for Peer Workers](#)

This resource link provides the core competencies peer support workers may need in order to provide services to specific groups who also share common experiences, such as family members.

Medication-Assisted
Recovery Anonymous

This website offers information on groups that welcome individuals using MAT. The website has a locator service to find local groups nearby.

PeerRX's
INTELLI-MATCH

This technology works in seconds to find the best peer match for the patient. This app works to match vetted peer support with justice-involved individuals in medical settings. The website discusses fees associated with the app.

What are Peer
Recovery Support
Services?

This manual explains peer recovery support services designed and delivered by people in recovery from substance use disorders.

NOTE: The below examples are resources specific to their state. Peer support/peer navigation and social networking resources vary by state and city availability.

Texas Recovery
Support Organizations

Recovery support service organizations provide a variety of services to increase long-term recovery. Services are provided by peers who help to initiate services like counseling, sober housing, transportation, and medications. Through this program, peers may provide support before, during, and after treatment.

Recovery Oriented
Systems of Care
Across Texas

This framework for coordinating across systems is person-centered, self-directed, and designed to readily adjust to meet an individual's needs and individualized path to recovery. The system builds upon the strengths and resilience of individuals, families, and communities.

Anchor ED

(Rhode Island)

This is a program created in Rhode Island that provides 24/7 availability of peer support for post-overdose victims who present to the Emergency Department. Recovery coaches may link the survivor to treatment and recovery resources, provide Naloxone education to families, and follow up with survivors for retention.

Behavioral Health
Referral and Outreach
Call Center

(West Virginia)

A 24-hour point of entry for accessing behavioral health resources. Anyone who calls is offered education on behavioral health, service options in their area, and referrals based on their needs.

Tele-Behavioral Health Resources

PeerRX's INTELLI-MATCH

This technology works in seconds to find the best peer match for the patient. This app works to match vetted peer support with justice-involved individuals in medical settings. The website discusses fees associated with the app.

Tele-Behavioral Health and Opioid Use Disorders Toolkit

The toolkit compiles resources to support organizations in identifying and implementing telehealth programs to address the challenges clients in rural communities may endure.

Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders

This guide by SAMHSA reviews telehealth modalities for treatment of serious mental illness and substance use disorders among adults. The guide also makes recommendations for practice and provides examples of how these recommendations can be implemented.

Using Technology- based Therapeutic Tools in Behavioral Health Services (TIP 60)

This manual helps healthcare and treatment providers with implementing technology-assisted care. It highlights the importance of using technology-based assessments and interventions in treatment services.

SAMHSA's National Helpline

This Helpline provides 24-hour free and confidential treatment referrals in English and Spanish.

BJA's Comprehensive Opioid Stimulant, and Substance Abuse Program

This page gives resources to help guide telehealth implementation as well as considerations that would need to be made during telehealth implementation.

SMART Recovery

Self-Management And Recovery Training (SMART) is a community of mutual support groups around the world. At meetings, participants help one another resolve problems with any form of addiction. This form of recovery is different in that participants develop their personal will to change and lead balanced lives. Meetings take place virtually and in person.

NOTE: The below examples are resources specific to their state. Tele-behavioral health resources vary by state and city availability.

New York State Hotline
to Access Treatment
Services

24/7 service for clients living in New York to access virtual assessment with a professional counselor and referrals to an appropriate course of treatment.

Be Well, Texas

This resource is available 24/7 and offers comprehensive care for substance use disorder and non-severe mental illness. Services offered through this resource include psychiatric evaluation, medication management, counseling, peer recovery support, technology tools, and case management. Services through this program are available regardless of ability to pay.

Behavioral Health
Referral and Outreach
Call Center

(West Virginia)

A 24-hour point of entry for accessing behavioral health resources. Anyone who calls is offered education on behavioral health, service options in their area, and referrals based on their needs.

Transition Resources

Continuity of Offender
Treatment for
Substance Use
Disorder from Institution
to Community

This manual, targeted towards substance use disorder treatment clinicians and case workers, provides guidance on assisting justice-involved individuals reentering the community. There is an overview of assessment, transition plans, important services, special populations, and confidentiality.

GAINS Reentry
Checklist for Inmates
Identified with Mental
Health Needs

This publication provides a checklist and template for creating a successful reentry plan for individuals with co-occurring mental health and substance use disorders.

Second Chance
Resources Library

Tools and guides for justice-involved individuals wanting job readiness and job searching assistance.

Transition from Prison
to Community Reentry
Handbook

The TPC Reentry Handbook was developed as a resource for a range of stakeholders invested with improving transition and reentry practices.

[Inside Out Reentry Network \(ION\)](#)

An app to match justice-involved individuals transitioning into the community to needed resources. This app lets individuals communicate with providers.

[Reentering Your Community: A Handbook](#)

This handbook by the Federal Bureau of Prisons is meant to help justice-involved individuals transition from prison back into the community. This handbook has 3 checklists and additional resources for a variety of ancillary needs.

[The Elected Official's Toolkit for Jail Reentry](#)

This toolkit provides information and resources for local government officials interested in creating or redesigning a jail reentry program. The toolkit includes an overview of jail reentry, steps for developing a jail reentry initiative, facts to engage stakeholders, and sample legislation.

Transportation Resources

NOTE: *Transportation services vary by state and city. In order to determine the best resource for your clients, look into available transportation services through your locality. The resources provided below are meant to be an example of additional organizations and non-profits that may provide this resource. The following resources are those that are available in the Tarrant County area of Texas.*

[Uber](#)

Uber is a rideshare service that uses real-time GPS location services for drivers to meet passengers. Passengers can request an Uber through an app on their phone.

[Lyft](#)

Lyft is a rideshare service that uses real-time GPS location services for drivers to meet passengers. Passengers can request a Lyft through an app on their phone.

[Trinity Metro](#)

Trinity Metro is the public transportation service in the City of Fort Worth. This service includes buses, trains, and vans.

[Catholic Charities of Fort Worth](#)

Catholic Charities works with several other non-profits in the Tarrant County area. This transportation program helps older adults and individuals who are disabled get to work, doctor appointments, and more.

[6 Stones](#)

This is another non-profit in the Tarrant County area that has paired up with Catholic Charities. Not only can clients receive direct transportation, but they also provide transit vouchers as well.

Get a Ride Guide

This all-encompassing guide has a list of transportation services in the North Texas area. Additionally, there are helpful descriptions of the different types of transportation that may be listed in the guide.

Trauma-Informed Resources

Jail Tip #2: Take Steps to be More Trauma Informed

This tip sheet provides a few key action steps that jail leadership and staff can take to become trauma-informed.

Trauma-Informed Care: Principles & Practices for Justice-Involved Women with Serious Mental Illness and Co-Occurring Substance Use

This handout provides tips, tools, and best practices for trauma-informed care of justice-involved women with serious mental illness and co-occurring substance use disorder.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

This paper presents an overview of trauma and the importance of a trauma-informed approach to develop a shared understanding of these concepts across an array of service systems and stakeholder groups.

