Opioid Response Network

Cultivating Law and Medicine Partnerships to Support Justice-Involved Individuals With Substance Use Disorders

American Academy of Addiction Psychiatry
Translating Science. Transforming Lives.

SAMHSA
Substance Abuse and Mental Health Services Administration

NCSC
National Center for State Courts

SJI
State Justice Institute

Opioid Response Network

What is the *Opioid Response Network*?

The *Opioid Response Network (ORN)* was created to address the opioid and stimulant use disorder crisis. *ORN* was formed in May 2018 through a grant awarded to the American Academy of Addiction Psychiatry (AAAP) in collaboration with the Addiction Technology Transfer Center Network (ATTC) at the University of Missouri - Kansas City, Columbia University Division on Substance Use Disorders and a large coalition of over 40 national professional organizations. Since the grant for this program launched, it has already had an impact on more than three million people and climbing.

Through training and technical assistance via more than 800 local experts across the country, *ORN* focuses on applying evidence-based practices in prevention, treatment, and recovery of substance use disorders to meet locally identified needs — **all at no cost** to the requester.

Learn more at www.opioidresponsenetwork.org and make a request for education and training.

This guide is available online at www.aaap.org and will be updated as needed. Learn more at www.OpioidResponseNetwork.org or ORN@aaap.org.

Funding for this initiative was made possible (in part) by grant nos. 6H79TI080816 and 1H79TI083343 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Cultivating Law and Medicine Partnerships to Support Justice-Involved Individuals With Substance Use Disorders

American Academy of Addiction Psychiatry

Conference of Chief Justices

Conference of State Court Administrators

Opioid Response Network

Physicians and Lawyers for National Drug Policy

National Center for State Courts

National Judicial Opioid Task Force

State Justice Institute

Substance Abuse and Mental Health Services Administration

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Cultivating Law and Medicine Partnerships to Support Justice-Involved Individuals With Substance Use Disorders

With the alarming increase in fatal and non-fatal overdoses related to the opioid epidemic and the rising rates of stimulant use, the need for cross-system collaboration and the development of partnerships between justice and medical professionals has never been greater. These partnerships provide support to judges and other justice-system stakeholders and build a foundation for effectively treating individuals with a substance use disorder (SUD) who come in contact with the justice system.

The basis for these critical partnerships has been built over a number of years. In 2004, a group of legal and medical leaders came together to form the Physicians and Lawyers for National Drug Policy (PLNDP), funded by the Robert Wood Johnson and Catherine T. MacArthur Foundations, and led by David Lewis, MD, George Lundberg, MD, Richard Bonnie, JD, and Kathryn Cates-Wessel. The goal of PLNDP was to promote evidence-based policies and practices that support effective treatment of individuals with SUD in the justice system. Their mission was to provide education and information on the science of addiction, endorse policies and practices that are clinically appropriate and legally viable, and to encourage cross-system collaboration. One of the primary goals of the PLNDP was to foster an integrated approach to responding to justice-involved individuals with SUD that promotes recovery, reduces recidivism, and builds on best practices in the field.

More recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) dedicated funding to states to address the opioid crisis through the State Targeted Response/States Opioid Response grants to support local communities. In 2018, SAMHSA funded the American Academy of Addiction Psychiatry (AAAP) and more than forty national professional organizations representing over two million stakeholders from prevention, treatment and recovery. This coalition formed the *Opioid Response Network (ORN*), which provides local education and training at no cost in everyU.S. state and nine territories in the prevention, treatment and recovery of opioid and stimulant use disorders with evidence-based practices.

This guide builds on the foundational work of the PLNDP and AAAP's Law and Addiction Committee. Recognizing the unique role of the judiciary as leaders and conveners within the justice system and in their communities, AAAP, in partnership with the National Judicial Opioid Task Force and a working committee of key judicial leaders, addiction psychiatrists and *ORN* partners, including the State Justice Institute, the Conference of Chief Justices, and Conference of State Court Administrators, held a three-day training in November 2019 at The National Judicial College in Reno, NV. Forty-six Chief Justices identified a champion judge from their state to participate. The discussions that took place throughout that training helped develop this guide.

Hon. Tina L. Nadeau, Chief Justice, New Hampshire Superior Court, at The National Judicial College training in Reno, NV.

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**We would like to acknowledge and honor the life and outstanding judicial service of Judge Timothy Brock (TN) who died unexpectedly on November 11, 2019 while attending this training.*

RIGHT LANE MUST TURN RIGHT
COURT 6
EXIT
RED STATE COLLEGE

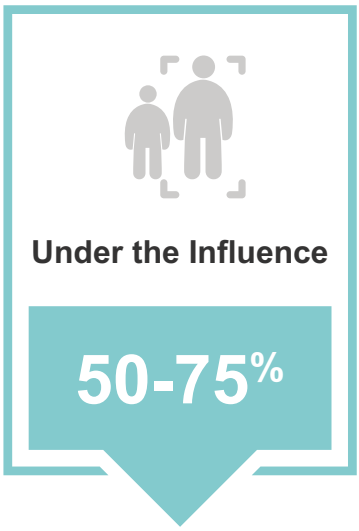
1 Introduction

This resource guide is intended to support judges and other justice-system stakeholders as they seek to further integrate evidence-based substance use disorder (SUD) treatment practices into their work. It is also designed to support the development of partnerships between the justice system and the medical community. The benefits to both systems are clear as the evidence confirms that effective treatment saves lives, reduces recidivism, reduces costs for the healthcare and justice systems and supports healthy individuals, families, and communities.

How does substance misuse and substance use disorders impact the justice system?

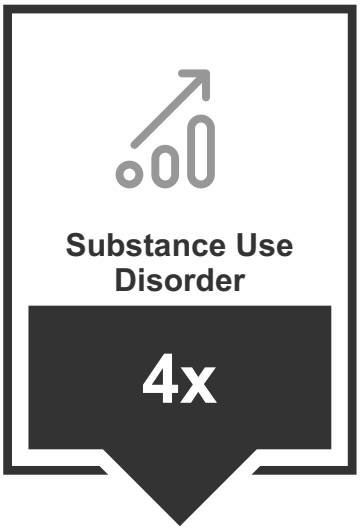
SUDs are seen across all justice settings. Data shows that the majority of individuals are involved in cases on the courts' civil and family dockets, not only in criminal cases. Incarceration in the United States correlates strongly with drug-related offenses, to a large extent because of policies and practice that criminalize drug-related offenses.

As society has shifted its understanding that SUDs are health conditions, it has been recognized that effectively addressing them requires an integrated public health and public safety approach involving coordination of efforts across many systems including the medical and legal systems. Research shows that evidence-based treatment can significantly decrease drug problems, crime and criminal recidivism while improving health (Chandler, et. al, 2008).



Juvenile Justice

In juvenile justice settings, it is estimated that 50-75% of juveniles were under the influence of drugs or alcohol at the time of their offense. (NIDA, 2017)



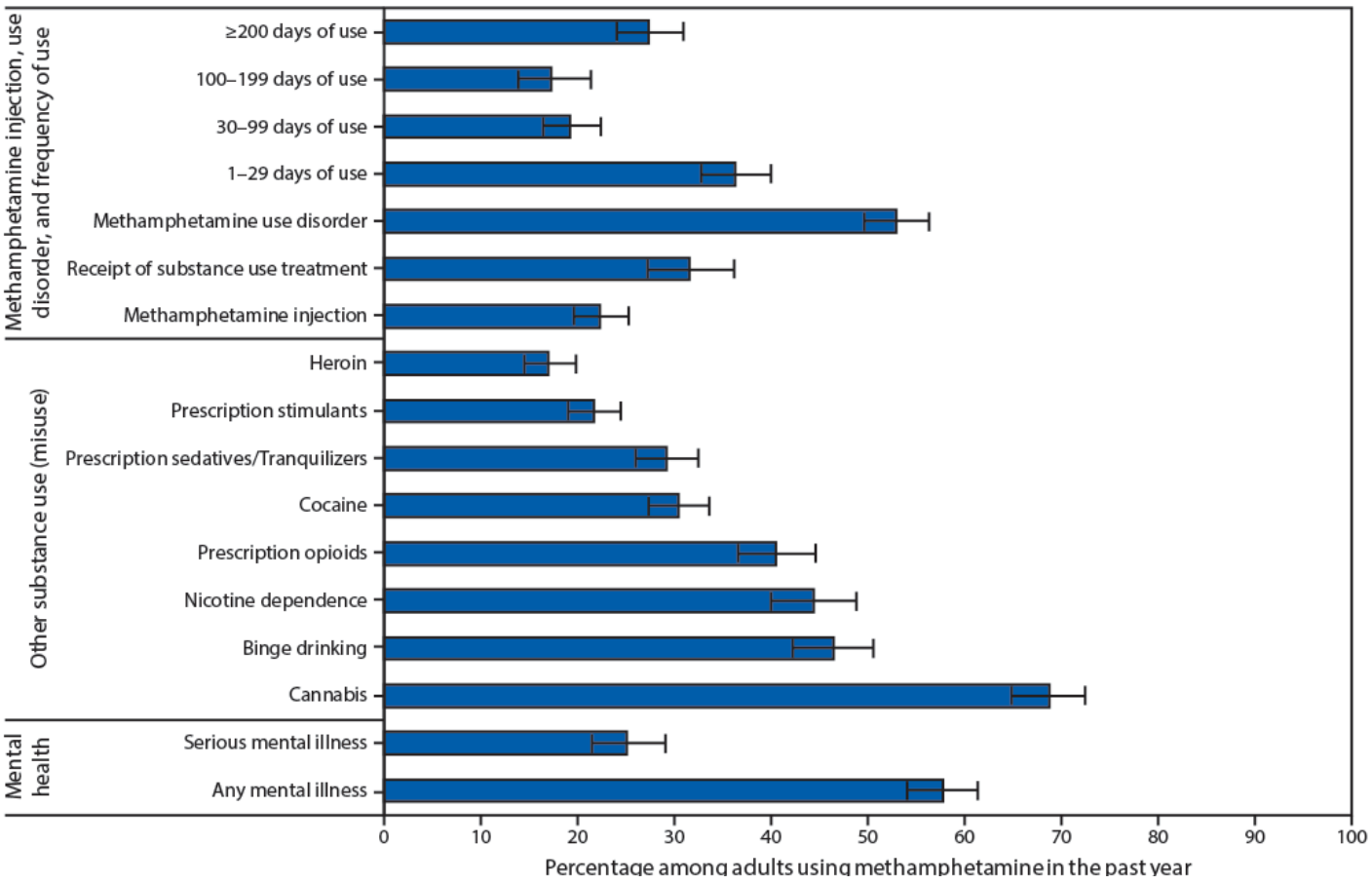
Adult Offenders

Estimates suggest that adult offenders have rates of substance use disorder that are more than 4x that of the general population.

Prevalence

In 2019, 23.9% of Americans aged 12 or older reported they binge drank alcohol in the prior month, and 20.3% reported they had used an illicit drug in the prior year. According to SAMHSA (2020), illicit drug use in 2019 continues to be driven primarily by marijuana use and the misuse of prescription pain relievers. Both fentanyl and methamphetamine represent growing regional threats.

During 2015–2018, an estimated 1.6 million U.S. adults aged ≥18 years, on average, reported past-year methamphetamine use; 52.9% had a methamphetamine use disorder; and 22.3% reported injecting methamphetamine within the past year. Co-occurring substance use and mental illness were common among those who used methamphetamine and other stimulants within the past year.



(Jones, et al. 2018)

Economic Impact

Substance use disorders have a huge direct and indirect economic impact on society through healthcare expenditures, lost earnings including of those who die by overdose, psychosocial disruption and expenses associated with crime and injury.

The heaviest societal and economic burden of SUDs falls on states and localities, funding public programs like Medicaid and child welfare systems. In addition to the deaths and illnesses associated with opioid use disorder, newly emerging information about stimulants and other substances on the rise indicate that alarming economic losses have resulted. According to one government estimate, the yearly economic cost of the opioid crisis is $504 billion, or 2.8% of the Gross Domestic Product (Center for Behavioral Health Statistics and Quality, 2019). These losses arise from healthcare spending, criminal justice costs and lost productivity (Council of Economic Advisors, 2017).

The cost of SUDs to society is even greater when the impact on public health is considered as they contribute to the spread of infectious diseases like Hepatitis C and HIV/AIDS, either through high risk behavior such as sharing of drug paraphernalia or unprotected sex, homelessness, and motor vehicle crashes. Other associated costs are more difficult to quantify, such as compromised family environments that contribute to poor developmental outcomes in children, lower socioeconomic status, poor marital relations and parental conflict. (See section on *Social Determinants of Health and Structural Competences* on page 45.)

The yearly economic cost of the opioid crisis is

$504 BILLION

or 2.8% of the Gross Domestic Product.

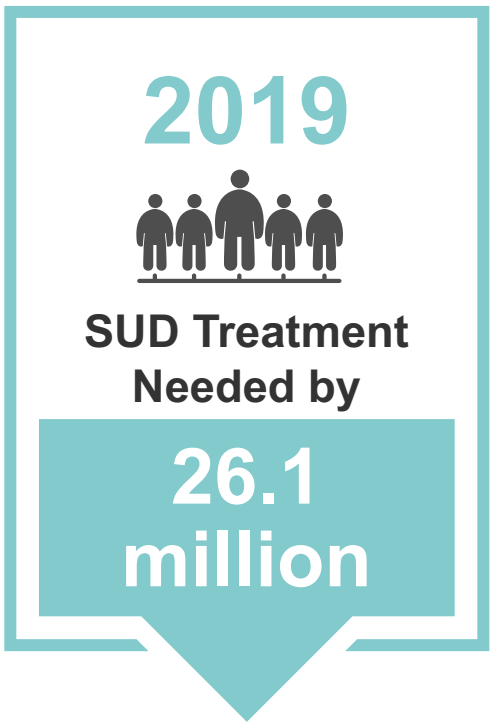
These losses arise from healthcare spending, criminal justice costs and lost productivity (Council of Economic Advisors, 2019).

Champion State Judges at The National Judicial College November 2019 in small group discussions.

