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

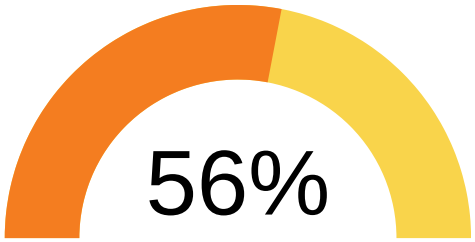
- Understand addiction as a chronic disease that requires long-term care
- Determine the gaps in service continuity for justice-involved individuals
- Learn about the Opioid Services Cascade of Care framework and each of its stages
- Learn about the Sequential Intercept Model
- Recognize the use of the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

The Importance of Addressing Opioid Use Disorder

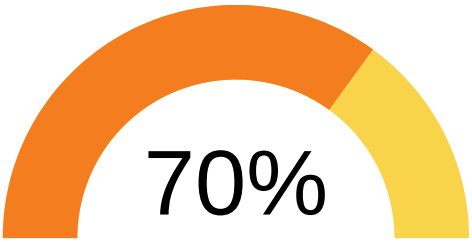
When reading through the O-TLM, keep in mind the information presented below on the prevalence and severity of opioid use disorder (OUD) among justice-involved individuals. It is important to know the following information on addiction when interacting with individuals with OUD. Understanding addiction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

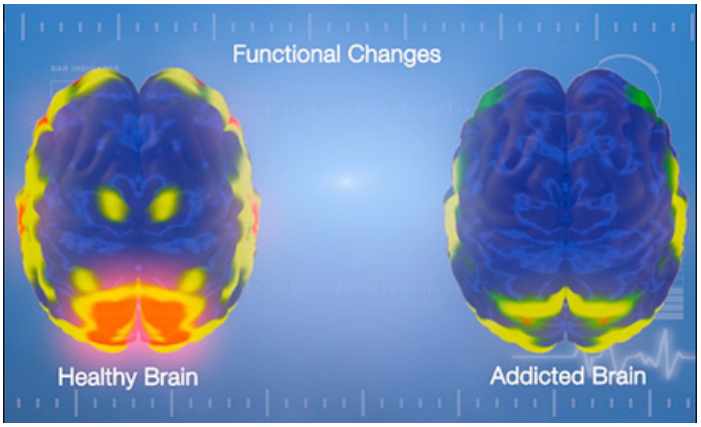
Why is Addiction Considered a Disease?