Trauma-Informed Care in Behavioral Health Services (TIP 57)

This manual helps treatment professionals understand the impact of past and current trauma on substance use and behavioral health.

Breaking the Silence: Trauma-Informed Behavioral Healthcare

(National Council Magazine)

This issue of the National Council Magazine has several articles to help the reader understand trauma-informed behavioral healthcare. Additionally, there are a variety of fieldwork stories of trauma-informed behavioral healthcare in action.

Substance Abuse Treatment and Domestic Violence (TIP 25)

This TIP gives providers an introduction to domestic violence and the link between substance use and domestic violence. Some useful information presented in this guide includes tips on eliciting information and ideas on how to modify treatment to ensure victims' safety.

TREATMENT TERMS AND DEFINITIONS

MOUD	<ul style="list-style-type: none"> • Medications for Opioid Use Disorder • These medications include naltrexone, buprenorphine, and methadone
MAT	<ul style="list-style-type: none"> • Medication Assisted Treatment • MAT is a term that encompasses the use of medications and counseling to overcome SU
Naltrexone	<ul style="list-style-type: none"> • Taken orally weekly or monthly • To begin taking naltrexone, the patient needs to be without opioids in their system for 7-14 days
XR-NTX	<ul style="list-style-type: none"> • Extended-Release Naltrexone • This form of Naltrexone is taken through an intramuscular injection.
Buprenorphine	<ul style="list-style-type: none"> • Methods of administration include: sublingual, buccal, subdermal implant, and subcutaneous extended release • Medication is taken daily to weekly in an office or clinical setting; medication is taken daily in an OTP setting • Buprenorphine works by reducing withdrawal symptoms and cravings
Methadone	<ul style="list-style-type: none"> • Taken orally every day through an OTP setting • Only available at certified Opioid Treatment Programs and in-patient hospital settings • Methadone works by reducing withdrawal symptoms and cravings as well as blocking the effect of opioids • NIDA recommends methadone be taken for at least 12 months
Opioid Receptor Agonist	<ul style="list-style-type: none"> • This type of medication activates receptors in the brain to reduce withdrawal symptoms • Patients receiving this type of treatment get an opioid-like effect • Methadone (full) and Buprenorphine (partial)
Opioid Receptor Antagonist	<ul style="list-style-type: none"> • This type of medication blocks opioids and attaches to receptors in the brain to reduce withdrawal symptoms • Patients receiving this type of treatment get no opioid-like effect • Naltrexone
Cognitive Behavioral Therapy (CBT)	<ul style="list-style-type: none"> • A type of cognitive behavioral intervention • This type of therapy works to address thoughts and feelings relating to substance use • CBT is commonly used in SU treatment along with MOUD

Counseling	<ul style="list-style-type: none"> Working concurrently with MOUD, counseling provides additional support for patients. Counseling enables the patient to understand their thoughts, emotions, and actions relating to their addiction.
Residential Treatment/Residential Treatment	<ul style="list-style-type: none"> This form of treatment is conducted in an in-patient setting using a variety of treatment types. These settings usually provide housing, counseling, support groups, case management, and maintenance of buprenorphine or methadone. Some programs provide medically supervised withdrawal, mental health services, and starting buprenorphine or methadone. Treatment planning in this setting prepares the patient for transition to community-based providers.
Outpatient Treatment	<ul style="list-style-type: none"> These settings include OTPs and office-based settings of buprenorphine-waivered providers Visits may vary by treatment provider and treatment type (e.g., visit daily to a methadone clinic)
Intensive Outpatient Treatment/Partial Hospitalization Services	<ul style="list-style-type: none"> This type of outpatient treatment requires more time commitment than typical outpatient treatment. Patients utilizing IOT may be required to attend individual counseling, group therapy, case management, and support groups Treatment in this setting allows the patient to live at home while also receiving similar care to inpatient treatment
Buprenorphine Waivered Providers	<ul style="list-style-type: none"> Providers may apply for a waiver to prescribe buprenorphine outside of an opioid treatment program. Prescribing providers include physicians, nurse practitioners, or physician assistants
Medically Supervised Withdrawal	<ul style="list-style-type: none"> This is a form of detoxification where the individual takes doses of an opioid receptor agonist in a supervised setting. Opioid agonists start with a specified dose and progress with each subsequent dose less than the previous. This form of detox lasts a series of days or weeks until any form of medication is no longer needed.
Office-based Opioid Treatment	<ul style="list-style-type: none"> MOUD is provided in a medical setting (i.e., primary care provider, psychiatry) rather than an in-patient treatment setting.
Maintenance Treatment	<ul style="list-style-type: none"> Medications are used to sustain sobriety from substance use. There is no specified end of treatment as this form of treatment is meant to maintain sobriety and prevent relapse.

TREATMENT PLANNING

Treatment plans should be individualized for each patient. Treatment providers should work with patients to determine the treatment types/activities to ensure the patient has a say in the treatment they received. The treatment plan will be revisited often and revised to meet the needs of the patient. There are several variations of required components for a treatment plan, for the purpose of this appendix, we will use the following: problem statement, goal statement/objectives, action steps, and target dates.

Problem Statement

- Treatment providers will collaborate with the patient to determine what the patient would like to resolve or achieve
- This statement should not be so broad that it is a topic
- These problem statements may correspond with other factors besides their substance use
- This is an overall statement of what the patient hopes to eventually reach

Goal Statement

- These are the smaller pieces of the problem that will be addressed
- It is recommended goals be determined using SMART (specific, measurable, achievable, realistic, time-bound)
- By completing goals, the patient is working towards achieving a resolution to the problem statement

Action Steps

- Action steps are the specific activities the patient (or treatment provider) will do to achieve the goals
- A couple of important aspects to note in the action steps are the type of service provided, by whom, the frequency of the service, and how often the service will be provided.

Target Dates

- These are the important dates relating to the treatment plan.
- Some examples of important target dates are the date the goal statement and/or action steps were established, the date the goal statement and/or action steps were completed, and the targeted completion of the goal statement and/or action steps

EXAMPLE TREATMENT PLAN

Problem: “I can’t keep a job for very long because of my drug use. I want to figure out a better way to deal with work stress other than drugs. I need the money to provide for my family.”

Goal: The patient will keep a log of the events leading to their cravings over the next 30 days. This will lead to a better understanding of the stressors and triggers that enable drug use.

Action Step 1: The patient will keep a log of cravings and the events surrounding their cravings. These events will be kept for 30 days with no restrictions on the number of events the patient tracks each day.

Date Established: 1/18/2015

Targeted Completion: 2/20/2015

Completion:

Action Step 2: The patient will work with a counselor to learn healthier ways to cope with their triggers. It is recommended the patient visits with the counselor once a week for one hour each session.