The Role of the Justice System

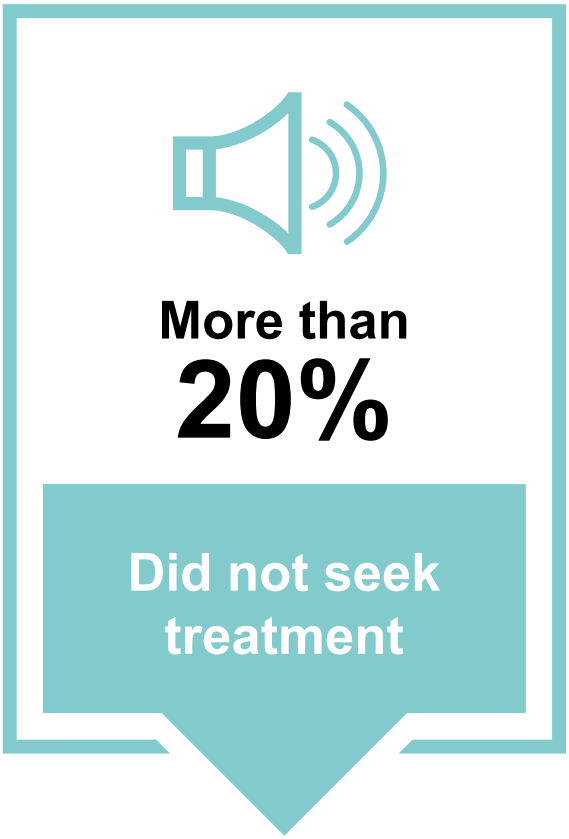
While the traditional role of judges is to adjudicate cases, many judges and judicial branch partners are now providing a wide range of more holistic and therapeutic programs to more effectively address the needs of individuals with SUDs who are involved with the court system.

The justice system is often society's first and, many times, only opportunity to identify and provide treatment for individuals with SUDs. As a result, judges are uniquely positioned to link these individuals to health professionals, evidence-based treatment programs, mutual-help groups, local specialty treatment courts and other related resources.



In 2019, approximately 4.2 million people aged 12 or older received any substance use treatment in the past year, or which 2.6 million received substance use treatment at an SUD specialty facility (SAMHSA 2020).

State Champion Judges.



According to SAMHSA 2014, more than 20% of individuals with substance use disorders did not seek treatment because they were worried about the negative impact treatment could potentially have on their employment. The extent of misinformation about substance use disorders in public discussion—healthcare provides, educators, policymakers and media reinforces barriers that prevent people from seeking treatment.

Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral health treatments and services. 2015. [January 25, 2016]. http://www.samhsa.gov/treatment accessed 7/20/19

If Research Shows That Treatment Saves Lives And Money, Why Aren't More People Being Treated?

Individuals with SUD have many reasons to not seek or stay in treatment. One of the most difficult barriers to overcome where it relates to SUD is stigma. The public and many health providers have a general lack of understanding of SUDs and put too much focus on blaming individuals for "willful conduct."

Stigma is not limited to the general public but also within the medical field. Most health professionals have little if any training in SUDs. Quite often, the only exposure medical trainees receive is in the emergency room. They are often seeing the most advanced cases of the disease, homeless individuals or others involved in a life-threatening situation where substance use may be an issue. Yet, research shows that 20% of the patients in any hospital setting have an SUD and most are not detected or treated (Center for Behavioral Health Statistics and Quality, 2019).

Language Matters

Throughout the guide, we use language that does not stigmatize individuals with SUDs and co-occurring psychiatric disorders. For example, the term "addict" is considered unhelpful and stigmatizing. It is important to remember these are people who have a medical disorder. The best descriptor would be "a person with a substance use disorder."

Most people living with an SUD have often experienced considerable societal hostility, abuse and rejection by friends, family members, significant others and employers.

In 2013, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth (DSM-5), redefined the descriptor "substance abuse" to "substance use disorder," to remove the word "abuse" because it is stigmatizing and has connotations of entirely willful behavior. Similarly, "addiction" was reserved for the most extreme cases, because the word addiction can be construed as negative (For more information about DSM-5 go to page 23).

Say this:	Not this:
Negative test, positive test	Clean sample, dirty drug test
Maintaining recovery, substance free	Staying clean
Substance use disorder, substance use	Habit or drug habit
Treatment, medication	Opioid replacement
Experiencing/being treated for a mental illness/history of mental illness	Suffering from, a victim of mental illness

SUD Dictionary for State Courts, created by the National Judicial Opioid Task Force

The ADDICTIONary, created by Facing Addiction and the Recovery Research Institute

Words Matter – Judicial Language and Substance Use Disorders

Links to the above resources can be found in the Resource section.

Alcohol and Other Substance Use

Alcohol and other drug use lead to a wide range of problems, including unhealthy or hazardous drinking and drug use. Harmful alcohol and/or drug use includes mild SUDs and moderate to severe SUDs. *Note: In this guide we will use the term "substance use disorders" to cover all substances*.

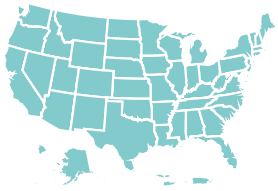
Alcohol Use Disorder

A chronic brain disorder marked by compulsive drinking, loss of control over alcohol use, and negative emotions when not drinking. AUD can be mild, moderate or severe. Recovery is possible regardless of severity. (See more: https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics)

Heavy Alcohol Use

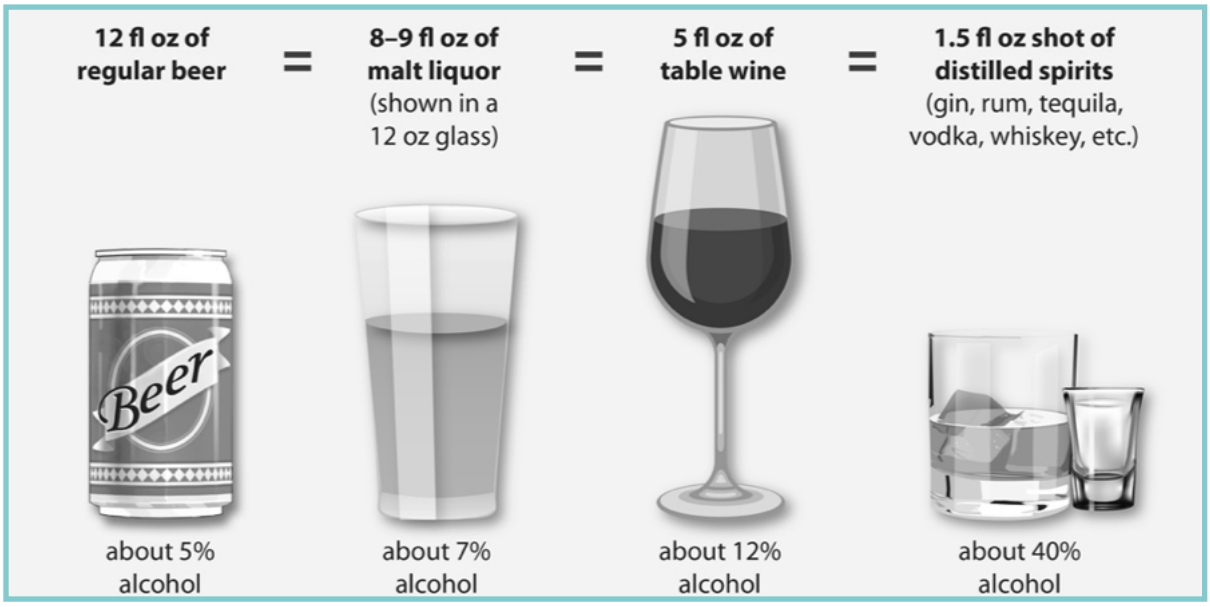
National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines unhealthy levels of drinking as a pattern of drinking that brings blood alcohol concentration (BAC) levels to 0.08 g/dL. This typically occurs after 4 standard drinks for women and those over age 65 and 5 drinks for men—in a two-hour period.

Alcohol Use in the United States



14.4 million adults ages 18 and older have Alcohol Use Disorder (AUD)

- *7.9% received treatment in the past year.*
- *An estimated 401,000 adolescents ages 12–17 have an AUD and only 5% have received treatment in the past year.*
- *An estimated 88,000 people die from alcohol-related causes annually, making alcohol the third leading preventable cause of death in the United States (NIDA 2018).*
- *Furthermore, alcohol misuse was estimated by NIDA to cost the United States $249 billion in 2010.*



Agonist
A chemical that binds to and activates certain receptors on cells, causing a positive biological response. Oxycodone, morphine, heroin, fentanyl, methadone and endorphins are all examples of opioid receptor agonists.

Antagonist
A chemical substance that binds to and blocks the activation of certain receptors on cells, preventing a biological response. Naloxone and naltrexone are examples of opioid receptor antagonists.

Behavioral Health
The scientific study of the emotions, behaviors and biology relating to a person's mental well-being, their ability to function in everyday life and their concept of self.

Brief Intervention
Evidence-based practices designed to motivate individuals to change their behavior by helping them understand how their behavior puts them at risk and how to reduce harm. Components of a brief intervention include providing feedback about the extent and effects of behavior on their health, enhancing motivation to change behavior and offering recommendations for how to do so. An intervention can be provided by a counselor or other trained health professional.

Buprenorphine/XR-Buprenorphine
Buprenorphine is a partial agonist medication at the opioid receptor. It is a schedule III drug, with an improved safety profile with less potential for overdose. This medication is injected and used to treat opioid use disorder, including in a primary care setting or correctional facility.

Denial
Generally used to describe a common reaction when a person with an SUD is confronted, they refuse to accept it. It is a set of defenses and distortions in thinking caused by the use of substances (SAMHSA, 2015).

Detoxification or Detox
A more current term is "withdrawal management." For some substances (e.g., opioids), detoxification may create other risks. This is a process that helps the body rid itself of toxins. Withdrawal symptoms may appear during the detoxification process; the body has adapted to the presence of a substance, therefore when it is withheld the system becomes out of balance, which can result in adverse physical or emotional response.

DSM-5 Criteria/DSM-5 (Diagnostic and Statistical Manual of Mental Disorders)

The diagnosis of alcohol use disorder, which can also be used for all substance use disorders, was introduced in DSM-5 to replace older diagnostic terminology. SUDs are classified as mild, moderate or severe. The criteria for SUDs are similar for the 11 listed below. Criteria being met for mild, for example, if two to three of the following occur within a 12-month period (American Psychiatric Association, 2013).

1. Alcohol is often taken in larger amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

4. Craving, or a strong desire or urge to use alcohol.

5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.

6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

8. Recurrent alcohol use in situations in which it is physically hazardous.

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

10. Tolerance, as defined by either of the following:
    1. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    2. A markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:
    1. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal).
    2. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Evidence-Based

At least one randomized clinical trial that can be replicated has shown a practice to be effective and either targets behaviors or shows positive impact on behaviors that are generally accepted outcomes, such as reduced substance use or decreased criminal behavior or improvements in health.

Harm Reduction

Policies, programs and practices that aim to reduce the harms associated with the use of alcohol and/or other drugs. The defining features include a focus on the prevention of harm, rather than on the prevention of substance use itself, with attention and focus on the individual's active substance use (e.g., needle exchange program can reduce rates of transmission of hepatitis C, HIV, or other infectious disease for individuals suffering from heroin use disorder).

Justice System

The term justice system is used to refer to family, criminal, and civil courts and other agencies/ organizations that play a significant role in the administration of justice, including prosecutors, defense attorneys, and corrections, where applicable. The focus of this guide is addressing the needs of individuals with SUDs who may, as a result of their disorder, come into contact with the justice system. *Note: Throughout this resource guide, references to the justice system will be made. This term is intended to be inclusive of the civil, family, traffic, adult criminal and juvenile justice systems, as well as probation and parole.*

Medications for Addiction Treatment (MAT)

Historically, many refer to MAT as “medications for addiction treatment,” “medication assisted treatment,” or “medication assisted therapy.” While behavioral therapies such as cognitive-behavioral therapy is recommended, in the case of OUDs, medication treatment is the standard of care. Because it should not be implied the medication “assists” the behavioral therapy, MAT for OUD is a term now replaced by “medications for opioid use disorder treatment” or MOUD. One might also say medication for AUD for alcohol and medication for nicotine use disorder, where medication for addiction treatment would be used.

Maintenance Treatment

Medications for treating opioid use disorder (MOUD) include treatment with FDA-approved medications methadone, XR-naltrexone or buprenorphine for varying lengths of time, depending on an individual’s needs. These medications may be administered for several months, years or indefinitely. Treatment and which medication is used is based on the individual’s specific needs. Some of these medications are opioids that are long-acting and elicit rapid tolerance to their cognitive and emotional effects; properly treated individuals do not experience intoxication while taking them and can engage in most daily activities safely and effectively. Research shows that individuals on medications for opioid use disorder have markedly better outcomes than those who cease using or are not treated with medications.

Medications for Opioid Use Disorder (MOUD)

Three FDA medications (buprenorphine, X/R-naltrexone or methadone) are approved for the treatment of opioid use disorder.

Methadone

Methadone is one of the oldest medications used to treat opioid use disorder and has been highly effective for many people. It is a long-acting full opioid agonist (described above) and a schedule II controlled medication. Methadone reduces opioid craving and withdrawal and blunts or blocks the effects of opioids. As with all medications used in MOUD, methadone is most typically prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs. It is only dispensed through federally regulated opioid treatment programs (OTPs).

Naltrexone X/R
Extended-release injectable naltrexone, approved by the FDA for alcohol use disorder in 2006 and opioid use disorder in 2010, is an antagonist at the *mu*-opioid receptor. Patients take effective medication monthly, as opposed to the daily dosing required by other medications. Oral naltrexone is rarely used to treat opioid use disorder today due to low patient adherence and lack of effectiveness compared to buprenorphine maintenance, though it may be initiated in some settings (Schottenfeld, et. al, 2008).

Neonatal Abstinence Syndrome (NAS)
Neonatal abstinence syndrome (NAS) is a group of withdrawal signs that may occur in a newborn who has been exposed to substances. NAS signs may include high-pitched and excessive crying, seizures, feeding difficulties, irritability and poor sleeping. NAS is a treatable condition. When a child is born with a substance in their system it does not mean they are addicted but that they may be physically dependent or have the substance in their system.

Neonatal Opioid Withdrawal Syndrome (NOWS)
This term specifically applies to the withdrawal signs that may occur in a newborn who has been exposed to opioids in the womb and is the term preferred in the medical community versus NAS when referring to opioid dependence.

Partial Agonist
A chemical substance that binds to but only partially activates certain receptors on cells, causing a less-than 100% positive biological response. Buprenorphine is an example of an opioid receptor partial agonist.

Opiate
Opiates are drugs directly derived from the opium plant. Examples include heroin, morphine and codeine.

Opioid
Opioids (including the opiates) cause sedation, pain-relief and respiratory depression. They are a class of drugs that include prescription painkillers like hydrocodone (Vicodin) and oxycodone (OxyContin), as well as fentanyl and methadone. *Note: The distinction between opiates and opioids is that opioids are semi-synthetics or synthetics produced in the laboratory. Often, the term opioid is used to refer to both opiates and opioids*.