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

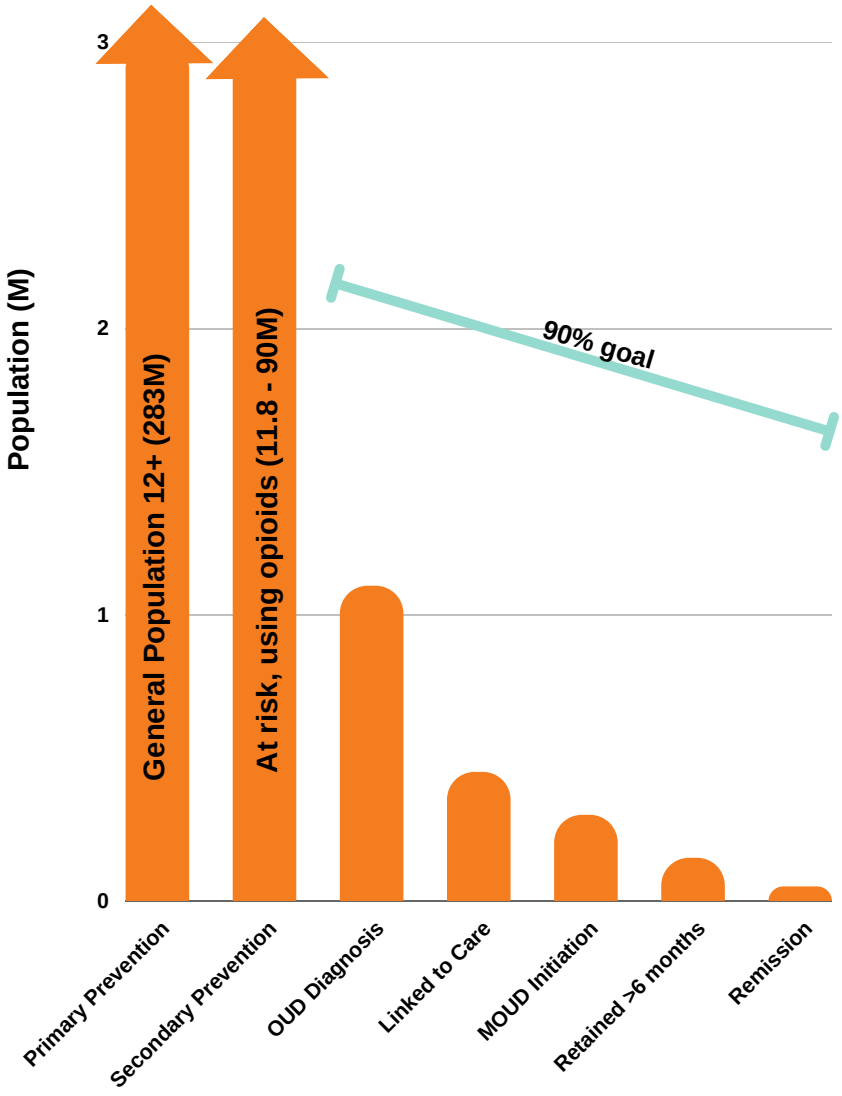


Figure 2.1. OUD Cascade of Care among reporting providers in 2016, based on Williams et al., 2019