Date Established: 1/18/2015

Targeted Completion: 2/20/2015

Completion:

References:

Orange County Health Care Agency. (2020). SUD Counselor Handbook with Documentation Guidelines.

Retrieved May 12, 2022, from

<https://www.ochealthinfo.com/sites/hca/files/import/data/files/77324.pdf>

Serenity at Summit. (2021). Treatment plans & goals for substance abuse. Serenity at Summit.

Retrieved May 12, 2022, from <https://serenityatsummit.com/resources/goals-of-addiction-treatment/>

Southwest Michigan Behavioral Health. (n.d.). Treatment planning for substance use disorders.

Retrieved May 12, 2022, from [https://www.swmbh.org/wp-](https://www.swmbh.org/wp-content/uploads/Tx_Planning_for_SUD_v3.0.pdf)

[content/uploads/Tx_Planning_for_SUD_v3.0.pdf](https://www.swmbh.org/wp-content/uploads/Tx_Planning_for_SUD_v3.0.pdf)

STAGES OF MAT IN AN OPIOID TREATMENT PROGRAM

Acute	Rehabilitative	Supportive Care	Medical Maintenance	Tapering	Continuing Care
<ul style="list-style-type: none"> • Detoxification <ul style="list-style-type: none"> ◦ Patients may be treated up to 180 days in an OTP ◦ Focuses primarily on stabilization with medication ◦ Tapering from medication ◦ Referral for continuing care • Other barriers and co-occurring disorders are identified 	<ul style="list-style-type: none"> • Empower patients to cope with issues <ul style="list-style-type: none"> ◦ Gives patients time to work on longer term goals ◦ Ex. Housing, employment, education, etc. • Stabilize the dosage of MOUD • Patients may be able to receive take-home medications • Continued referrals to community-based resources outside of the OTP • Patients discuss triggers to opioid use as well as learn about and develop skills to cope with triggers of relapse 	<ul style="list-style-type: none"> • Patients are able to receive take-home medications • Continued counseling and support from OTP activities <ul style="list-style-type: none"> ◦ Patients may be able to make fewer visits to the OTP • Patients have abstained from substance use for an extended period of time • Patients are making strides in overcoming issues and barriers <ul style="list-style-type: none"> ◦ Patients do not move to the next phase unless there is no demonstrable progress in overcoming life issues and barriers 	<ul style="list-style-type: none"> • Patients are allowed a greater supply of take-home medication (up to a 30-day supply) • Fewer treatment visits to the OTP <ul style="list-style-type: none"> ◦ less services during each visit • Typically, already have 2 years of consistent treatment • The patient has overcome some long-term life issues <ul style="list-style-type: none"> ◦ Stable job and housing ◦ No criminal activities for at least 3 years ◦ Stable social support system ◦ Consistent medical and mental health care ◦ Patients are monitored for relapse 	<ul style="list-style-type: none"> • This is an OPTIONAL stage of treatment in an OTP • Reduction and eventual elimination of medication <ul style="list-style-type: none"> ◦ Patients should decide whether they want to taper medication ◦ Providers should not coerce patients to taper medication ◦ Patients can request to go back to a previous dose if needed • While medications are being tapered, other support services such as counseling should increase 	<ul style="list-style-type: none"> • This phase happens after successful tapering of MOUD • The patient has consistent visits with healthcare providers, some visits with an OTP counselor, and involvement in support groups • Since a SUD is a chronic illness, the patient continues treatment for their SUD • Visits to the OTP occur on average every 1-3 months

For additional information on stages of MAT in an OTP, view [this guide](#) by Quantum Units Education.

PHASES OF MAT

The timeline for each phase of MAT may vary for patients. These are general overviews of the three different phases of MAT, which may not encompass every step of the process a patient may encounter during MAT.

Induction

- Typically the first 1-2 days of treatment
- Screening, assessment, and other testing such as labs and psychiatric evaluation
- May require the patient to abstain from opioids
- This phase includes exploration to find the correct dose for the patient

Stabilization

- Several weeks
- May continue to find the correct dose for the patient
- Incorporate counseling into treatment (develop treatment goals)
- The patient may be referred to counseling or other programs

Maintenance

- As long as it takes
- 12-18 months is the recommended amount of time
- Some people remain in the maintenance phase for longer
- Medication will be tapered to allow for smaller dosages as time goes on

Reference:

American Society of Addiction Medicine. (n.d.). *Medication Assisted Treatment Program*. Retrieved May 11, 2022 from https://www.asam.org/docs/default-source/education-docs/mat-program-overview_2-12-2019239e2b9472bc604ca5b7ff000030b21a.pdf?sfvrsn=93224bc2_0#:~:text=There%20are%20three%20main%20phases,about%20your%20plans%20for%20treatment.

sfvrsn=93224bc2_0#:~:text=There%20are%20three%20main%20phases,about%20your%20plans%20for%20treatment.

MOTIVATIONAL INTERVIEWING SAMPLE SCRIPT

Let's talk about what it might mean for you to stay on this path to recovery.

Are there any issues or concerns that you feel could make recovery difficult for you going forward? For example, some people have told us that they worry about handling daily stress. Again, these sessions are a time for you to talk openly without being judged, so please feel free to tell me whatever's on your mind.

Response and Reflection

OK, I would like to understand a little more about what [SELECTED TOPIC(S)] means to you in terms of your recovery process and why it's an important issue. Could you tell me more about why [SELECTED TOPIC(S)] is important to your recovery?

Reflect:

So [SELECTED TOPIC(S)] is something that is important to you, and it's important because...

Explore: [Interviewing Staff: Explore participant's past experience dealing with [SELECTED TOPIC]]

Affirm: [Counselor: Strengths that helped them in their past experience.]

Thank you for sharing this with me. To help me understand how important this is to you, on a scale from 0 to 10 with 0 being not at all important and 10 being very important, how important is [SELECTED TOPIC] to you?

0 1 2 3 4 5 6 7 8 9 10

What makes this a(n) [SELECTED NUMBER] instead of a(n) [SELECTED NUMBER - 2]?

Now, what would have to happen for it to move from a(n) [SELECTED NUMBER] to a(n) [SELECTED NUMBER + 2]?

Alternate ways to process strengths and barriers:

*[Interviewing Staff: **If more than one topic** was selected by the participant]*

Which of these topics is **most** important to you to discuss today?

*[Interviewing Staff: **If discussion of the topic is not obviously related to recovery**]*

Can you tell me **how**, if at all, this might help you with your recovery?

*[Interviewing Staff: **If the discussion topic is completely unrelated to recovery** state examples for the participant.]*

Because this session is about your recovery process, could we pick something new to talk about that may be related to your recovery?

[Counselor processes with Reflect, Explore, and Affirm from above, and finishes with the 0 to 10 rating of important.]