Recovery
Recovery is a process of change through which people improve their health and wellness, live self-directed lives and strive to reach their full potential. Individuals should have a variety of options to consider as their pathway to recovery. For opioid use disorder, research supports MOUD combined with counseling as the gold standard to improve the likelihood of better outcomes. *Note: One can be considered in recovery even when on a medication to assist sobriety.*

What are Fentanyl, Carfentanil, and Their Analogs?

Fentanyl and carfentanil are synthetic opioids and powerful anesthetics. Fentanyl is a Schedule II narcotic approved for pain relief for humans by the U.S. Food and Drug Administration. It is 30 to 50 times more potent than heroin and 50 to100 times more potent than morphine.

Carfentanil is a tranquilizing agent for elephants and other large mammals and is over 100 times more potent than fentanyl.

Note: You will not overdose or die by merely touching fentanyl or carfentanil. This is a common myth.

Relapse

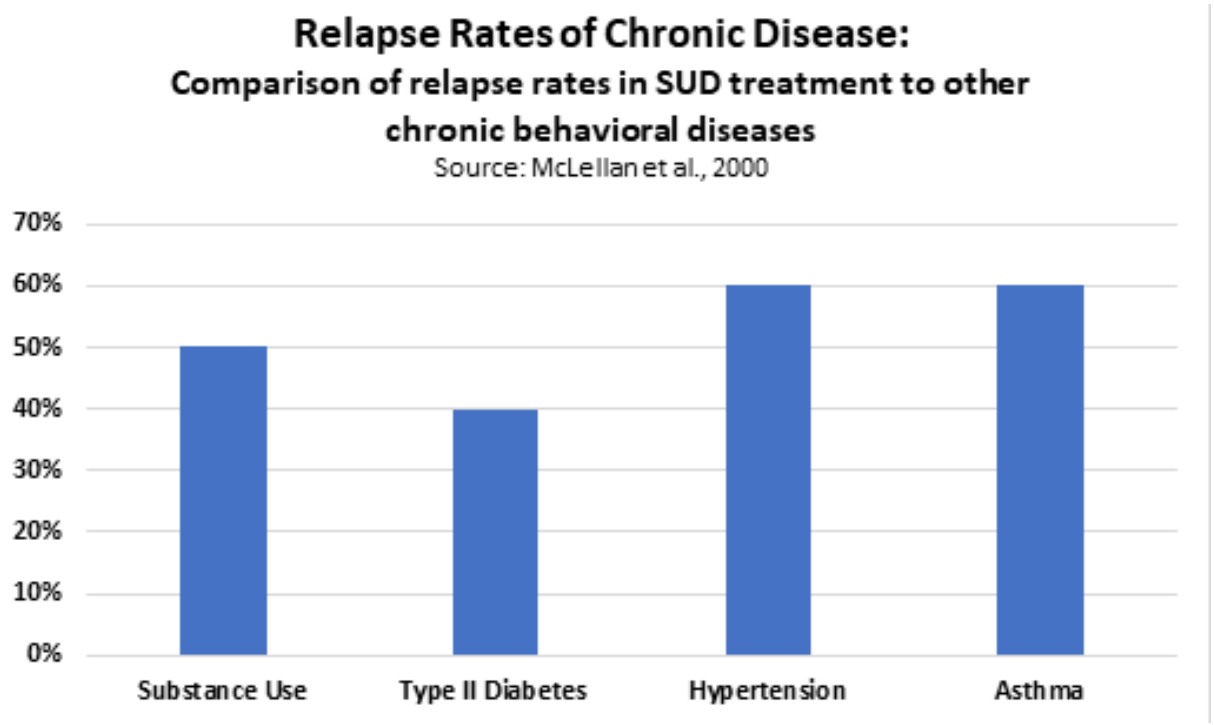
Relapse is a re-occurrence of the use of a substance after a period of abstinence. A relapse can be more or less significant, such as with one misuse incident or a "slip," or a pattern of misuse and a downward spiral away from recovery goals.

In either case, given the chronic and relapsing nature of SUDs, part of recovery is recognizing that relapse at times can be expected, with a goal of treatment to support the individual to minimize relapses and sustain recovery in a positive direction and with the minimum amount of harm to the individual.

Relapse can occur when:

- Cravings and withdrawal drive the urge to resume substance use. Cravings can be intense and driven by changes in brain chemistry and therefore difficult to resist.
- Over time, rather than seeking a "high," individuals use substances to avoid the pain and discomfort of withdrawal due to brain changes that have occurred with regular use.
- Lack of pleasure from the basic joys of life leads to boredom, depression and the need for stimulation.
- Impaired attention, judgment and insight make it difficult to pay attention in treatment, heed warnings and practice new skills.
- Routine stressors of life (or severe stressors from traumatic events) can overwhelm the altered brain of someone with a prior SUD, causing anxiety, panic, tenseness and perceived inability to cope without using alcohol or other drugs.

From a medical perspective, relapse during or after treatment is not considered a failure. It represents an opportunity for treatment modification. Relapse to SUDs occurs at similar rates to other chronic medical conditions such as diabetes, hypertension and asthma. Like other chronic relapsing disorders, SUDs may require a change in treatment until abstinence is achieved. For example, when a patient with diabetes does not take their medication or fails to exercise as outlined by their health provider, the non-compliance and relapse are not seen as a willful failure. Rather the treatment is altered to address their problems. Quite often when treating opioid use disorder this would suggest a need to increase the medication dose to offset the craving associated with it, to increase treatment intensity or to address environmental stressors.



(McLellan et al., 2000)

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an evidence-based practice used to identify, reduce and prevent problematic use of alcohol and other drugs. The SBIRT model was prompted by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use, especially alcohol and nicotine use disorders. Recent outcome data from a SAMHSA initiative demonstrates its effectiveness to lower alcohol and drug use (Aldridge, Linford, and Bray, 2017). More on SBIRT can be found on page 72.

Substance Use Disorder

Substance use disorder is “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance (alcohol or the other drugs) despite significant substance-related problems” (American Psychiatric Association, 2013). SUD can range from mild to severe and recovery is possible regardless of severity.

Treatment

A service or set of services that may include medication, counseling and other supportive services designed to support an individual in reducing or eliminating alcohol and/or other drug use; address associated physical or mental health problems; and restore the patient to maximum functional ability (SAMHSA, 2015). *Note: AA/NA and other mutual help groups are not treatment but can be a support system for some to enhance or augment their treatment.*

Treatment System

Treatment System refers to a broad range services—including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services, legal assistance and case management.

Withdrawal Management

A psychological and medical process that provides support during the detoxification process. Withdrawal from some substances, such as alcohol or opioids, can be life threatening if not handled appropriately and under medical supervision. Increasingly, it is recognized that a withdrawal management goal might be to initiate maintenance treatments with medications for SUDs where medications have shown efficacy, including opioid use disorder.

Alcoholics Anonymous / Narcotics Anonymous are mutual-help groups and not treatment programs but meant to augment or support treatment. Not everyone chooses that path to support them and others find it critical to maintaining their recovery. Each individual should be advised of the availability of a variety of resources but respect everyone is unique and some find groups or religious-based organizations uncomfortable.

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TIP 39: Substance Abuse Treatment and Family Therapy. https://www.samhsa.gov/resource/ebp/tip-39-substance-abuse-treatment-family-therapy

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Addictionary from the Recovery Research Institute. https://www.recoveryanswers.org/addiction-ary/

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Comprehensive Addiction and Recovery Act of 2016 (CARA) - https://www.congress.gov/bill/114th-congress/senate-bill/524/text

SUPPORT for Patients and Communities Act (SUPPORT Act) - https://www.congress.gov/bill/115th-congress/house-bill/6

Coronavirus Aid, Relief, and Economic Security Act (CARES Act) - https://home.treasury.gov/policy-issues/cares

Support Groups
Alcoholics Anonymous (AA) – https://www.aa.org/pages/en_US

Narcotics Anonymous (NA) - https://www.na.org/

SMART Recovery – https://www.smartrecovery.org/

LifeRing – https://lifering.org/

Women for Sobriety – https://womenforsobriety.org/

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2 Science of Substance Use Disorders

Substance Use Disorders—A Brain Disease

The human brain is incredibly complex and has billions of cells, called neurons, that are organized into circuits and networks. Each neuron acts as a switch controlling the flow of information. If a neuron receives enough signals from neurons connected to it, it "fires," sending its own electrical or chemical signal to other neurons in the circuit.

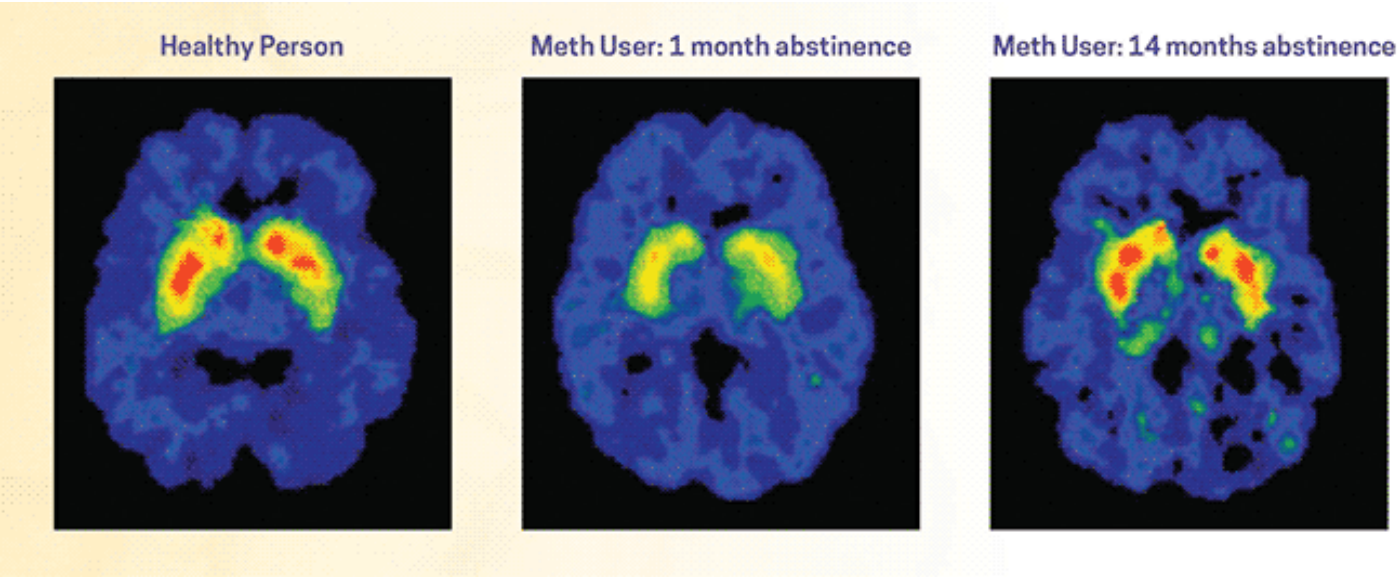
Impact on the Brain

The initial use of substances is typically voluntary, though under a multitude of circumstances, continued heavy use can lead to an SUD. Once an SUD develops, it is considered a chronic brain disease that causes physical changes in areas of the brain critical to judgment, decision-making, learning, memory and behavior control. As the individual develops an SUD, their ability to modify their behavior despite medical and legal consequences may be impaired as a result of their cravings.

SUDs create an intense drive to avoid withdrawal, which often includes physical illness (e.g. vomiting, diarrhea or seizures), combined with reduced ability to experience everyday pleasures and intrusive urges triggered by the people, places and things associated with substance use.

Substances alter the way brain cells communicate with each other. Neurons send messages to each other either electrically or through molecules called neurotransmitters.

Some drugs activate receptors and others block them. Drugs, such as marijuana and heroin, can activate receptors because their chemical structure mimics that of a natural neurotransmitter, which causes neurons to respond as if the natural neurotransmitter were present. Cocaine and amphetamines block the dopamine transporter that normally removes dopamine from the synapse, the space between



These images showing the density of dopamine transporters in the brain illustrate the brain's remarkable ability to recover, at least in part, after a long abstinence from drugs—in this case, methamphetamine. The Journal of Neuroscience, December 1, 2001, 21(23):9414-9418.

neurons. Both activation of receptors and blocking of transporters result in increased dopamine levels in an area of the brain called the nucleus accumbens, which in turn results in feelings of euphoria and motivation to seek substances.

How do drugs produce pleasure?

Pleasure or euphoria is created by surges of chemical-signaling, including dopamine and the body's natural opioids (endorphins).

The surges of the neurotransmitter dopamine are thought to occur as a result of repeated pleasurable activities or a reinforcement to repeat use to receive pleasure.

How the Brain is Affected by Substance Use

Substances can alter important areas of the brain that are necessary for life-sustaining functions and results in the compulsion to continue use even with negative consequences. This is most tragically seen in opioid overdoses.

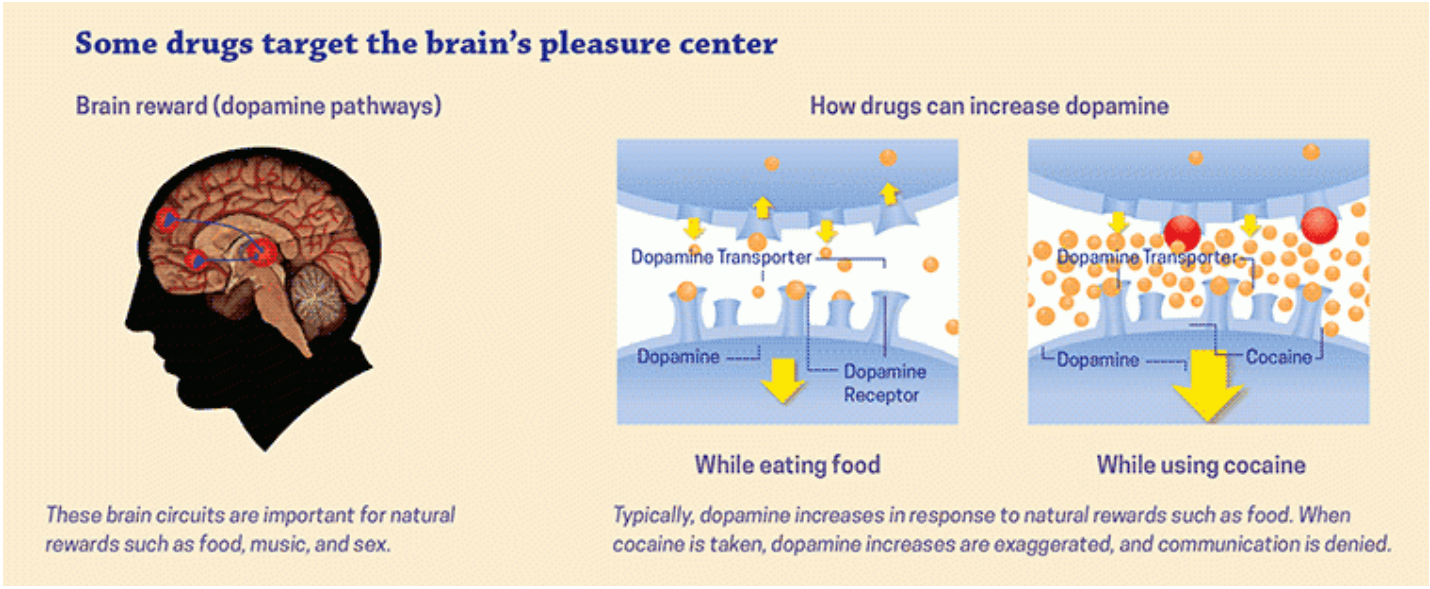
Different areas in the brain process information from our senses, enabling us to see, feel, hear and taste, including our ability to plan, solve problems and make decisions.