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

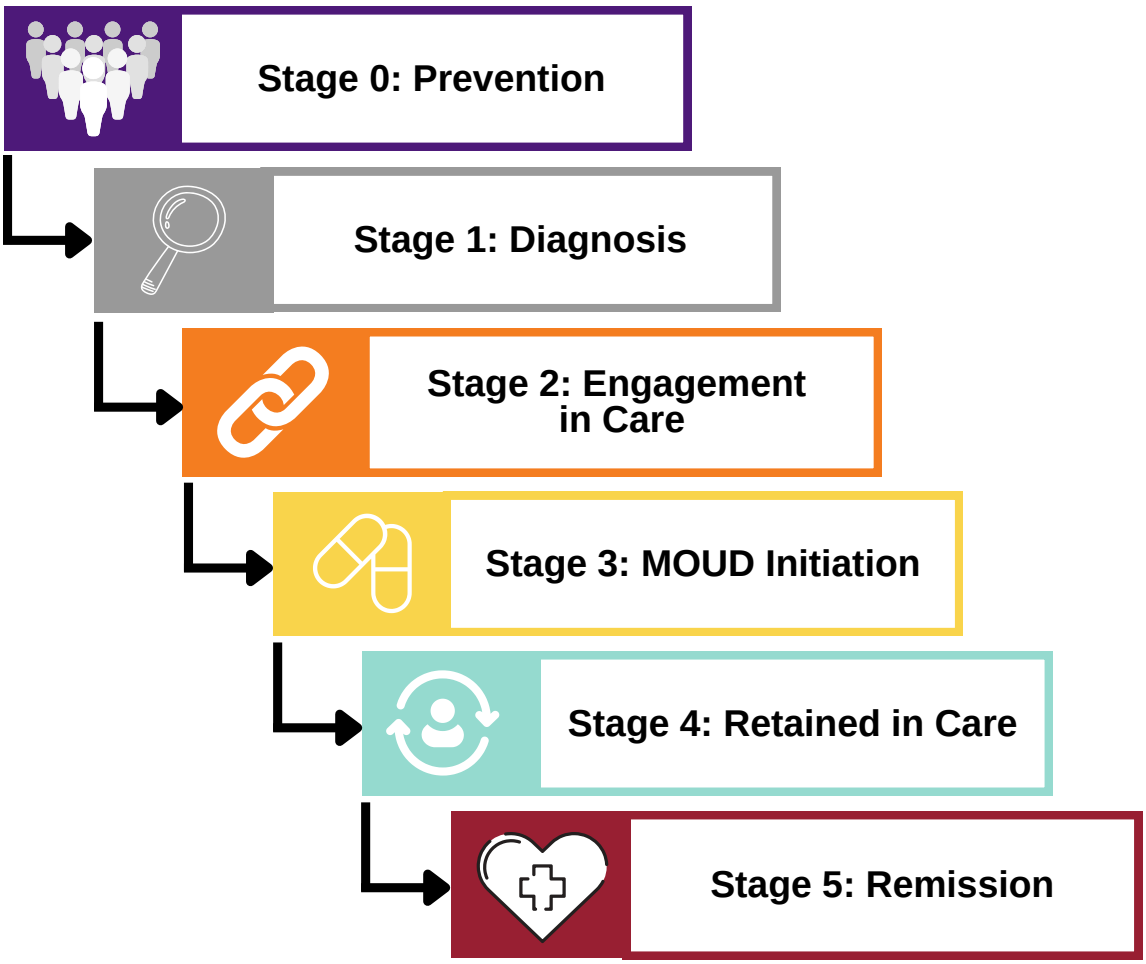
Stage 0: Prevention

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).

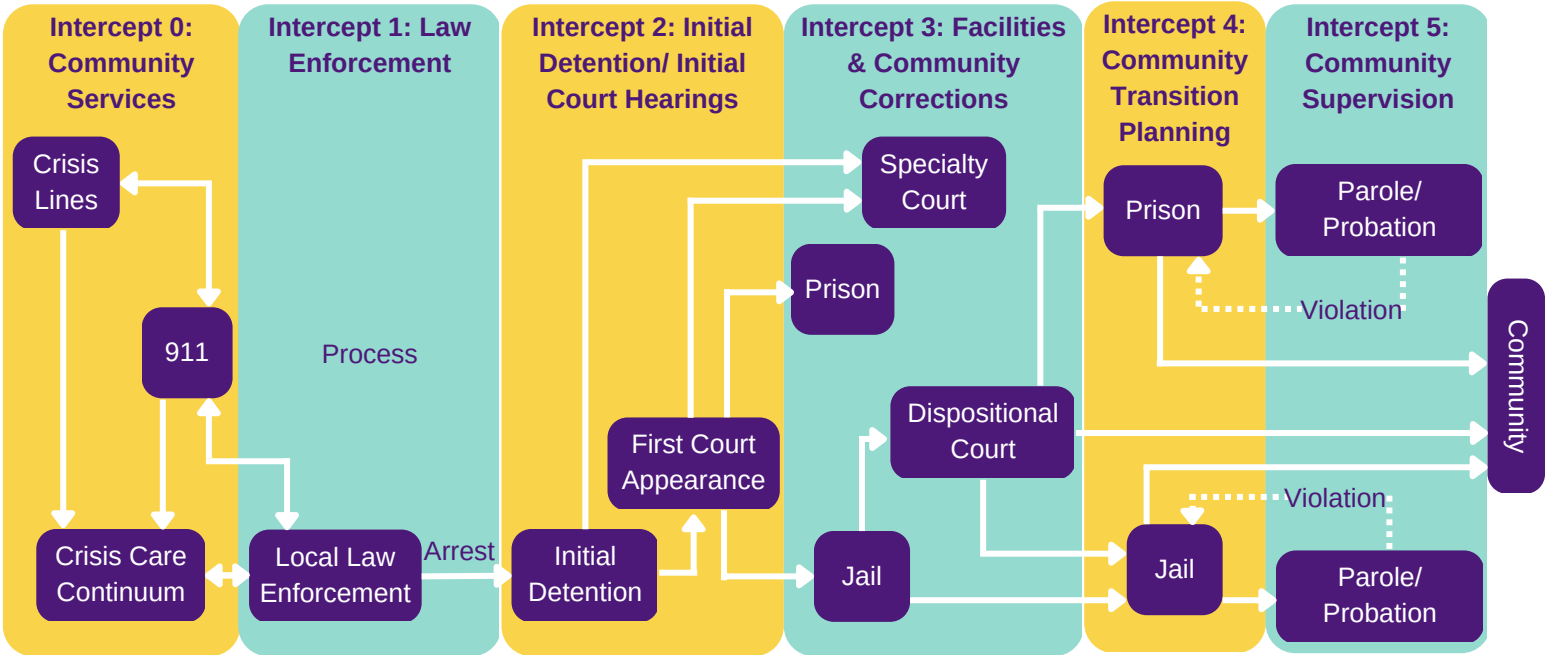
Opioid Use & Criminal Justice -- A Changing Landscape

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.

