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/OUD 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/OUD 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/OUD 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:

• Treatment type
  ◦ 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
  ◦ These can include recovery support (e.g. AA, NA), ancillary services (e.g. behavioral health services, telehealth services, socioeconomic needs), and mental health treatment
	• A comparison of OUD medications
	  ◦ This should include benefits, risk, and possible barriers
	• Recognition of socioeconomic barriers to treatment
	  ◦ Some examples include transportation, cost, and insurance status
	• Treatment types without the use of medication
	  ◦ Supervised withdrawal
	• Parole board requirements of the client's treatment plan
		• 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
		  ◦ Remember to get consent from the client before including these individuals
		• Listening to and answering questions clients may have about treatment
		  ◦ 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/prodceduraljustice#:~: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/procedural-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/OUD 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**.

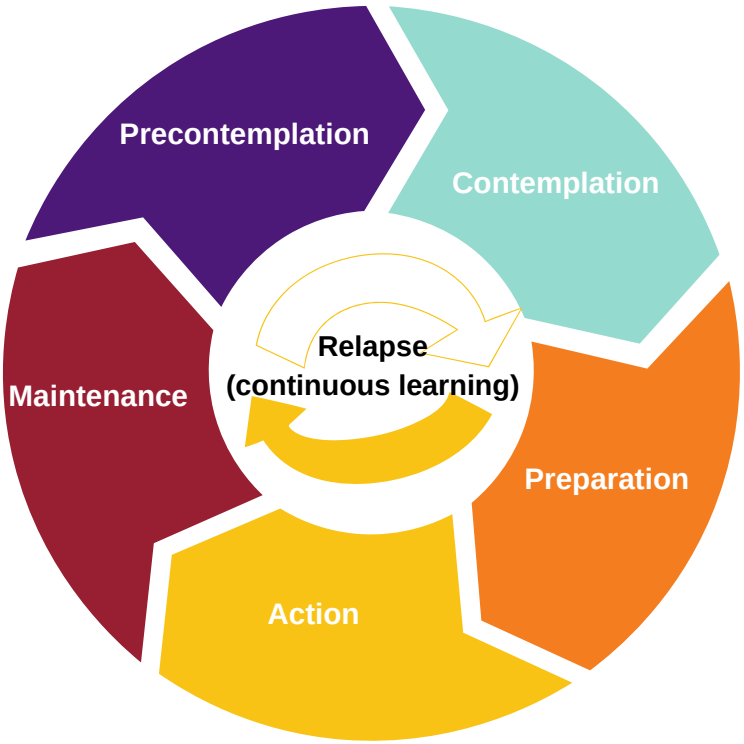
Summary

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**.

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