Alcohol and other drugs can over-activate our circuits by producing a rewarding effect. With repeated exposure, the circuit adapts to the presence of the substance, diminishing sensitivity to the drug and making it more difficult to feel pleasure from anything besides the substance.

When the substance is no longer available, other parts of the brain play a role in stressful feelings like anxiety, irritability and unease characterized by withdrawal. This is a motivation for the person to seek the substance again. Over time, a person with an SUD often finds they are using a substance to get temporary relief from physical discomfort rather than to feel pleasure or get high.

The brain's reward system controls and regulates our ability to feel pleasure. Feeling pleasure motivates us to repeat behaviors that are critical to our existence, such as eating.

Substances also affect other parts of the brain that control basic functions such as heart rate, breathing and sleep, causing depressed breathing and death. All substances that cause SUDs directly or indirectly target the brain's reward system. Dopamine pathways, known as the brain's reward pathways, are important for rewards like food and sex.



https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain

Why are Alcohol and Other Drugs More Addictive Than Natural Rewards?

The difference between normal rewards and substance rewards can be defined by the difference between someone whispering into your ear (normal reward) and someone shouting into a microphone (alcohol/drugs). When the volume gets too loud, we turn down the sound. The brain of someone with an SUD adjusts by producing fewer neurotransmitters in the reward circuit or by reducing the number/sensitivity of receptors that receive the neurotransmitter signals. As a result, the person's ability to experience pleasure from natural reward activities is also reduced (NIDA, 2020). Further, counteracting circuits are strengthened, such that when the substance is removed, there is a deficit of reward compared to the pre-addiction state.

The combination of drug use and the reduction of normal joy is why someone with an SUD eventually feels flat, without motivation, lifeless or depressed and unable to feel pleasure. The person will often increase the amount of the substance in an attempt to produce the familiar high or euphoria; this is tolerance.

Other health consequences are associated with substance misuse include lung or heart disease, stroke, cancer and psychiatric disorders. Substance use can increase the risk of contracting various infections such as human immunodeficiency virus (HIV) and hepatitis C often resulting from unsafe sexual activity and injection drug use.

Physically Dependent vs Addicted

Being physically dependent on a substance is different than having a substance use disorder or addiction. Physical dependence is when the body adapts to the drug, requiring more of it to achieve a certain effect (tolerance) and eliciting drug-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal). Merely having withdrawal and/or tolerance to a substance does not constitute a DSM-5 substance use disorder (NIDA, 2018).

Are some babies born addicted?

No. Even if a fetus is exposed to a substance and could be physically dependent or go through withdrawal after being born, that does not mean the baby is born addicted to the substance. Rather, the baby can be born physically dependent on the substance, and that physical dependence can be easily treated or simply observed. *In utero* exposure to a substance is usually not the reason babies have other health problems including low birth weight and developmental delays: generally poor prenatal care and nutrition have profound impacts on the baby's development.

Effects of substance use while pregnant and breastfeeding.

Opioid use during pregnancy can cause infants to go through withdrawal from the substance they were exposed to *in utero* after being born, which is known as neonatal opioid withdrawal syndrome (NOWS). Symptoms include tremors, problems with sleeping and feeding, irritability and sometimes seizures.

Drug-exposed babies may have developmental problems, though it is difficult to parse out effects of substance exposure from those of poor prenatal care, poor socioeconomic conditions after birth, genetic influences, etc. Importantly, alcohol use during pregnancy is the leading cause of preventable intellectual disability.

Unfortunately, the number of babies born with NOWS has increased in recent decades. Between 1999 and 2013, the number of cases of NOWS tripled; in 2013, it affected six out of every 1,000 newborns.

The term NOWS (neonatal opioid withdrawal syndrome) is considered a more accurate term for infants born physically dependent on opioids.

Does substance use cause psychiatric disorders or vice versa?

Substance use and psychiatric illness often co-exist. Psychiatric disorders such as anxiety, depression and schizophrenia may exist before the SUD, and in other cases substance use may trigger or intensify psychiatric conditions, particularly for those with specific vulnerability. A clear example is the association of early cannabis (marijuana) use, which can accelerate appearance of psychosis in those that later develop schizophrenia. Some people may use substances to alleviate psychiatric symptoms or self-medicate, which may exacerbate or intensify the symptoms of the psychiatric disorder, putting them at higher risk for an SUD. Identification and treatment of SUDs and psychiatric disorders should happen concurrently.

What determines if an individual will develop a substance use disorder?

Research on the biology of SUDs helps explain why they persist despite their negative impact on the health and the safety of individuals, families and communities.

Developing an SUD is impacted by a variety of factors related to the individual, such as: 1) genetics, 2) early childhood environment, 3) exposure to trauma, 4) childhood behavior, 5) social skills and 6) positive and negative peer family and group relationships and 7) exposure to alcohol and drugs. These factors can both decrease or increase the risk that an individual will develop a problem.

Who Can Get Addicted To Alcohol Or Other Drugs?

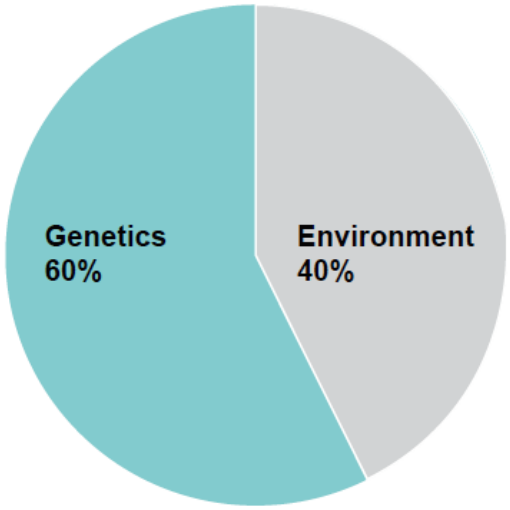
Anyone can become addicted to a substance. Addiction, as defined above, is manifested when an individual feels a strong urge to keep taking a substance (alcohol/drug-illicit or legal) even when causing harmful consequences. Addiction is not dependent on one's socioeconomic status, profession/job, race or age, though the risk can be impacted by those factors. Having a family member or relative with a problem with alcohol or drugs, using alcohol, cigarettes or other substances from an early age, having a mental health condition like depression, being exposed to trauma or associated with people who use drugs are all risk factors.

Why Do Some People Develop A Substance Use Disorder While Others Do Not?

As with any medical disease and disorder, whether or not someone develops an SUD varies from one individual to another. No single factor defines their vulnerability to develop an SUD. Arguably, substance use is the single factor that defines vulnerability.

Further, characteristics of the substance (potency, route of administration, age at first use, amount and frequency of use) confer higher risk of developing a substance use disorder than characteristics of the individual such as the presence of mental illness. The more risk factors a person has, the greater the chances that using a substance will lead to the development of an SUD. Alternatively, protective factors reduce a person's risk. Risk and protective factors may be either environmental or biological, and usually both.

Causes of SUD



Bevilacqua L and Goldman (2009)

Biological factors can impact a person's risk of SUD, including their genes, epigenetic changes, stage of development and gender, and psychiatric disorders. There are genetic predispositions to SUD.

Environmental factors like home, family and school can increase a child's risk of developing SUDs. Friends and other peers have strong influence on teens, which, in combination with genetic predispositions, learning disabilities, and poor social skills, further increase the risk of developing an SUD.

Why Do People Use Alcohol and Other Drugs?

People may use substances for many reasons including relief of withdrawal or...

To feel good - Most drugs, including alcohol, can produce feelings of pleasure, especially early in the course of substance use. For example, with stimulants such as cocaine, the “high” is often followed by feelings of empowerment, self-confidence and increased energy. In contrast, the euphoria caused by opiates, such as heroin, often is followed by feelings of relaxation and satisfaction.

To feel better - Some people who suffer from social anxiety, stress-related disorders, and depression begin misusing substances to lessen feelings of distress. Stress can play a major role in beginning use, developing an SUD and later, relapsing. The “dark side” of addiction refers to later stages of addiction, awhen one uses a substance to avoid withdrawal or to feel “normal,” rather than to get “high.”

To do better - The increasing pressure that some individuals feel to chemically enhance or improve their athletic or cognitive performance can play a role in initial experimentation and continued misuse.

Curiosity and “because others are doing it” - Adolescents are particularly vulnerable because of the strong influence of peer pressure; they are more likely to engage in “thrilling” and “risk taking” behaviors and experiment with alcohol and/or other drugs.

Research indicates that the prefrontal cortex—the part of the brain that allows people to assess situations, make sound decisions, and maintain emotions and desires—is still developing during adolescence into young adulthood (through age 25). Thus, adolescents and young adults are more likely to make poor decisions and take more risk, thus increasing the chance of developing an SUD. Early initiation of substances could potentially have profound and long-lasting consequences on the development of the brain (NIDA, 2020).

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Resources

General

Alcohol and Other Drug Problems: A Public Health and Public Safety Priority from the Physicians and Lawyers for National Drug Policy in partnership with The National Judicial College. https://www.brown.edu/Departments/PLNDP/resource_guide/files/PLNDP_resource_guide.pdf

The Need to Decrease Stigma Involving Addiction Begins With The Medical Profession from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/decreasing-stigma-involving-addiction-begins-with-the-medical-profession/

Underage Drinking: Why Do Adolescents Drink, What Are the Risks, and How Can Underage Drinking be Prevented? From the National Institute on Alcohol Abuse and Alcoholism (NIAAA). https://pubs.niaaa.nih.gov/publications/AA67/AA67.htm

Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/drug-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome

Intersection of Pain and Addiction from the Boston Medical Center, OBAT Training and Technical Assistance Team. https://pcssnow.org/resource/intersection-of-pain-and-addiction/

Polysubstance Use: The Norm Not the Exception from the Boston Medical Center, OBAT Training and Technical Assistance Team. https://www.youtube.com/watch?v=OWHyj5rAlHs

SUD 101 Core Curriculum from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/sud-core-curriculum/

Understanding Addiction: A New Perspective from the National Judicial Opioid Task Force with Judge Duane Slone and Dr. Stephen Loyd. https://www.youtube.com/watch?v=YLzEXYhMhs8&feature=youtu.be

Rural Community Action Guide from the U.S. Department of Agriculture (USDA). https://www.usda.gov/sites/default/files/documents/rural-community-action-guide.pdf

Ted Talk from Neuroscientist Nora Volkow, director of the National Institute on Drug Abuse (NIDA) at the NIH, applies a lens of addiction to the obesity epidemic - https://www.tedmed.com/talks/show?id=309096

Drug Use and Viral Infections (HIV, Hepatitis) DrugFacts from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/publications/drugfacts/drug-use-viral-infections-hiv-hepatitis

Drugs and the Brain

Drugs, Brains, and Behavior: The Science of Addiction from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain

Understanding the Basics of Addiction, National Judicial Opioid Task Force. http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/338

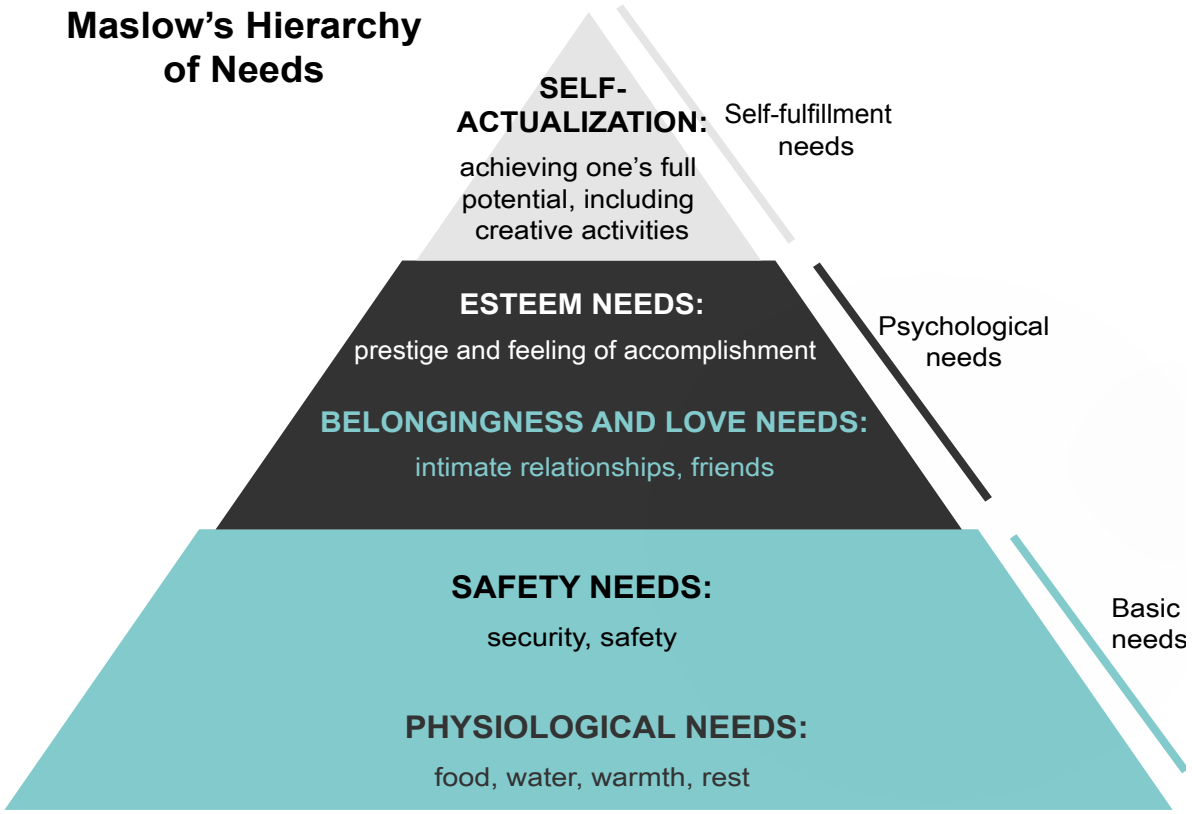
Prenatal Substance Exposure: Improving Outcomes for Women and Infants, National Judicial Opioid Task Force. http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/347

3 Social Determinants of Health

Social determinants of health are highly correlated with opioid and other substance use disorders. Poor health and structural factors, such as poverty, lack of employment and other community opportunities that could provide protective factors, lead to economic hardship, social isolation and hopelessness, all key reasons for substance use and misuse. Poverty and substance use, reinforced by untreated psychiatric disorders, lack of access to treatment and stable housing, are cited as the main contributors to SUDs in underserved communities. Communities with the lowest levels of social capital continue to have the highest overdose rates (Dasgupta et al., 2018).