Adapted from Telehealth-Clinical Advocacy Project (T-CAP) Motivational Interviewing Draft adapted from Seek, Test, and Treat (STT).

CONSENT FOR RELEASE OF INFORMATION SAMPLE FORM

I, _____ [insert client's name here], whose birthdate is ____/____/____ [insert DOB] authorize _____ [INSERT ORGANIZATION NAME], to communicate with and receive from:

List one individual/organization name and address:

1. _____

The following information (which shall not include psychotherapy notes):

- ___ Assessment
- ___ Diagnosis
- ___ Treatment Plan or Summary
- ___ Progress in Treatment
- ___ Medications
- ___ Continuity of Care Document
- ___ Criminal & Conviction History
- ___ Medical Information
- ___ Participation in Services
- ___ Insurance Information
- ___ Presence/Participation in Treatment
- ___ Lab Reports/Drug Screens
- ___ Demographic Information
- ___ Discharge/Transfer Summary
- ___ Reports from Probation, Corrections, or Parole
- ___ Psychological Evaluation
- ___ Other: _____
- ___ HIV/AIDS-related tests and services*

___ **(Initial) *Special Considerations for HIV/AIDS:** I understand that an HIV antibody or AIDS test cannot be required as a condition of treatment, and an individual cannot be required to disclose or to sign an authorization for release of information concerning their HIV antibody test or HIV or AIDS status as a condition of treatment. I also understand that an individual who wishes to be tested for HIV antibodies shall be informed that they may undergo testing on an anonymous basis.

The purpose and need for the disclosure of confidential information are to communicate with the individual(s)/organization(s) listed above regarding my participation and progress in assessment, case management, and treatment unless otherwise indicated here:

My treatment, payment, or eligibility for benefits will generally not be conditioned upon my authorization of this disclosure. However, to ensure reimbursement for services, I understand that I may be required to authorize disclosure to my health insurer or managed care organization.

I understand that if I am involved in the criminal justice system and participation in a [INSERT TYPE of PROGRAM] is a condition of the disposition of any criminal proceedings against me or a condition of my parole or other release from custody, I must maintain all necessary authorizations until this program has been successfully completed and the disposition of the proceedings have been finalized. In other circumstances, I have the right to revoke this authorization in writing at any time by sending a written notification to my treating facility. I further understand that a revocation is not effective to the extent that the disclosure agreed to have been acted on, and until the revocation is received by the person otherwise authorized to disclose records and communication. If not previously revoked, this authorization expires on the following date (if not otherwise stated, this date shall be one year from the date of this authorization):_____.

I also understand that any disclosure of confidential information is governed by State and Federal laws and regulations pertaining to the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2), the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR Parts 160 & 164) and/or under [INSERT APPLICABLE STATE LAWS]. Those laws and regulations prohibit recipients of this confidential information from redisclosing it.

Client Signature

Date

Client's Parent/Guardian/Authorized Representative Name (please print)

Client's Parent/Guardian/Authorized Representative Signature (if applicable)

Date

Staff/Witness Attesting to Identity Signature

Date

NOTICE TO RECEIVING AGENCY OR PERSON: This information has been disclosed to you from records protected by Federal Confidentiality of Substance Use Disorder Patient Records Rules (42 CFR Part 2), under the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR Parts 160 & 164), and/or under [INSERT APPLICABLE STATE LAWS]. These laws and rules prohibit you from making any further disclosure of this information in this record, including any information that identifies a patient as having or having had a substance use disorder, either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2 or 45 CFR Parts 160 & 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose (See §2.31). The Federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided by §§ 2.12(c)(5) and 2.65.

REFERENCES

- Agency for Healthcare Research and Quality. (2017). Warm handoff: Intervention. AHRQ. Retrieved March 15, 2022 from <https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html>
- Ali, R., Meena, S., Eastwood, B., Richards, I., & Marsden, J. (2013). Ultra-rapid screening for substance-use disorders: the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST-Lite). *Drug and Alcohol Dependence*, 132(1-2), 352–361. <https://doi.org/10.1016/j.drugalcdep.2013.03.001>
- American Psychiatric Association, & Parekh, R. (2017). What is a substance use disorder? What is addiction? Retrieved March 18, 2022, from <https://www.psychiatry.org/patients-families/addiction/what-is-addiction>
- American Psychological Association. (2017). What is cognitive behavioral therapy? PTSD Clinical Practice Guideline. Retrieved March 17, 2022, from <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>
- Baggett, T. P., Hwang, S. W., O'Connell, J. J., Porneala, B. C., Stringfellow, E. J., Orav, E. J., Singer, D. E., & Rigotti, N. A. (2013). Mortality among homeless adults in Boston: Shifts in causes of death over a 15-year period. *JAMA Internal Medicine*, 173(3), 189–195. <https://doi.org/10.1001/jamainternmed.2013.1604>
- Belenko, S., Knight, D., Wasserman, G. A., Dennis, M. L., Wiley, T., Taxman, F. S., Oser, C., Dembo, R., Robertson, A. A., & Sales, J. (2017). The juvenile justice behavioral health services cascade: A new framework for measuring unmet substance use treatment services needs among adolescent offenders. *Journal of Substance Abuse Treatment*, 74, 80-91.
- Belenko, S., & Peugh, J. (2005). Estimating drug treatment needs among state prison inmates. *Drug and Alcohol Dependence*, 77(3), 269–281. <https://doi.org/10.1016/j.drugalcdep.2004.08.023>
- Bonnie, R. J., Johnson, R. L., Chemers, B. M., & Schuck, J. A. (Eds.). (2013). *Reforming Juvenile Justice: A Developmental Approach*. Washington DC: National Academies Press. Retrieved from http://www.njjn.org/uploads/digital-library/Reforming_JuvJustice_NationalAcademySciences.pdf
- Brinkley-Rubinstein, L., Zaller, N., Martino, S., Cloud, D. H., McCauley, E., Heise, A., & Seal, D. (2018). Criminal justice continuum for opioid users at risk of overdose. *Addictive Behaviors*, 86, 104–110. <https://doi.org/10.1016/j.addbeh.2018.02.024>
- Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007 - 2009. *Office of Justice Programs*. Retrieved March 18, 2022, from <https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf>
- Bureau of Justice Assistance. (2019). Logic models. *Center for Research Partnerships and Program Evaluation (CRPPE)*. Retrieved April 18, 2022, from <https://bja.ojp.gov/program/crppe/logic-models>
- Butterfoss, F. D. (2019). Chapter 11: Building and sustaining coalitions. *Community and Public Health Education Methods: A Practical Guide* (4th ed., pp. 217–241). Jones & Barlett Learning.
- Butterfoss, F. D. (2020). Buddy program for member recruitment. *Coalitions Work*. <https://www.thecne.org/wp-content/uploads/2016/07/Buddy-Program-for-Member-Recruitment.pdf>