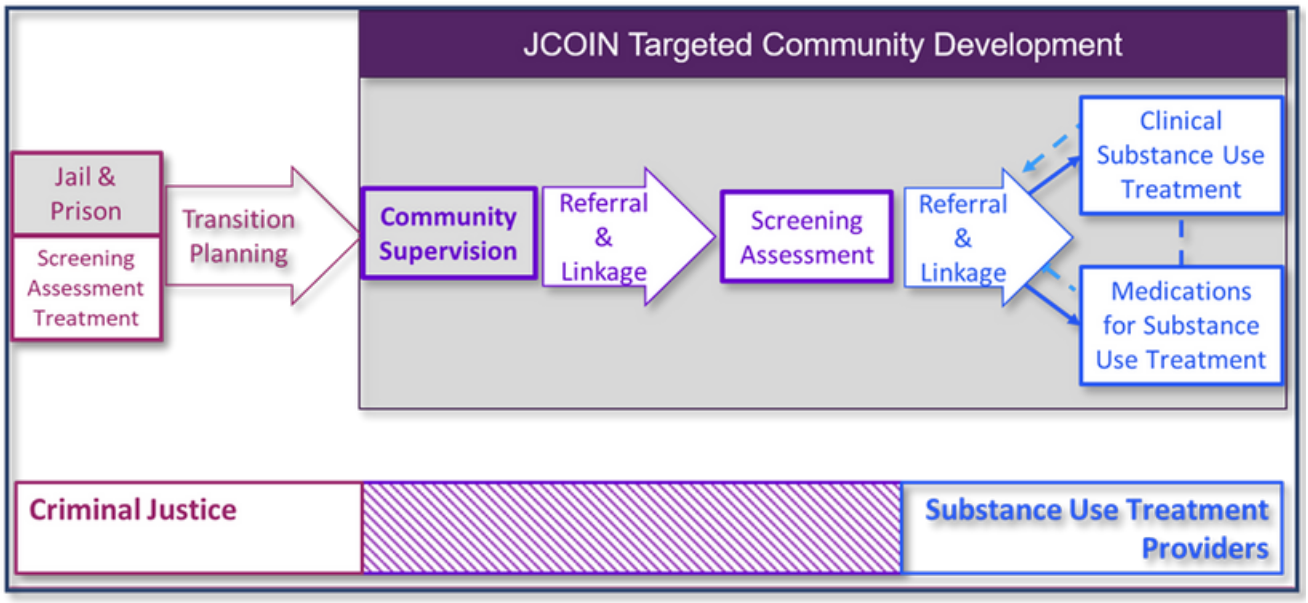
Figure 2.3 *Adapted Sequential Intercept Model*



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.

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.

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.

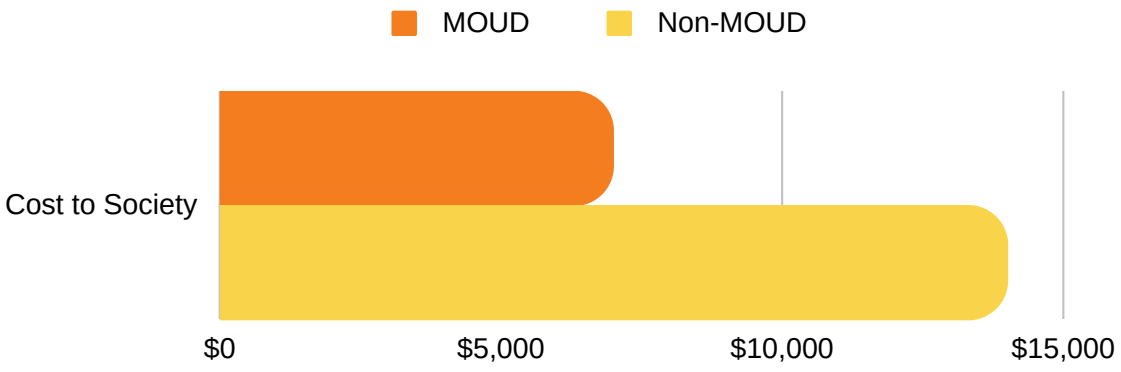


Figure 2.5 Average cost to society of individuals receiving MOUD versus not receiving MOUD according to the Gisev et al. (2015) study.

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 themself 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.

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