By applying what we know about social determinants of health, we can improve individual and population health. It is well understood from Maslow's Hierarchy of needs that individuals increase the possibility of becoming self-actualized when their basic needs are met.

Disease Prevention and Treatment Effective treatment must address a variety of social and environmental factors that compound the difficulty of overcoming SUDs. Many individuals with SUDs have multiple financial responsibilities they cannot meet, including: child support, family obligations, job requirements and restitution. These can be major obstacles to participating in treatment and achieving and maintaining sobriety. To the extent the medical and justice systems are able, it is important to assist individuals to meet their basic needs, including disease prevention and treatment, housing, transportation, job training, family care needs and legal assistance. Social services, including case management, can be ordered as a condition of bail/release, probation and parole to enhance the likelihood of successful completion of medical care and probation/parole. Child welfare workers can also lend support and monitoring of situations, with or without specified court orders, to enhance family safety.



Planning for those who are living in or re-entering the community from incarceration should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, tuberculosis, diabetes and obesity. Rates of infectious diseases are higher among individuals with SUDs, incarcerated individuals, and those under community supervision than in the general population. Infectious diseases affect not just the individual but also the community at large. Justice staff working with individuals with serious medical conditions should, to the extent possible within their roles, work with individuals to identify and access appropriate healthcare services, encourage compliance with medical treatment and re-establish their eligibility for health services such as Medicaid.

Barriers to Treatment

Housing - Stable living arrangements are crucial to successful treatment. A lack of stable housing is a major challenge for individuals struggling with SUD. The high degree of co-occurrence of SUDs and homelessness, in conjunction with the elevated risk for losing their housing due to financial loss associated with SUD, emphasizes the need to address residential instability as part of an overall treatment plan.

Job Training and Placement - Research shows individuals who are employed are more likely to remain in treatment and, therefore, less likely to recidivate. Job training and placement, as long as the individual has stabilized, should begin at the start of treatment (Lockwood et al., 2012). Job training and placement play a significant role in preventing relapse in preparation for re-entry back into the community after treatment and incarceration.

Transportation is a significant challenge for persons with SUD. This can make it especially difficult for individuals involved with the justice system who may be unable to access recommended treatment. This is further complicated when individuals live in rural communities where little if any public transportation is available. In some states, Medicaid will pay for taxi rides to and from treatment.

Prior to the COVID-19 pandemic, telemedicine was considered innovative and was not widely used. But in 2020, telemedicine became essential. During the pandemic, the treatment community quickly embraced telemedicine, proving treatment can work well for patients with SUDs.

The question remains, is telemedicine as effective to treat SUDs and behavioral health? A study conducted in the midst of the pandemic found that telemedicine can be an effective way to treat patients, though more studies need to be conducted (Batastini, et al., 2021).

Transportation Programs to Consider:

1. Bring transportation to the table. Make sure that representatives from the State or local transit office are engaged early. Invite them to join working groups or the taskforce that is formed to address substance use disorders in the community.

2. Understand the level of transportation that people seeking substance use disorders services need. Engage in a community prioritization exercise to identify the transportation needs of clients and the areas with the greatest needs.

3. Put the transportation need on the DOT radar. Make sure that the transportation need is reflected in the transit plan. Transportation is funded through the U.S. DOT and the Federal Transit Administration only if it is in a plan. If a transportation need is included in the transit plan for the region, that need may be considered for funding.

4. Identify the closest transit program that can help as well as the clear service gaps. Be sure to address special considerations like disabilities that may impact these needs. Special housing areas for those dealing with substance use disorders will need direct routes to treatment and recovery centers.

5. Consider whether plans or projects can be adapted to provide support. Coordinate with the transit program and stakeholders locally or at the State level to develop and amend a project to the State or local Coordinated Human Service and Transportation Plan.

6. Know the costs and leverage resources. Work with the local transit to identify the costs for developing the mobility the clients need to be successful. Seek opportunities to leverage resources, engage with other programs, and find public and private stakeholders that share an interest in addressing substance use disorders.

7. Add access to transportation to the treatment or recovery plan. Substance use disorder programs do not always provide transportation as part of the clinic services. Yet, people seeking substance use services usually lack financial, personal, or physical resources to meet their mobility needs. Find ways to build access to transportation into treatment and recovery modalities (Rural Community Action Guide https://www.usda.gov/sites/default/files/documents/rural-community-action-guide.pdf).

Cultural Awareness in the Treatment of Substance Use Disorders

Awareness to varying cultural norms, expectations and traditions is necessary for the effective treatment of SUDs. Since different groups use alcohol and drugs in socially sanctioned ways, strictly forbid the use of certain substances or simply tolerate the use, clinicians must carefully navigate cultural expectations and assumptions in an effort to be effective.

While it has been noted that racial and ethnic disparities in the justice system exist for youth and adults, it is also well recognized that these disparities also exist in healthcare services. The reasons for these disparities are multi-factorial, including underlying social, economic and political factors. Regardless of the reason, some systems, including court systems, have invested in approaches to attempt to ameliorate equity issues, such as through data-driven justice related decision-making implicit bias training and self-study. Awareness of these biases and disparities is a first step in addressing them.

How to Address Cultural Biases

- Understand your implicit bias, be more aware of these biases and consciously make decisions based on objective criterion rather than your own bias (See more: www.implicit.harvard.edu).
- Vulnerabilities in the social determinants of health exacerbate substance use amongst minoritized communities. Treatment recommendations must include tools to address the social determinants of health.
- For opioid use disorder, access to MAT does not require counseling or other behavioral treatments, although when behavioral supports are available, research shows they have been found to be helpful
- Clear and concrete criteria must be used in the development of protocols, and deliberate consideration of cultural factors and inequities are needed in order to have a more just system.

See more resources in the Resource Section.

Incarcerated drug offenses

10x more Black and Latinx

Rockefeller Laws incarcerated drug offenses of Black and Latinx people at a rate of 10x more than whites

Substance Use Disorders in LGBTQ+ Populations

Lesbian, gay, bisexual, transgender and queer/questioning+ (LGBTQ+) populations experience disproportionately high rates of tobacco, alcohol and cannabis use and other drugs. According to data from the National Survey on Drug Use and Health (NSDUH), adults defined as lesbian, gay or bisexual were more than twice as likely as heterosexual adults (39.1% versus 17.1%) to have used any illicit drug in the past year. Nearly one-third (30.7%) used marijuana in the past year compared to 12.9% of heterosexual adults. About 1 in 10 (10.4%) misused prescription pain relievers compared to 4.5% of heterosexual adults (Center for Behavioral Health Statistics and Quality, 2016).

Often, LGBTQ+ individuals experience an additional type of stress (minority stress) as a result of discrimination, stigma and societal prejudice. This model is supported by numerous research studies, revealing that anti-LGBTQ+ discrimination places LGBTQ+ people at greater risk for substance use problems. In addition to more concrete forms of discrimination (e.g., being fired from a job for being LGBTQ+), LGBTQ+ individuals also experience heterosexism. For example, many settings, including healthcare organizations and the criminal justice system, assume individuals are heterosexual "until proven otherwise." Healthcare and justice system leaders can reduce heterosexism by putting in place policies that allow clients to self-report their sexual orientation or gender identity. Additionally, using gender-neutral language (e.g., partner instead of husband/wife), asking clients their preferred name and pronoun, including LGBTQ+ people in outreach materials, and supporting the visibility of openly LGBTQ+ staff can reduce heterosexism and make LGBTQ+ clients feel more comfortable and supported.

Less Treatment in Rural Communities

Rural communities face many hurdles when confronting substance use disorders and, in particular, opioid use disorder. Research shows that those living in rural communities have myriad barriers to overcome including 1) treatment services that are insufficient to meet the need, 2) access to quality medical care/medications, 3) transportation, 4) employment, 5) sober housing and 6) little if any specialized training.

In fall 2019, Harvard University released a survey of rural Americans that identified drug addiction as the biggest challenge facing their communities.

Trauma and Abuse

There is a strong, bi-directional link between substance misuse and traumatic experiences (Simmons and Saurez, 2016).

Those in the justice settings have significantly higher rates of trauma-exposure than the general population (Cruise and Ford, 2011). This is especially true among Black and female persons who are incarcerated (Anderson, Geier, and Cahill, 2016). As many of 90%

As many as 28% of women and 10% of men in the prison population suffer from PTSD.

Facer-Irwin E, et al. (2019)

of women in prison have experienced trauma, and that the most common type of traumatic experience for female inmates is repeated sexual violence, followed by intimate partner violence (Miller and Najavits, 2012).

Youth and adolescents with trauma histories, known as Adverse Childhood Experiences (ACES, see next page) are at elevated risk to develop externalizing problems, e.g., hostility, oppositionality, impulsivity (Ford et al., 2010). Trauma exposure and the development of post-traumatic stress disorder (PTSD) may be the primary mediator of subsequent psychiatric disorders of all types in incarcerated adults, especially depression and SUDs.

Justice-involved youth may have experienced victimization including abuse and exposure to violence, life-threatening accidents or disasters, and interpersonal losses. Unfortunately, the children and families of those incarcerated may also experience the trauma of a parent being absent, and within prisons and jails victimization may continue. Retrospectively, some 90% of youth in juvenile detention facilities reported a history of exposure to at least one potentially traumatic event, and those with multiple exposures are at highest risk of justice involvement (Ford et al., 2010).

While most individuals will find their negative mood and consequences will decrease over the first few months of abstinence, depression, anxiety, nightmares and other trauma-related symptoms might persist indefinitely unless treated. If symptoms are not severe enough to require immediate treatment at a mental health services program, the individual should be referred to a mental health professional for further assessment and treatment.

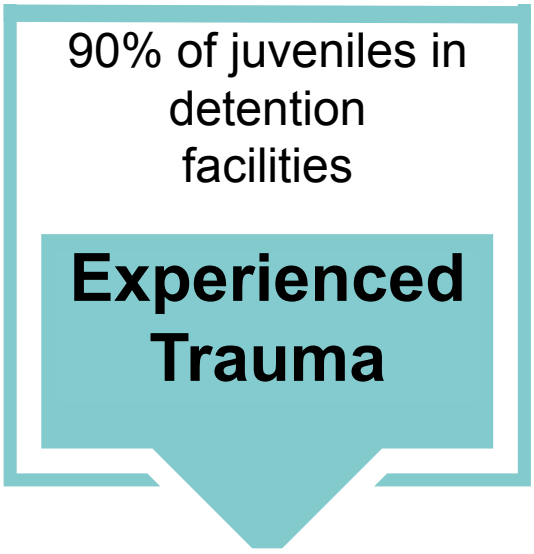
Along with an assessment for need of medication for their SUD, the individual could be recommended for antidepressants and/or anti-anxiety medications and behavioral treatment. These interventions may be instrumental in keeping an individual engaged in treatment and less likely to relapse. For example, someone who appears to be acting disrespectfully in court may be reacting to the stress of the situation and because of trauma, inappropriately demonstrating that response.

It is important for all systems when addressing SUDs and psychiatric disorders to assess for and address unmet needs to achieve sustained decrease in recidivism.

Paths to healing include the employment of trauma-informed approaches and practices. Trauma-informed approaches have also been adapted for court consideration (see SAMHSA's guide on trauma informed practices for judges in the resources section). In treatment settings, mindfulness and meditation are evidence-based trauma-informed approaches that have been used successfully in the context of SUDs, trauma and healing.

Trauma refers to an event that results in a reaction or response that can range from intense fear, helplessness or horror.

(Briere and Scott, 2006)



Baranyi, Cassidy, Fazel, Priebe, and Mundt, (2018)

Overall, being trauma informed **1)** restores a sense of basic humanity, **2)** inherently renders you culturally-responsive and **3)** builds greater capacity for empathy.

Trauma-informed court practices can include taking steps to be aware of the issues of trauma and help all staff recognize the role of trauma in an individual's life.

Impact on Families

Legal and substance use problems are not only individual problems; they have a tremendous impact on families. It is important for those working in the justice system not to make decisions based solely on allegations of substance use or an initial screening test. There should be solid basis supporting a judicial decision to remove a child from a parent's custody. A removal could cause additional stresses that increase the challenge for the parent of successfully completing treatment. Parental alcohol and/or drug use as a contributing factor in a child's removal from parents rose by 16.8% between 2000 and 2016, raising a host of issues for child welfare, family courts and other aspects of the justice system (SAMHSA, 2016).

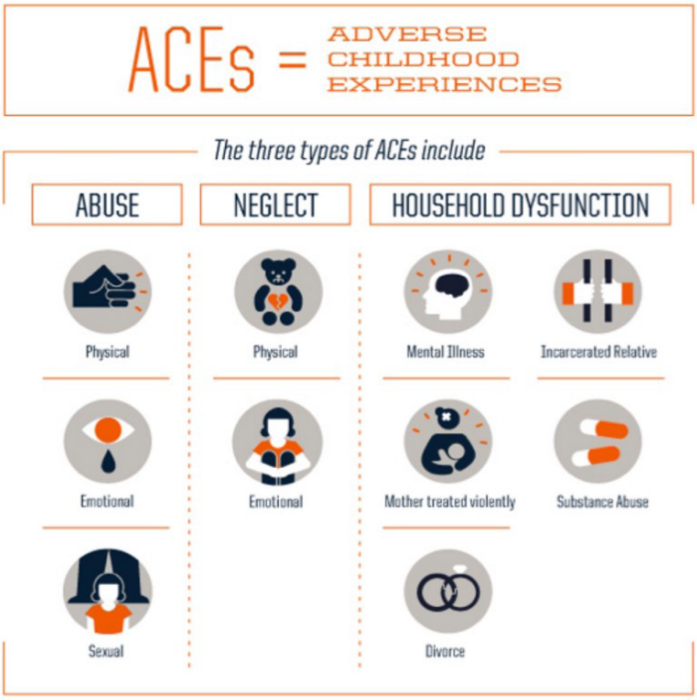
As such, justice staff play a vital role in preventing the cycle of SUDs. At another level, it is important to realize that the developing brain of adolescents functions differently from adults, making it harder for them to make sound decisions. Justice professionals can take this into account in working with youth and young adults.