- Casey, P.M., Elek, J. K., Warren, R. K., Cheesman, F., Kleiman, M., Ostrom, B. (2014). Offender Risk & Needs Assessment Instruments: A Primer for Courts. National Center for State Courts. https://www.ncsc.org/data/assets/pdf_file/0018/26226/bja-rna-final-report_combined-files-8-22-14.pdf
- Centers for Disease Control and Prevention. (2022a). Fast facts: Preventing adverse childhood experiences. *Violence Prevention*. <https://www.cdc.gov/violenceprevention/aces/fastfact.html>
- Centers for Disease Control and Prevention. (2022b). Social determinants of health at CDC. *About CDC*. <https://www.cdc.gov/about/sdoh/index.html>
- Centre for Addiction and Mental Health. (2016). Opioid agonist therapy. *CAMH*. Retrieved March 17, 2022, from <https://www.camh.ca/-/media/files/oat-info-for-clients.pdf>
- Committee on the Science of Changing Behavioral Health Social Norms. (2016, August 3). Understanding stigma of mental and substance use disorders. *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*. <https://www.ncbi.nlm.nih.gov/books/NBK384923/>
- Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, B. M., Oliva, J. R., Thompson, N. J., & Watson, A. C. (2014). The police-based crisis intervention team (CIT) model: I. Effects on officers' knowledge, attitudes, and skills. *Psychiatric Services (Washington, D.C.)*, 65(4), 517-522. <https://doi.org/10.1177/appi.ps.201300107>
- Compton, M. T., Broussard, B. N., Munetz, M., Oliva, J. R., & Watson, A. C. (2011). *The Crisis Intervention Team (CIT) Model of Collaboration Between Law Enforcement and Mental Health*. Hauppauge, NY: Nova.
- Confidentiality of Substance Use Disorder Patient Records, 42 CFR, Part 2. (2020). Retrieved May 13, 2022, from <https://www.federalregister.gov/documents/2020/07/15/2020-14675/confidentiality-of-substance-use-disorder-patient-records>
- Council on Social Work Education. (2020). Social work: A vital workforce to address the opioid crisis. *Policy Agenda*. Retrieved May 2, 2022, from <https://www.cswe.org/getattachment/46968606-2400-4b77-9ef0-a07e553fb02f/Social-Work-and-Opioid-Epidemic-Principles.aspx>
- Cunningham, C., Edlund, M. J., Fishman, M., Gordon, A. J., Jones, H. E., Kampman, K. M., Langleben, D., Meyer, M., Springer, S., Woody, G., Wright, T. E., & Wyatt, S. (2010). The ASAM National Practice Guideline for the treatment of opioid use disorder: 2020 Focused Update. *Journal of Addiction Medicine* 14(2S): p 1-91. doi.org/10.1097/ADM.0000000000000633
- Donenberg, G. R., Emerson, E., Mackesy-Amiti, M. E., & Udell, W. (2015). HIV-risk reduction with juvenile offenders on probation. *Journal of Child and Family Studies*, 24(6), 1672–1684. <https://doi.org/10.1007/s10826-014-9970-z>
- Duncan, M. (2017). Collaborative care model effective for addiction treatment. *Psychiatric News*. Retrieved April 26, 2022, from <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2017.9b9>
- Family and Youth Services Bureau. (2020). Logic model tip sheet. *PREP Logic Model Tip Sheet*. Retrieved April 18, 2022, from https://www.acf.hhs.gov/sites/default/files/documents/prep-logic-model-ts_0.pdf
- Ferguson, W. J., Johnston, J., Clarke, J. G., Koutoujian, P. J., Maurer, K., Gallagher, C., White, J., Nickl, D., & Taxman, F. S. (2019). Advancing the implementation and sustainment of medication assisted treatment for opioid use disorders in prisons and jails. *Health & Justice*, 7(1), 19. <https://doi.org/10.1186/s40352-019-0100-2>

- Feucht, T., & Holt, T. (2016). Does cognitive behavioral therapy work in criminal justice? A new analysis from CrimeSolutions. *National Institute of Justice*. Retrieved May 5, 2022, from <https://nij.ojp.gov/topics/articles/does-cognitive-behavioral-therapy-work-criminal-justice-new-analysis-crimesolutions>
- Fletcher, B. W., Lehman, W. E. K., Wexler, H. K., Melnick, G., Taxman, F. S., & Young, D. W. (2009). Measuring collaboration and integration activities in criminal justice and substance abuse treatment agencies. *Drug and Alcohol Dependence*, *103*(1), S54–S64. <https://doi.org/10.1016/j.drugalcdep.2009.01.001>
- Gisev, N., Shanahan, M., Weatherburn, D. J., Mattick, R. P., Larney, S., Burns, L., & Degenhardt, L. (2015). A cost-effectiveness analysis of opioid substitution therapy upon prison release in reducing mortality among people with a history of opioid dependence. *Addiction (Abingdon, England)*, *110*(12), 1975–1984. <https://doi.org/10.1111/add.13073>
- Gottfredson, D.C., Kearley, B.W., Najaka, S.S., Rocha, C.M. (2007). How drug treatment courts work: An analysis of mediators. *Journal of Research in Crime and Delinquency*, *44*(1), 3-35. <https://doi.org/10.1177/0022427806291271>
- Hedges, A., Johnson, H., Kobulinsky, L., Estock, J., Eibling, D., & Seybert, A. (2019). Effects of cross-training on medical teams' teamwork and collaboration: Use of simulation. *Pharmacy*, *7*(1), 13. <https://doi.org/10.3390/pharmacy7010013>
- Henggeler, S. W., Clingempeel, W. G., Brondino, M. J., & Pickrel, S. G. (2002). Four-year follow-up of multisystemic therapy with substance-abusing and substance dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, *41*(7), 868-874. <https://doi.org/10.1097/00004586-200207000-00021>
- Hill, T. (2018, June 11). Leveraging Medicaid Technology to Address the Opioid Crisis [Letter to State Medicaid Director]. Retrieved May 5, 2022, from <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>
- Hollingsworth, A., Ruhm, C. J., & Simon, K. (2017). Macroeconomic conditions and opioid abuse. *National Bureau of Economic Research*. Retrieved March 21, 2022, from <https://doi.org/10.3386/w23192>
- Hollis, Meghan E. (2016). Community-based partnerships: Collaboration and organizational partnerships in criminal justice. *Journal of Family Strength*, *16*(2). Retrieved April 16, 2022, from <https://digitalcommons.library.tmc.edu/jfs/vol16/iss2/1>
- Humeniuk, R. E., Henry-Edwards, S., Ali, R. L., Poznyak, V., & Monteiro, M. (2010). *The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST): Manual for use in Primary Care*. Geneva, World Health Organization. <https://www.who.int/publications/i/item/978924159938-2>
- Institute for Quality and Efficiency in Health Care. (2016, September 8). Cognitive behavioral therapy. *InformedHealth.org*. Retrieved March 17, 2022, from <https://www.ncbi.nlm.nih.gov/books/NBK279297/>
- Joe, G. W., Simpson, D. D., & Broome, K. M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction (Abingdon, England)*, *93*(8), 1177–1190. <https://doi.org/10.1080/09652149835008>
- Joudrey, P. J., Khan, M. R., Wang, E. A., Scheidell, J. D., Edelman, E. J., McInnes, D. K., & Fox, A. D. (2019). A conceptual model for understanding post-release opioid-related overdose risk. *Addiction Science & Clinical Practice*, *14*(17). <https://doi.org/10.1186/s13722-019-0145-5>