Family involvement in treatment can be a key element of effective treatment for SUDs (Freudenberg et al., 2008).

According to Austin and Hardyman (2004):

- Formerly incarcerated persons can be less likely to recidivate if they live with their loved ones after returning home from incarceration; and

- Recidivism rates are inversely proportional to the amount of contact individuals receive from their families while incarcerated. The more contact incarcerated persons have with their family during their prison stay, the less likely they are to return to prison.



Reintegrating with family throughout the continuum of care at a rehabilitation center or a correctional facility can be a powerful source of strength for an individual in recovery. However, the home environment for some may threaten the individual's treatment progress by increasing stressors, such as health or financial problems and exposure to others who are misusing substances. Domestic violence and child abuse situations present additional issues including the personal safety of family members. Justice system and treatment staff should assess the home environment when defining a treatment plan, not only to identify these threats but also to proactively look for positive family support. A growing body of evidence highlights the role of parental substance misuse as a significant contributing factor to the increased rates of child abuse, neglect and foster care entry. (Young, et. al, 2007)

Legal and medical systems will achieve much better outcomes when they support the family as a system of care, recognize the manage trauma and seek to meet basic needs. Family involvement is key to successful re-entry, reducing recidivism and prevention of re-incarceration risks. Family should be appreciated as a "system of care" worth of greater focus in the justice system.

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Resources

American Indian / Alaska Native

American Indian and Alaska Native Culture Care: A Guide to Build Cultural Awareness from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/American-Indian-and-Alaska-Native-Culture-Card/sma08-4354

Tribal Cultural Competency Information for Judges, National Judicial Opioid Task Force. http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/336

Indian Health Services (IHS) National Committee on Heroin Opioids and Pain Efforts - https://www.ihs.gov/opioids/hope/

TIP 61: Behavioral Health Services for American Indian and Alaska Natives from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TIP-61-Behavioral-Health-Services-For-American-Indians-and-Alaska-Natives/SMA18-5070?referer=from_search_result

Children and Families

Addiction Impacts the Entire Family from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/resource/addiction-impacts-the-entire-family/

Law Enforcement Collaborations to Support Children Affected by the Opioid Epidemic. https://www.cossapresources.org/Content/Documents/Articles/RTI_LE_Collaborations_to_Support_Children.pdf

Alternatives for Families - A Cognitive Behavioral Therapy from The National Child Traumatic Stress Network. https://learn.nctsn.org/course/index.php?categoryid=70

Family Treatment Court Best Practice Standards from the Center for Children and Family Futures and National Association of Drug Court Professionals. https://www.nadcp.org/standards/family-treatment-court-best-practice-standards/

Couple and Family Psychology: Research and Practice from the American Psychological Association. https://www.apa.org/pubs/journals/cfp

Justice Resources from The National Child Traumatic Stress Network. https://www.nctsn.org/trauma-informed-care/trauma-informed-systems/justice/nctsn-resources

TIP 39: Substance Use Disorder Treatment and Family Therapy from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/treatment-improvement-protocol-tip-39-substance-use-disorder-treatment-and-family-therapy/PEP20-02-02-012

Parent Partner Programs - Promising Practice to Keep Families Struggling with SUD Together, National Judicial Opioid Task Force. http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/346

Family Treatment Courts: National Best Practice Standards, National Judicial Opioid Task Force. https://www.ncsc.org/__data/assets/pdf_file/0023/16772/ftcstandardsfinal2.pdf

Gender

Virtual Coffee Break: Gender-Appropriate Language: Practical Skill Development from HealtheKnowledge. https://healtheknowledge.org/course/index.php?categoryid=88

HIV/AIDS
Cocaine, Methamphetamine, and HIV: What Clinicians Need to Know from the Addiction Technology Transfer Center (ATTC). https://attcnetwork.org/centers/pacific-southwest-attc/product/cocaine-methamphetamine-and-hiv-what-clinicians-need-know

Interventions for Disruptive Behavior Disorders Evidence-Based Practices (EBP) KIT from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/Interventions-for-Disruptive-Behavior-Disorders-Evidence-Based-Practices-EBP-KIT/SMA11-4634

Implicit Bias and Cultural Humility
Cultural Competence Intensive Technical Assistance Options from the Addiction Technology Transfer Center (ATTC). https://attcnetwork.org/centers/great-lakes-attc/product/cultural-competence-intensive-technical-assistance-options-great

Cultural humility Checklist from the Opioid Response Network, a SAMHSA funded initiative. https://documentcloud.adobe.com/link/review?uri=urn:aaid:scds:US:55937e06-6892-43b6-ac73-58e2cbf26bbe#pageNum=1

Harvard's Project Implicit- https://implicit.harvard.edu/implicit/education.html

Implicit Bias Materials from The National Consortium on Racial and Ethnic Fairness in the Courts. http://www.national-consortium.org/Implicit-Bias/Implicit-Bias-Materials.aspx

TIP 59: Improving Cultural Competence from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849?referer=-from_search_result

LGBTQ+
Providing Care for Addiction in the LGBT Community from the National LGBTQIA+ Health Education Center, a Program of the Fenway Institute. https://www.lgbtqiahealtheducation.org/wp-content/uploads/2016/11/Keuroghlian-Addictions-Webinar.pdf

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Social Determinants
Social Determinants of Health from the Office of Disease Prevention and Health Promotion (ODPHP). https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Social Determinants of Health, Illustrated from GovWebworks. https://www.govwebworks.com/2017/08/22/social-determinants-of-health-illustrated/

Social Determinants of Health Guide to Social Needs Screening from the American Academy of Family Physicians (AAFP). https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf

Trauma
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Bench Cards for the Trauma-Informed Judge from The National Child Traumatic Stress Network. https://www.nctsn.org/resources/nctsn-bench-cards-trauma-informed-judge

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Essential Elements of a Trauma-Informed Juvenile Justice System from The National Child Traumatic Stress Network. https://www.nctsn.org/resources/essential-elements-trauma-informed-juvenile-justice-system

Making the Connection: Trauma and Substance Abuse from The National Child Traumatic Stress Network. https://www.nctsn.org/resources/making-connection-trauma-and-substance-abuse

TIP 57: Trauma-Informed Care in Behavioral Health Services from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

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Think Trauma: A Training for Working with Justice Involved Youth, 2nd Edition from The National Child Traumatic Stress Network. https://www.nctsn.org/resources/think-trauma-training-working-justice-involved-youth-2nd-edition

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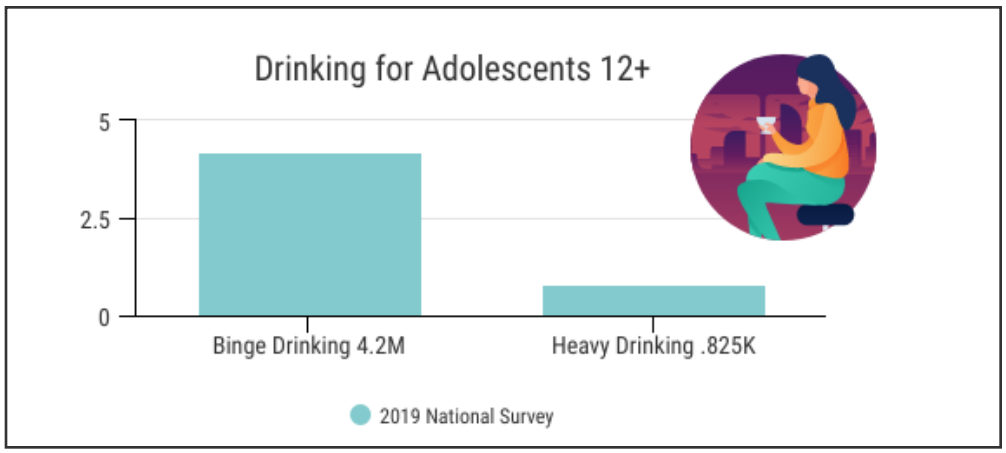
https://pcssnow.org/education-training/training-courses/treatment-in-rural-areas/

4 Adolescence and Substance Use

Adolescent substance use is a major public health problem. The 2019 National Survey on Drug Use and Health indicates past month binge drinking and heavy alcohol use rates were 4.2 million and 825,000 respectively among adolescents age 12 or older.



While use of virtually all substances of misuse has been declining in those aged 12-17, rates of cannabis use remain the same or have increased, and this trend will likely be accentuated by widening legalization of its use by adults. A new and growing concern is adolescent vaping of nicotine and tetrahydrocannabinol (THC). In 2020, 19.6% of high school students reported using e-cigarettes, a decrease from 27.5% in 2019. E-cigarettes are not safe for anyone to use (Wang, et al., 2020). The association of early use of alcohol, cigarettes and cannabis by youth with increased rates of SUDs later in life is well documented.

Adolescence is a period of impulsivity and risk-taking behaviors; therefore the risk for developing an SUD is elevated at this time. Adolescents involved in the juvenile justice system are considerably more likely to have substance use problems than adolescents in the general population, with 57% of males and 47% of females meeting diagnostic criteria for an SUD upon entry into the justice system. This occurance far exceeds the rate among all individuals age 12 to 25. Many of these individuals also have co-occurring psychiatric disorders. Yet, only 0.2% receive mental health services they need.

Behavioral therapy is a critical part of the treatment plan for an adolescent with an SUD. Behavioral therapy involves building and maintaining the adolescent's motivation to change, and teaching them skills to pursue alternative positive activities to substance use.

Along with behavioral intervention, adolescents should be assessed for, and offered when indicated, medication for AUD and other SUDs. Adolescents in the justice system also have a much higher rate of health-risk behaviors (Winkelman et al., 2017).

Risk and Protective Factors in Youth

Research has demonstrated many risk factors for developing an SUD in youth, each representing a challenge to the psychological and social development of an individual and each having a different impact depending on the phase of development. These factors include genetics, epigenetics (environment causing lasting changes in gene expression), societal, familial, and peer influences, pre-existing psychiatric disorders and the addictive properties and availability of the specific substance. One risk factor is the lack of a stable home. Between 2000 and 2017, the number of U.S. children living in foster care and entering foster care rose 12% and 8% respectively. Both increases have been linked to the opioid epidemic and likely increased during the COVID-19 pandemic.

Specific Risk Factors

Factors in the family that may be critical in the potential development of SUD include:

- Chaotic home environments, particularly when parents use substances or suffer from mental illness;
- Ineffective parenting, especially with children who have difficult temperaments and conduct disorders; and
- Lack of mutual attachments and nurturing.

Other risk factors relate to children interacting with others outside of the family, specifically at school, with peers and in the community. Some of these factors are:

- Inappropriate shy or aggressive behavior in the classroom;
- Failure in school performance;
- Poor social coping skills;
- Affiliations with peers exhibiting deviant behaviors; and
- Perceptions of approval of substance-using behaviors in the school, peer and community environments.

Warning Signs for Substance Use

- Changes in school performance (falling grades, skipping school, tardiness)
- Changes in peer group (hanging out with drug-using, antisocial, older friends)
- Breaking rules at home, school, in the community
- Extreme mood swings, depression, irritability, anger, negative attitude, suicidal thinking
- Sudden increases or decreases in activity level
- Withdrawal from the family; keeping secrets
- Changes in physical appearance (weight loss, lack of cleanliness, strange smells)
- Red, watery, glassy eyes or runny nose not due to allergies or cold
- Changes in eating or sleeping habits
- Lack of motivation or interest in things other teenagers enjoy (hobbies, sports)
- Lying, stealing, hiding things
- Using street or drug language or possession of drug paraphernalia/items

Additional factors, such as the availability of substances, trafficking patterns, reduced perception of harm from substance use and belief that substance use will be generally tolerated, also influence the number of young people who initiate use. It is important to assess the level and severity of an adolescent's problem and utilize interventions that target their specific needs.

Protective Factors

NIDA reports some of the most salient protective factors for adolescents, including:

- Strong bonds with the family;
- Experience of parental monitoring with clear rules of conduct within the family unit and involvement of parents in the lives of their children;
- Success in school performance;
- Strong bonds with pro-social institutions such as the family, school and religious organizations; and
- Adoption of conventional norms about alcohol and other drug use.

Research suggests that when people feel bonded to society or to a social unit like the family or school, they want to live according to its standards or norms (Hawkins et al., 1992). Normative influences may strongly influence the behavior of individuals such as greater exposure to the social media posts of peers demonstrating substance use increase the likelihood for them to engage in substance use themselves. Still, substances can contribute to risky behavior and referrals for treatment should be prioritized.

Community Involvement in Prevention

An adolescent's community, including family, teachers, coaches and churches, has a responsibility to assist the adolescent to make healthy decisions. Research on factors and processes that increase the risk of using substances or protect against the use of substances has identified the following primary targets for preventive intervention: 1) family relationships; 2) peer relationships; 3) school environment; and 4) the community environment. Each of these domains can deter the initiation of substance use through increasing social and self-competency skills, adoption of pro-social attitudes and behaviors, and awareness of the harmful health, social and psychological consequences of substance use. Educating children about the negative effects of substances, especially the most immediate adverse effects in their lives, is an important element in any prevention program. In addition, helping children become more successful in school helps them form strong social bonds with their peers, the school and the community.

Highest Risk Periods for Youth

For most children, research has shown that the vulnerable periods for engaging in at-risk behaviors occur during transitions from one developmental stage to another. For example, when children advance from elementary school to middle school or junior high, they often face social challenges such as learning to get along with a wider group of peers. Even day-to-day transitions between school and home make adolescents more vulnerable to misuse alcohol and other drugs. Adolescents not engaged in school or other formal activities like summer and after school programs show an increase in substance use. Prevention programs need to provide support at each developmental stage and during transitions between stages.

Influence of Early Use

Preventing adolescent substance use is critical as research shows that preventing early use is associated with a decrease in SUDs later in life. Previous reports by SAMHSA demonstrate the likelihood of having a multi-substance use disorder is inversely related to age of substance use onset, with 78.1% of individuals between the ages of 18 and 30 who initiated use of substances by age 11 reporting multiple SUDs.

13 years old or younger who use substances

3x more likely to develop a substance use disorder in adulthood

Recent research found that adolescents (13 years old or younger) who use substances they are three times more likely to develop a substance use disorder in adulthood than those who do not use. Early alcohol and other drug use does not always cause substance use disorders later, but it is a risk factor that can increase one's risk of a substance use disorder and the likelihood of a shorter than average lifespan (King and Chassin, 2007; McCambridge et al., 2011).

Young Adult Principles of Care

Identifying Those in Need

Determining the appropriate level of intervention for an adolescent is no small task. In addition to factors normally considered when intervening or treating an individual for a substance use problem, such as severity of substance use, cultural background and presence of co-existing disorders, interventions must also examine variables such as age, level of maturity, gender, family and peer environment. Once these factors are identified and the severity of the problems assessed, the intervention can be defined to most effectively address the adolescent's needs concurrently.

Research has established clinical screening for alcohol and other drug problems as a valid and necessary standard of care in a variety of settings, including emergency departments, trauma centers, primary care, pediatrics, family practices and the justice system. The most commonly used and validated screening methods are confidential questioning or interviewing of adolescents and/or their parents.

Most methods rely on self-reporting, which is generally valid but not always perfect, so obtaining collateral information is important.

Screening Tools

- Adolescents Drug Involvement Scale (ADIS)
- Drug and Alcohol Problem (DAP) QuickScreen
- Global Appraisal of Individual Needs (GAIN)
- CRAFFT

Because adolescents are a unique population, it is imperative that screening and assessment instruments are specifically designed for them.

It is important to screen adolescents for both psychiatric disorders and SUDs because the two often co-occur, and research indicates that treating concurrently provides better outcomes.

If a screening questionnaire identifies the presence of a problem, a clinical assessment should be administered. Formal clinical assessments can confirm the presence of a disorder, determine the level and severity of the problem and identify what services and/or treatment would be most effective to treat the problems (Center for Behavioral Health Statistics and Quality, 2019).

A specialist, such as an addiction or pediatric psychiatrist or addiction physician specialist, social worker, certified SUD counselor or psychologist, should conduct and interpret results of clinical assessments. Sharing information gathered from an assessment between the treatment and justice systems is critical. A clinical diagnosis is important to ensure understanding of the needs and risks of individuals and/or their families.

Treatment

Adolescents present unique challenges to the treatment and justice systems because of the physical, psychological and developmental changes associated with their age group in addition to the factors associated with their delinquency.

No one method is most effective for treating adolescents for SUDs. To promote successful outcomes, treatment programs should be specifically designed to meet an individual's short- and long-term needs.

Five Things To Remember About Treatment For Adolescents

1) Relapse is common. Most adolescents initiate treatment 2 to 4 times before they are able to maintain recovery.

2) Learn to recognize the signs of relapse (spending time with friends who use substances, breaking rules, staying out, inattention, anger, poor hygiene, declining grades) and get adolescents back into treatment and on the road to recovery right away.

3) Helping adolescents participate in continuing care and other recovery support services during the first 90 days after treatment (and ideally the first year) is a key factor in helping them to maintain recovery.

4) While treatment is focused on getting an individual with an SUD to stop, mutual-help support groups, recovery schools and other recovery support services can be helpful for some to help maintain recovery. *NOTE: It is important to try to link adolescents to continuing care services with other adolescents.*

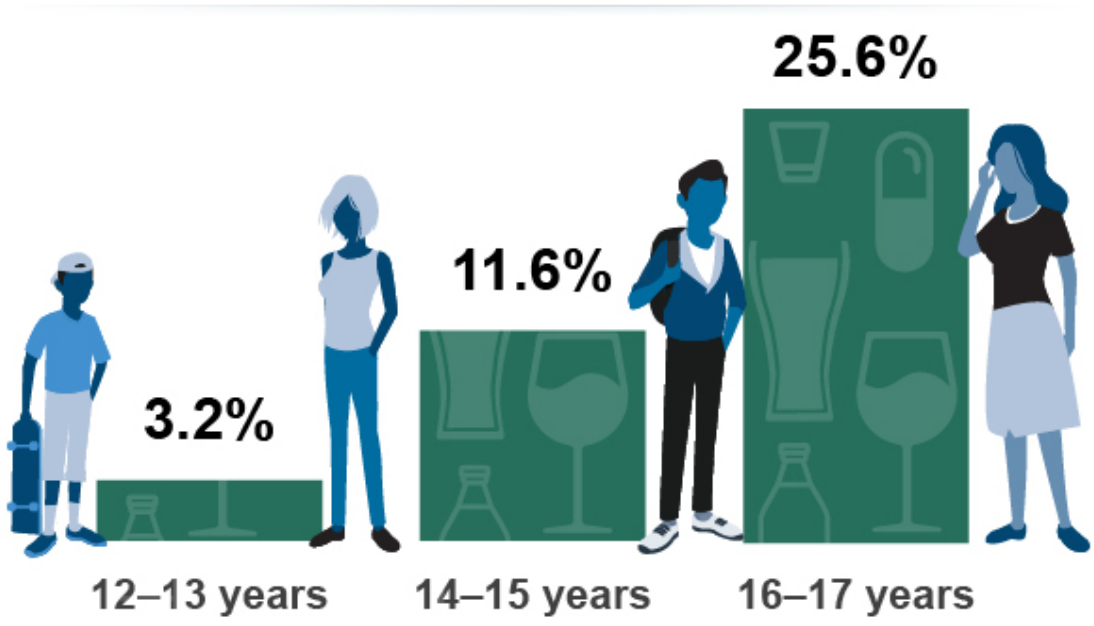
5) Most adolescents are seen in an outpatient setting several hours a week. Residential treatment is usually reserved for adolescents who are not succeeding in outpatient treatment and/or who have an environment (peers, home) that is making it difficult for them to stop their substance use.

Knowledge of the needs of treating adolescent SUDs and defining appropriate treatment continues to increase, and with this knowledge comes a clearer understanding of our shortcomings. While the capacity for treatment continues to grow, it is either still insufficient to meet the current demand for treatment or are being heavily underutilized (Yazzie et al., 2011; White, 2017). It is imperative to address the lack of treatment delivery and remain up to date on the most effective treatments for SUDs as determined by empirical research.

When adolescents do receive treatment, the interventions delivered often lack the support of empirical evidence for their efficacy, i.e., they are not evidence-based. Further, most services in the juvenile justice setting are not provided when an adolescent first becomes involved in the system and do not involve families in the treatment process. Even when evidence-based treatment is provided, there is often a lack of cooperation among service providers resulting in fragmented services that are not effective, even in contexts outside of the justice setting.

Duration of treatment length predicts outcome, with longer durations predicting better outcomes among youth with SUDs. Biological, psychological, psychiatric and sociological (biopsychosocial) factors also interact to influence the risk of relapse for any individual, therefore successful recovery involves the maintenance of new skills and lifestyle patterns that promote positive, independent patterns of behavior. The integration of these behaviors into regular day-to-day activities is the essence of effective relapse prevention. Yet, because adolescents are minors, they do not have the luxury to choose another home, community or school to return to after treatment and they may have to return an environment that is far from ideal from a relapse prevention perspective.

Rates of alcohol or illicit drug use in the past 30 days among adolescents aged 12–17 years increased with age. The rate for adolescents aged 16–17 years was **more than 7.5 times** the rate for adolescents aged 12–13 years.



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Resources

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About the CDC-Kaiser ACE Study from the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/violenceprevention/aces/about.html

ACES Too High. Got Your ACE Score? https://acestoohigh.com/got-your-ace-score/

Adolescence
Smoking & Tobacco Use: Youth and Tobacco Use from the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.html

Teen Drinking and Driving from the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/vitalsigns/teendrinkinganddriving/index.html

Treatment Episode Data Set (TED) from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set

Young adult seeking treatment after overdosing (Part 1) from the Providers Clinical Support System (PCSS), a SAMHSA initiative. https://pcssnow.org/education-training/training-courses/teenager-seeking-treatment-after-overdosing-part-1/

Young adult seeking treatment after overdosing (Part 2) from the Providers Clinical Support System (PCSS), a SAMHSA initiative. https://pcssnow.org/education-training/training-courses/teenager-seeking-treatment-after-overdosing-part-2/

Caring for Young Adults with Substance Use Disorder from the Boston Medical Center, OBAT Training and Technical Assistance Team. https://www.opioidlibrary.org/video/caring-for-young-adults-with-substance-use-disorder/

Youth Risk Behavior Surveillance System (YRBSS) from the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/healthyyouth/data/yrbs/index.htm

Mind Matters Series from the National Institute on Drug Abuse (NIDA). https://teens.drugabuse.gov/teachers/mind-matters

Medication-Assisted Treatment for Adolescents with OUD, National Judicial Opioid Task Force. http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/342

Families
Addiction Impacts the Entire Family from the Providers Clinical Support System (PCSS), a SAMHSA initiative. https://pcssnow.org/resource/addiction-impacts-the-entire-family/

Neonatal Abstinence Syndrome (NAS)
New Studies Clarify Risk Factors for Neonatal Abstinence Syndrome from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/news-events/nida-notes/2019/1/new-studies-clarify-risk-factors-neonatal-abstinence-syndrome

5 Identifying the Problem

Step 1: Screening and Assessment

Screening and assessment of SUD and co-occurring psychiatric disorders should be conducted at the earliest possible time and continue throughout the individual's involvement within the legal system.

Screening can be done anywhere and does not require the screener to be licensed or specially credentialed. Screening is the initial step in the evaluation process to determine whether an individual may suffer from an SUD and/or other related issues such as mental illness, traumatic life events, intellectual disability, and risk for overdose, suicide, and/or recidivism. A screen should be brief with a few questions that identify "red flags" and determine whether a follow-up evaluation assessment for the suspected problem(s) is warranted. Special attention should be given to identify any source of evaluator bias and steps taken to address it.

Screening is a process to examine whether an individual is at elevated risk for having an SUD or hazardous use but does not determine whether they meet diagnostic criteria for an SUD.

Screening tools cast a relatively wide net and suffer from false positives (indicating elevated risk in someone without a substance use issue) or false negatives (failing to identify someone who has a substance use issue). Instruments used for screening must be standardized and evidence-based, which means they have been tested for validity between users. Research has established that clinical screening for SUDs should be the standard of care in emergency departments, trauma centers, primary care, pediatrics, family practice and the justice system. In the justice system it is also important to gather additional information, such as a drug test, police report or through a conversation with family members, to corroborate the client's report and appropriately identify an individual's problem.

Given the high prevalence of SUDs among individuals processed through the justice system, across-the-board screening is advisable. And given the minimal training required to administer a screening questionnaire, staff within the justice system can administer screens with little additional training or cost.

Examples of Evidence-Based Screening Questionnaires for Adults in the Justice System

- Addiction Severity Index (ASI)
- Drug Abuse Screening Test (DAST)
- Global Appraisal of Individual's Needs (GAIN)
- Rapid Opioid Dependence Screen (RODS)
- Severity of Opioid Dependence Questionnaire (SODQ)
- Texas Christian University (TCU) Drug Screen 5- Opioid Supplement

See a SAMHSA list of instruments for screening and assessing mental disorders on page 25: https://store.samhsa.gov/system/files/sma13-4056.pdf

When developing a screening protocol, it is important to answer these questions:

- What is the purpose of the screening?
- What screening instruments/tools are best suited for the clientele and environment where the screen will be performed?
- Where, when and how will the screening be conducted?
- Who will administer the screening protocol?
- What happens with the results?
- How will confidentiality be maintained?

The ideal screening instrument for the justice system must be standardized, evidence-based, age-appropriate and easy to use, particularly in busy courtrooms or other justice settings.

Choosing the appropriate screening tool requires consideration of a number of factors, including:

1. Environmental factors like the setting within the judiciary (i.e. juvenile justice system, family court, criminal justice/civil system, problem-solving courts)

2. Client characteristics: age, gender, education and ethnicity

3. Whether the client can read, has the capacity to understand the questions, etc.

If possible, screening for psychiatric disorders should occur at the same time as screening for substance use disorders due to the high co-occurrence of both disorders. Because these disorders affect one another, simultaneous treatment is also the most effective approach (see page 83 under co-occurring for more information).

Stopping the Problem Before It Starts

Screening and Brief Intervention and Referral to Treatment (SBIRT) is a procedure designed to identify individuals using unhealthy levels of alcohol and other drugs. SBIRT is directed toward changing an individual's pattern of use to reduce consumption before more serious problems develop.

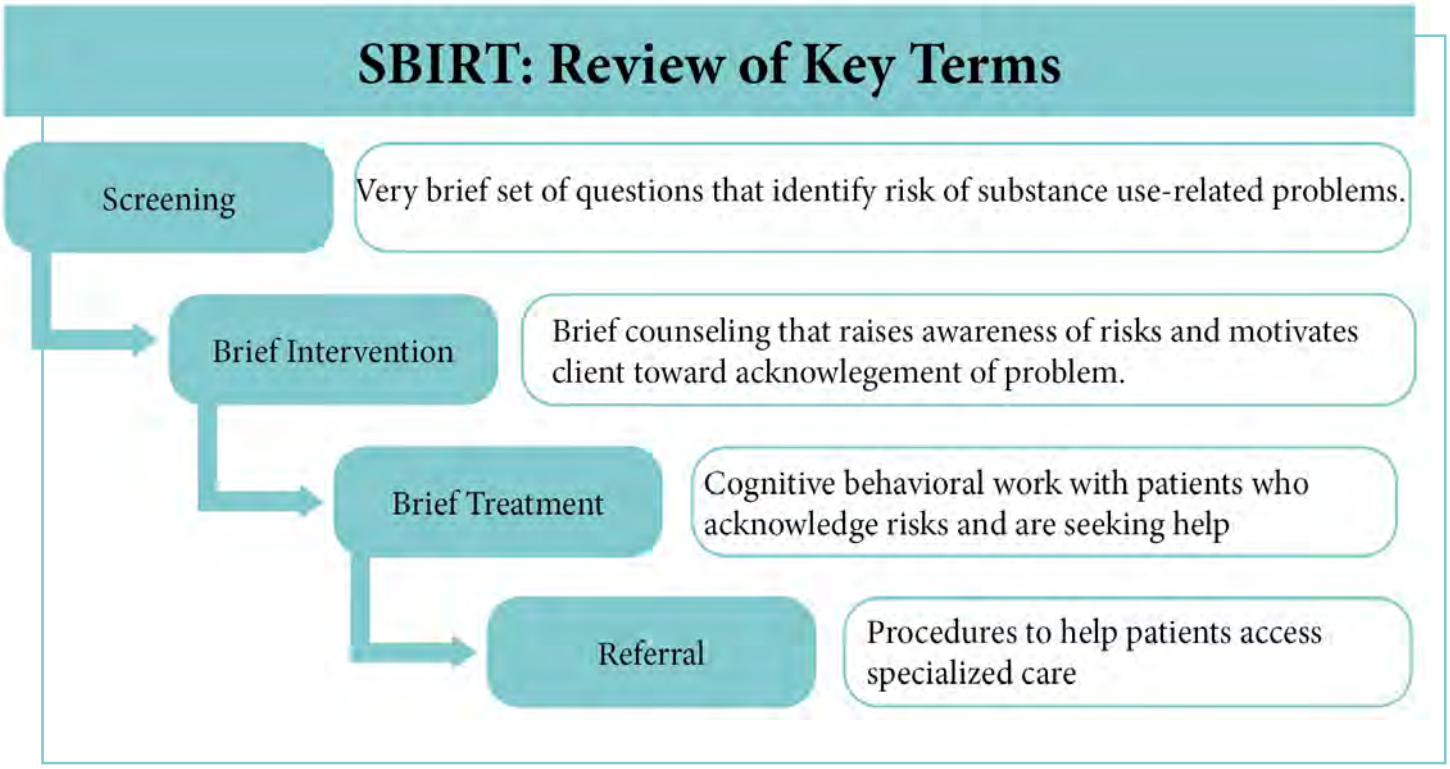
Screening with a confidential, standardized questionnaire identifies if an individual's use places them at risk for developing a problem. If screened positive, a behavioral health specialist will conduct a brief intervention—a manualized, educational and motivational counseling session between five and 15 minutes in length.