- Kekahio, W., Lawton, B., Cicchinelli, L., & Brandon, P. R. (2014). Logic models: A tool for effective program planning, collaboration, and monitoring. *U.S. Department of Education*. Retrieved April 19, 2022, from <https://www2.ed.gov/about/offices/list/oese/oss/technicalassistance/easnlogicmodelstoolmonitoring.pdf>
- King, R. D., & Light, M. T. (2019). Have racial and ethnic disparities in sentencing declined? *Crime and Justice*, 48, 365–437. <https://doi.org/10.1086/701505>
- Kirk, D. S., & Papachristos, A.V. (2011). Cultural mechanisms and the persistence of neighborhood violence. *American Journal of Sociology* 116(4), 1190-1233. Retrieved May 4, 2022, from <https://doi.org/10.1086/655754>
- Kirk, D. S. (2016). Prisoner reentry and the reproduction of legal cynicism. *Social Problems* 63, p.222-243. <https://doi.org/10.1093/socpro/spw003>
- Knight, D. K., Becan, J. E., Landrum, B., Joe, G. W., & Flynn, P. M. (2014). Screening and assessment tools for measuring adolescent client needs and functioning in substance abuse treatment. *Substance Use & Misuse*, 49(7), 902–918. <https://doi.org/10.3109/10826084.2014.891617>
- Knight, D. K., Blue, T. R., Flynn, P. M., & Knight, K. (2018). The TCU Drug Screen 5: Identifying justice-involved individuals with substance use disorders. *Journal of Offender Rehabilitation*, 57(8), 525-537. <https://doi.org/10.1080/10509674.2018.1549180>
- Kosten, T. R., & George, T. P. (2002). The neurobiology of opioid dependence: Implications for treatment. *Science & Practice Perspectives*, 1(1), 13-20. <https://doi.org/10.1080/10509674.2018.1549180>
- Lombardi, B. M., Zerden, L. S., Guan, T., & Prentice, A. (2018). The role of social work in the opioid epidemic: Office-based Opioid Treatment Programs. *Social Work in Health Care*, 58(3), 339-344. <https://doi.org/10.1080/00981389.2018.1564109>
- Marks, M. A., Sabella, M. J., Burke, C. S., & Zaccaro, S. J. (2002). The impact of cross-training on team effectiveness. *Journal of Applied Psychology*, 87(1), 3-13. <https://doi.org/10.1037/0021-9010.87.1.3>
- Marks, K. R., Leukefeld, C. G., Dennis, M. L., Scott, C. K., & Funk, R. (2019). Geographic differences in substance use screening for justice-involved youth. *Journal of Substance Abuse Treatment*, 102: 40-46. <https://doi.org/10.1016/j.jsat.2019.04.005>
- Martone, K., Arienti, F., Gulley, J., & Post, R. (2022). *The Role of Supportive Housing, Case Management, and Employment Services in Reducing the Risk of Behavioral Health Crisis*. NASMHPD. http://www.nasmhpd.org/sites/default/files/2022-11/Supportive-Housing-Case-Management-and-Employment-Services-in-Reducing-Risk-of-Behavioral-Health-Crisis_NASMHPD-8.pdf
- Maruschak, L. M., Bronson, J., & Alper, M. (2021). Alcohol and drug use and treatment reported by prisoners: Survey of prison inmates, 2016. *Bureau of Justice Statistics*. Retrieved May 3, 2022, from <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/adutrpspi16st.pdf>
- Matusow, H., Dickman, S. L., Rich, J. D., Fong, C., Dumont, D. M., Hardin, C., Marlowe, D., Rosenblum, A. (2013). Medication assisted treatment in US drug courts: Results from a nationwide survey of availability, barriers and attitudes. *Journal of Substance Abuse Treatment*, 44(5), 473-480. Retrieved from <https://doi.org/10.1016/j.jsat.2012.10.004>
- McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H., & Argeriou, M. (1992). The Fifth Edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment*, 9(3), 199–213. [https://doi.org/10.1016/0740-5472\(92\)90062-s](https://doi.org/10.1016/0740-5472(92)90062-s)

- McNeely, J., Wu, L. T., Subramaniam, G., Sharma, G., Cathers, L. A., Svikis, D., Sleiter, L., Russell, L., Nordeck, C., Sharma, A., O'Grady, K. E., Bouk, L. B., Cushing, C., King, J., Wahle, A., & Schwartz, R. P. (2016). Performance of the Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) Tool for Substance Use Screening in Primary Care Patients. *Annals of Internal Medicine*, 165(10), 690–699. <https://doi.org/10.7326/M16-0317>
- Medicaid and CHIP Payment and Access Commission. (2017). Chapter 2: Medicaid and the opioid epidemic. *Report to Congress on Medicaid and the Opioid Epidemic*. Retrieved March 21, 2022, from <https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf>
- Munetz, M. R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services (Washington, D.C.)*, 57(4), 544–549. <https://doi.org/10.1176/ps.2006.57.4.544>
- National Alliance on Mental Illness. (n.d.). Crisis intervention team (CIT) programs. *Crisis Intervention Team (CIT) Programs*. [https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs)
- National Institute of Corrections. (2020). Drugs & substance abuse in the criminal justice system. Topics in Corrections. <https://nicic.gov/resources/resources-topics-and-roles/topics/drugs-substance-abuse-criminal-justice-system>
- National Institute on Drug Abuse. (2015). How are therapeutic communities integrated into the criminal justice system? *Therapeutic Communities Research Report*. Retrieved May 5, 2022, from <https://nida.nih.gov/publications/research-reports/therapeutic-communities/how-are-therapeutic-communities-integrated-criminal-justice-system>
- National Reentry Resource Center. (2017). *Collaborative Comprehensive Case Plans: Addressing Criminogenic Risk and Behavioral Health Needs*. National Reentry Resource Center. <https://nationalreentryresourcecenter.org/resources/collaborative-comprehensive-case-plans>
- Office for Civil Rights. (2013). Summary of the HIPAA privacy rule. *HHS.gov*. Retrieved March 15, 2022, from <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.htm>
- Osher, F., D'Amora, D. A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*. Retrieved March 21, 2022, from https://csgjusticecenter.org/wp-content/uploads/2020/02/9-24-12_Behavioral-Health-Framework-final.pdf
- Painter-Davis, N., & Ulmer, J.T. (2020). Discretion and disparity under sentencing guidelines revisited: The interrelationship between structured sentencing alternatives and guideline decision-making. *Journal of Research in Crime and Delinquency*, 57(3), 263-293. <https://doi.org/10.1177/0022427819874862>
- Paniagua, F. A. (2014). *Assessing and Treating Culturally Diverse Clients a Practical Guide* (4th ed.). SAGE Publications.
- Partnership to End Addiction. (2022). Is addiction a disease? *Partnership to End Addiction*. Retrieved May 6, 2022, from <https://drugfree.org/article/is-addiction-a-disease/>
- Peters, R. [speaker], Charlier, J. [speaker], Barbour, P. [speaker], & Upton, A. [speaker]. (2018). Opioid addiction screening and assessment for people in the criminal justice system [webinar]. *National Reentry Resource Center*. Retrieved from <https://youtu.be/0q9X2o6rbY0>

- Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. *Drug and Alcohol Dependence*, 58(1-2), 9-25. [https://doi.org/10.1016/s0376-8716\(99\)00071-x](https://doi.org/10.1016/s0376-8716(99)00071-x)
- Pendergast, M., & Hall, E. (2011). *A treatment manual for implementing contingency management: Using incentives to improve parolee enrollment and attendance in community treatment*. Los Angeles: UCLA Integrated Substance Abuse Programs. Retrieved from http://www.uclaisap.org/assets/documents/Manual%20for%20Implementing%20Contingency%20Management_11-8-2011%20clean.pdf
- Rackets, M. (2021). What's collaborative care? And how does it help with addiction treatment? *Encore Outpatient Services*. Retrieved April 26, 2022, from <https://encorerecovery.com/what-is-collaborative-care-encore/>
- Rudd, R. A., Aleshire, N., Zibbell, J. E., & Gladden, R. M. (2016). Increases in drug and opioid overdose deaths - United States, 2000–2014. *Morbidity and Mortality Weekly Report (MMWR)*. Retrieved March 18, 2022, from <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm>
- Sampson, R. J., & Bartusch, D. J. (1998). Legal cynicism and (subcultural?) tolerance of deviance: The neighborhood context of racial differences. *Law & Society Review*, 32(4), 777–804. Retrieved March 16, 2022, from https://scholar.harvard.edu/files/sampson/files/1998_lsr_bartusch.pdf
- Scientific American. (2012, March 1). The neglect of mental illness exacts a huge toll, human and economic. *Mind & Brain*. Retrieved March 18, 2022, from <https://www.scientificamerican.com/article/a-neglect-of-mental-illness/>
- Shore, J. (n.d.). Ryan Haight online pharmacy consumer protection act of 2008. *Ryan Haight Act*. Retrieved March 17, 2022, from <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/ryan-haight-act>
- Skeem, J. L., & Lowenkamp, C. T. (2016). Risk, race, and recidivism: Predictive bias and disparate impact. *Criminology: An Interdisciplinary Journal*, 54(4), 680–712. <https://doi.org/10.1111/1745-9125.12123>
- Substance Abuse and Mental Health Services Administration. (2005a). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: A Treatment Improvement Protocol (TIP) 43*. Retrieved March 21, 2022, from <https://www.ncbi.nlm.nih.gov/books/NBK64164/>
- Substance Abuse and Mental Health Services Administration. (2005b). *Substance Abuse Treatment for Adults in the Criminal Justice System: A Treatment Improvement Protocol (TIP) 44*. Retrieved March 21, 2022, from <https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4056.pdf>
- Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services (HHS) (2012). Opioid drugs in maintenance and detoxification treatment of opiate addiction; proposed modification of dispensing restrictions for buprenorphine and buprenorphine combination as used in approved opioid treatment medications. Final rule. *Federal Register*, 77(235), 72752–72761. <https://www.govinfo.gov/content/pkg/FR-2012-12-06/pdf/2012-29417.pdf>
- Substance Abuse and Mental Health Services Administration. (2015a). *Comprehensive Case Management for Substance Abuse Treatment: A Treatment Improvement Protocol (TIP) 27*. Retrieved March 21, 2022, from <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4215.pdf>
- Substance Abuse and Mental Health Services Administration. (2015b). *Substance Abuse Treatment: Addressing the Specific Needs of Women: A Treatment Improvement Protocol (TIP) 51*. Retrieved March 21, 2022, from <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4426.pdf>

- Substance Abuse and Mental Health Services Administration. (2019a). *Leveraging Telehealth for Justice-Involved Individuals: Expanding Access to Mental and Substance Use Disorder Treatment* [webinar]. <https://integrationacademy.ahrq.gov/new-and-events/events/samhsa-leveraging-telehealth-justice-involved-individuals-expanding-access>
- Substance Abuse and Mental Health Services Administration. (2019b). Medication-assisted treatment (MAT) in the criminal justice system: Brief guidance to the states. SAMHSA. Retrieved March 21, 2022, from https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matbriefcjs_0.pdf
- Substance Abuse and Mental Health Services Administration (2019c). *Treatment Improvement Protocol (TIP) 35: Enhancing Motivation for Change in Substance Use Disorder Treatment*. Retrieved March 21, 2022, from https://store.samhsa.gov/sites/default/files/d7/priv/tip35_final_508_complaint_-_02252020_0.pdf
- Substance Abuse and Mental Health Services Administration. (2019d). *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf>
- Substance Abuse and Mental Health Services Administration. (2021a). *Medications for Opioid Use Disorder: For Healthcare and Addiction Professionals, Policymakers, Patients, and Families: Treatment Improvement Protocol (TIP) 63*. Retrieved March 21, 2022 from <https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002>
- Substance Abuse and Mental Health Services Administration. (2021b). The sequential intercept model (SIM). SAMHSA. Retrieved May 6, 2022, from <https://www.samhsa.gov/criminal-juvenile-justice/sim-overview>
- Substance Abuse and Mental Health Services Administration. (2022a). Behavioral health treatments and services. SAMHSA. Retrieved May 6, 2022, from <https://www.samhsa.gov/find-help/treatment>
- Substance Abuse and Mental Health Services Administration. (2022b). MAT medications, counseling, and related conditions. SAMHSA. Retrieved May 6, 2022, from <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions>
- Substance Abuse and Mental Health Services Administration. (2022c). Person- and family-centered care and peer support. SAMHSA. Retrieved May 6, 2022, from <https://www.samhsa.gov/section-223/care-coordination/person-family-centered>
- Sunshine, J. & Tyler, T. (2003). The role of procedural justice in shaping public support for policing. *Law & Society Review*, 37. 513-548. <https://doi.org/10.1111/1540-5893.3703002>
- Tapia, M., McCoy, H., & Tucker, L. (2016). Suicidal ideation in juvenile arrestees: Exploring legal and temporal factors. *Youth Violence and Juvenile Justice*, 14(4), 468-483. <https://doi.org/10.1177/1541204015579522>
- Texas Administrative Code, Ch. 25 § 448.1401 (rev. 2022). [https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPagesl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=448&rl=1401](https://texreg.sos.state.tx.us/public/readtac$ext.TacPagesl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=448&rl=1401)
- Tompkins, D. (Ed.). (2004). What does it take to make collaborations work? Lessons learned through the Criminal Justice System Project. *NIJ Journal*, (251), 8–13. <https://doi.org/10.1037/e533002006-003>
- Treatment Research Institute. (2015). *RANT: An Evidence Based Supervision and Clinical Services Recommendation Solution*. Treatment Research Institute. <http://www.innovatingjustice.org/sites/default/files/RANTSummaryVlavianos.pdf>
- Tyler, T. R. (2006). *Why People Obey the Law*. New Haven: Princeton University Press.

- Tyler, T., & Fagan, J. (2006). Legitimacy and cooperation: Why do people help the police fight crime in their communities? *Ohio State Journal of Criminal Law*, 6, 231-276. <https://doi.org/10.2139/ssrn.887737>
- US Department of Health and Human Services, & Office of the Surgeon General. (2016). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS. Retrieved March 18, 2022, from <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>
- United States Department of Justice. (n.d.). Procedural justice. *PROCEDURAL JUSTICE | COPS OFFICE*. Retrieved March 17, 2022, from <https://cops.usdoj.gov/procdceduraljustice#:~:text=Procedural%20justice%20refers%20to%20the,change%20and%20bolsters%20better%20relationships>
- Volpe, C. E., Cannon-Bowers, J. A., Salas, E., & Spector, P. E. (1996). The impact of cross-training on team functioning: An empirical investigation. *Human Factors: The Journal of the Human Factors and Ergonomics Society*, 38(1), 87-100. <https://doi.org/10.1518/001872096778940741>
- Walters, S. T., Clark, M. D., Gingerich, R., & Meltzer, M. L. (2007). *A Guide for Probation and Parole: Motivating Offenders to Change*. U.S. Department of Justice. <https://s3.amazonaws.com/static.nicic.gov/Library/022253.pdf>
- Wakeman, S. E. (September 2017). Why it's inappropriate not to treat incarcerated patients with opioid agonist therapy. *AMA Journal of Ethics*, 19(9):922-930. doi: 10.1001/journalofethics.2017.19.9.st.as1-1709
- Watson, A. C., Compton, M. T., & Draine, J. N. (2017). The crisis intervention team (CIT) model: An evidence-based policing practice? *Behavioral Sciences & The Law*, 35(5-6), 431-441. <https://doi.org/10.1002/bsl.2304>
- Webster, L. R., & Webster, R. M. (2005). Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the Opioid Risk Tool. *Pain Medicine*, 6(6), 432-442. <https://doi.org/10.1111/j.1526-4637.2005.00072.x>
- White, W., & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, 8(4), 12-30. <https://www.researchgate.net/publication/265148872>
- Wickersham, J. A., Azar, M. M., Cannon, C. M., Altice, F. L., & Springer, S. A. (2015). Validation of a brief measure of opioid dependence: The rapid opioid dependence screen (RODS). *Journal of Correctional Health Care: The Official Journal of the National Commission on Correctional Health Care*, 21(1), 12-26. <https://doi.org/10.1177/1078345814557513>
- Wiese, A. L., Blue, T. R., Knight, D. K., & Knight, K. (2019). The validity of the TCU Drug Screen 5 for identifying substance use disorders among justice-involved youth. *Federal Probation Journal*, 83(2), 65-70. Retrieved March 16, 2022, from <https://www.uscourts.gov/federal-probation-journal/2019/09/validity-tcu-drug-screen-5-identifying-substance-use-disorders#:~:text=Results%20revealed%20that%20the%20TCU,this%20screeener%20within%20juvenile%20systems.>
- Wiese, A. L. (2020). Analyses of the TCU Drug Screen 5: Using an item response theory model with a sample of juvenile justice youth. <https://repository.tcu.edu/bitstream/handle/116099117/39887/27961338.pdf?sequence=1>
- Williams, A. R., Nunes, E., & Olfson, M., (2017, August 8). To battle the opioid overdose epidemic, deploy the 'cascade of care' model. *Health Affairs Blog*. Retrieved May 10, 2022, from <https://academiccommons.columbia.edu/doi/10.7916/D8RX9QF3>

- Williams, A. R., Nunes, E. V., Bisaga, A., Pincus, H. A., Johnson, K. A., Campbell, A. N., Remien, R. H., Crystal, S., Friedmann, P. D., Levin, F. R., & Olfson, M. (2018). Developing an opioid use disorder treatment cascade: A review of quality measures. *Journal of Substance Abuse Treatment*, 91, 57-68. <https://doi.org/10.1016/j.jsat.2018.06.001>
- Williams, A. R., Nunes, E. V., Bisaga, A., Levin, F. R., & Olfson, M. (2019). Development of a cascade of care for responding to the opioid epidemic. *American Journal of Drug and Alcohol Abuse*, 45(1), 1-10. <https://doi.org/10.1080/00952990.2018.1546862>
- Williams, A. R., Johnson, K. A., Thomas, C. P., Reif, S., Socias, M. E., Henry, B. F., Neighbors, C., Gordon, A. J., Horgan, C., Nosyk, B., Drexler, K., Krawczyk, N., Gonsalves, G. S., Hadland, S. E., Sten, B. D., Fishman, M., Kelley, A. T., Pincus, H. A., & Olfson, M. (2022). Opioid use disorder cascade of care framework design: A roadmap. *Substance Abuse*, 43(1), 1207-1214. <https://doi.org/10.1080/08897077.2022.2074604>
- World Health Organization. (2010). *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Manual for use in primary care*. Geneva: World Health Organization. Retrieved from <https://www.who.int/publications/i/item/978924159938-2>
- Yale Law School. (n.d.). Procedural justice. *The Justice Collaboratory*. Retrieved March 17, 2022, from <https://law.yale.edu/justice-collaboratory/procedural-justice>
- Young, J. L. (2015). Untreated mental illness. *Psychology Today*. Retrieved May 10, 2022, from <https://www.psychologytoday.com/us/blog/when-your-adult-child-breaks-your-heart/201512/untreated-mental-illness>
- Young, J. D., & Badowski, M. E. (2017). Telehealth: Increasing Access to High Quality Care by Expanding the Role of Technology in Correctional Medicine. *Journal of Clinical Medicine*, 6(2), 20. <https://doi.org/10.3390/jcm6020020>