A more recent systematic review of brief motivational interventions has found that this technique is effective in reducing use across a variety of substances, with most evidence surrounding its effectiveness regarding alcohol and tobacco, and some studies pointing to its help with marijuana and cocaine. Although research results about the effectiveness of SBIRT for illicit drug use are mixed (Hingson and Compton, 2014), outcome data from SAMHSA demonstrate its effectiveness to lower alcohol consumption, alcohol misuse and drug use (Center for Behavioral Health Statistics and Quality, 2019).

In general, SBIRT is an effective intervention for people drinking or using at risky levels to get them to cut back. If someone has a severe alcohol/drug use disorder, more intense treatment would be recommended.

Recommended Screening Questionnaires for Adults (NIDA. 2021)

Tool	Alcohol	Drugs	Adults	Adolescents	Self-Administered	Clinician Administered
Screens						
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)	X	X	X	See APA Adapted NM ASSIST tools	See APA Adapted NM ASSIST tools	X
Opioid Risk Tool		X		X		
Helping Patients Who Drink Too Much: A Clinician's Guide	X		X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide	X			X		X



Drug Testing

Drug testing, or toxicology screening, is a laboratory procedure used to determine if a substance is in bodily fluid or hair. Drug testing is primarily conducted on urine, but hair, saliva, sweat or blood can also be used. U.S. Department of Transportation (DOT) programs mandate amphetamines, cannabinoids, cocaine, opioids and phencyclidine be tested.

Other drugs, including alcohol, may be tested, but what substances are tested varies upon the screening. Judges may request testing for additional substances based on the needs of a case, substance usage in a geographic area, and the capabilities of the court and laboratory. Drug tests do not determine if a person has an SUD.

While drug testing is an essential tool, studies have found that even some prescribers lack the training to accurately interpret drug test results. Therefore, whether in the medical or the justice system, careful oversight and handling procedures are necessary to prevent inaccuracies and detect falsified or inaccurate results. Another precaution is that while judges may order many of the typically used drug tests, many standard drug test panels do not detect drugs such as alcohol, ecstasy (MDMA), OxyContin and Vicodin. Similarly, drugs like fentanyl and synthetic THC must be specifically requested in drug panels and, at least in the case of synthetic THC, are unlikely to be within the capacity of the laboratory. (For more information on drug testing, see SAMHSA's Medical Review Officer Guidance Manual for Federal Workplace Drug Testing Programs (https://www.samhsa.gov/sites/default/files/workplace/mro-guidance-manual-oct2017_2.pdf).)

Toxicology screening is a powerful tool to monitor and address relapse episodes and serves as an "early warning" device to detect problems while an individual is in treatment so adjustments can be made to the treatment plan to increase medication and decrease cravings. Drug testing should be used with other clinical screening tools to gather important data needed to determine the severity of the individual's problems (https://www.samhsa.gov/sites/default/files/workplace/mro-guidance-manual-oct2017_2.pdf)

Someone's behavior may begin to change prior to the actual use of a substance, an early warning sign, and the use of the substance is the final part of the relapse. Either can serve as a warning sign, depending on the context and patient.

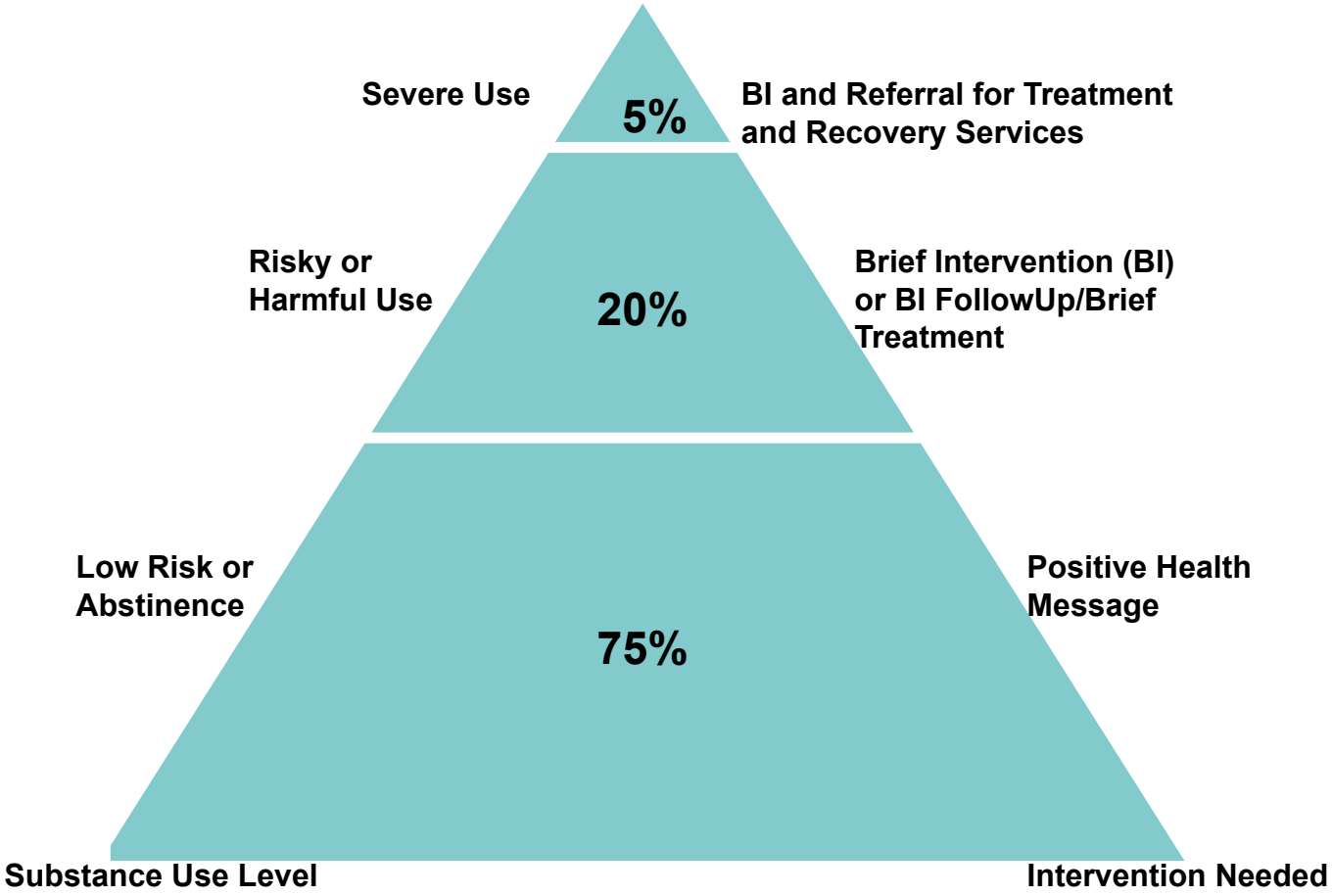
Step 2: Assessment/Diagnosis

If an initial screening determines that a person may have an SUD or another related problem or if a drug test indicates recent use not explainable by the client, the person should then be assessed through a comprehensive, follow-up evaluation assessment. This assessment must be conducted by a licensed or otherwise credentialed professional, preferably with knowledge of and experience in the justice system. The evaluator may conduct a clinical interview, psychological and other testing, and obtain other information that may be relevant to the individual's condition (e.g., criminal history, interview of a family member, prior treatment records). The purpose of an assessment is to determine the presence of an SUD, the extent of the problem, whether there are co-occurring mental or medical conditions, and to assist in the development of a treatment plan.

An assessment consists of gathering key information and engaging in a process with an individual that enables a health professional to understand the individual's readiness for change, problem areas, diagnosis, disabilities and strengths.

Clinical assessments can and should identify factors that affect the course of an SUD, like social support networks, employment history, health, housing, motivation to change, and a history of physical and sexual abuse and mental illness. Sharing the information gathered from an assessment between the treatment and justice systems is critical. This information can be used by the justice system to ensure appropriate treatment and legal interventions are employed.

This triangle shows different levels of substance use and how to intervene at each level. According to national estimates, 75% of individuals are considered non-users or low risk users and only 5% would be possibly classified as having a substance use disorder (CDC, 2016).



Assessments, like screenings, should be performed periodically throughout an individual's involvement in the justice system and throughout treatment to determine if it has been effective in reducing the health and associated legal problems. For example, a health provider would reevaluate the insulin dosage for a person with diabetes based on blood sugar measurements, A1C testing, etc. The same should happen with SUDs and psychiatric disorders to ensure the treatment level is effective and appropriate.

The Brief Addiction Monitor (BAM) to assess evidence-based risk and protective factors for recovery. Changes in these serve as "early warning signs" of potential relapse before substance use occurs (Cacciola JS, Alterman AI, Dephilippis D, et al., 2013).

Specific Population Considerations

In clinical contexts, most screening and assessment instruments were developed and tested in adult white male populations. These instruments vary in their ability to detect SUDs and other problems among different populations. Many instruments used in correctional settings are not designed to detect SUDs from a clinical perspective. Gender, age, ethnicity, literacy, and physical or cognitive inability may affect the ability of the instrument to identify and address problems.

When assessing women, modifications may be needed to more effectively meet the needs of theh individual. Women are more likely to have trauma-related problems and co-occurring psychiatric and substance use disorders. In addition, women are affected in different ways including: poverty, trauma/abuse histories, unstable social supports, and medical problems.

In clinical settings, screening and assessment instruments can be adapted to use with women, adolescents or a particular group. If a questionnaire is substantially modified for use with specific populations, research is needed to validate the effectiveness of the modified instrument. The administration of the questionnaire may also be altered for specific populations. For example, when providing a clinical assessment to adolescents, it may be necessary to: (1) schedule breaks during interview sessions, (2) move at a slower pace during the interview, and (3) obtain collateral information to verify key information related to psychiatric disorder symptoms, treatment and medication use, and interactive effects of psychiatric disorders and alcohol and other substance disorders.

Step 3: Referral

If an assessment indicates an individual has an SUD, the individual should be referred to the appropriate level of treatment. Referral for treatment of other mental and physical health problems are also critical. Whenever possible, treatment for all conditions should be integrated. Many types of treatment exist, and it is important to provide individuals with the type of treatment appropriate to address the severity of their problems. Treatment options are described in detail in Section 7. Some individuals will be referred for treatment that is court ordered or part of a monitoring system, like drug courts. One size does not fit all when it comes to the treatment of SUD. The justice system should be familiar with the various forms of treatment and support and should be knowledgeable about the resources in their area.

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Resources

General

TAP 32: Clinical Drug Testing in Primary Care from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TAP-32-Clinical-Drug-Testing-Primary-Care/SMA12-4668

TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003

TIP 44: Substance Abuse Treatment for Adults in the Criminal Justice System from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4056.pdf

TIP 58: Addressing Fetal Alcohol Spectrum Disorders (FASD) from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TIP-58-Addressing-Fetal-Alcohol-Spectrum-Disorders-FASD-/SMA13-4803

Medical Review Officer Guidance Manual for Federal Workplace Drug Testing Programs from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/sites/default/files/workplace/mro-guidance-manual-oct2017_2.pdf

The Fundamentals of Screening and Assessment in the Justice System, National Judicial Opioid Task Force. https://www.ncsc.org/__data/assets/pdf_file/0024/18825/screening-and-assessment-fundamentals-final.pdf

Sequential Intercept Model

The Court's Role in Combating the Opioid Crisis: Using the Sequential Intercept Model (SIM) as a Place to Start. https://ncsc.contentdm.oclc.org/digital/collection/spcts/id/349

Sequential Intercept Model Trifold Brochure from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/sequential-intercept-model-trifold-brochure/PEP19-SIM-BROCHURE

Data Collection Across the Sequential Intercept Model (SIM): Essential Measures from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/data-collection-across-the-sequential-intercept-model-sim-essential-measures/PEP19-SIM-DATA

SBIRT

How to Implement SBIRT: Processes, Tips, and Examples from the Field from the Institute for Research, Training & Education in Addictions: https://ireta.org/resources/how-to-implement-sbirt- processes-tips-and-examples-from-the-field/

Implementation of SBIRT onto Electronic Health Records: From Documentation to Data from Institute for Research, Education & Training in Addictions (IRETA). https://ireta.org/resources/implementation-of-sbirt-onto-electronic-health-records-from-documentation-to-data/

SBIRT Colorado. Learning Community Session #1: Fidelity Monitoring using the SBIRT Proficiency Checklist - https://www.youtube.com/watch?v=DtfWOQi6Jsg

ReThink Your Drinking Video from the National Institute on Alcohol Abuse and Alcoholism (NIAAA). https://www.niaaa.nih.gov/publications/presentations-and-videocasts

TAP 33: Systems-Level Implementation of SBIRT from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TAP-33-Systems-Level-Implementation-of-Screening-Brief-Intervention-and-Referral-to-Treatment-SBIRT/SMA13-4741

SBIRT (Screening, Brief Intervention and Referral to Treatment) from HealtheKnowledge. https://healtheknowledge.org/course/index.php?categoryid=50

Trauma
Trauma-Informed Juvenile Court Self-Assessment from The National Child Traumatic Stress Network. https://www.nctsn.org/resources/trauma-informed-juvenile-court-self-assessment

Screening Tools
Center of Excellence for Integrated Health Solutions from the National Council for Behavioral Health. https://www.thenationalcouncil.org/integrated-health-coe/

Addiction Severity Index (ASI) - https://pubs.niaaa.nih.gov/publications/assessingalcohol/instrumentpdfs/04_asi.pdf

Drug Abuse Screening Test (DAST-10) from the National Institute on Drug Abuse (NIDA). https://cde.drug-abuse.gov/sites/nida_cde/files/DrugAbuseScreeningTest_2014Mar24.pdf

Global Appraisal of Individual Needs (GAIN) - https://gaincc.org/instruments/

Rapid Opioid Dependence Screen (RODS) - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4435561/

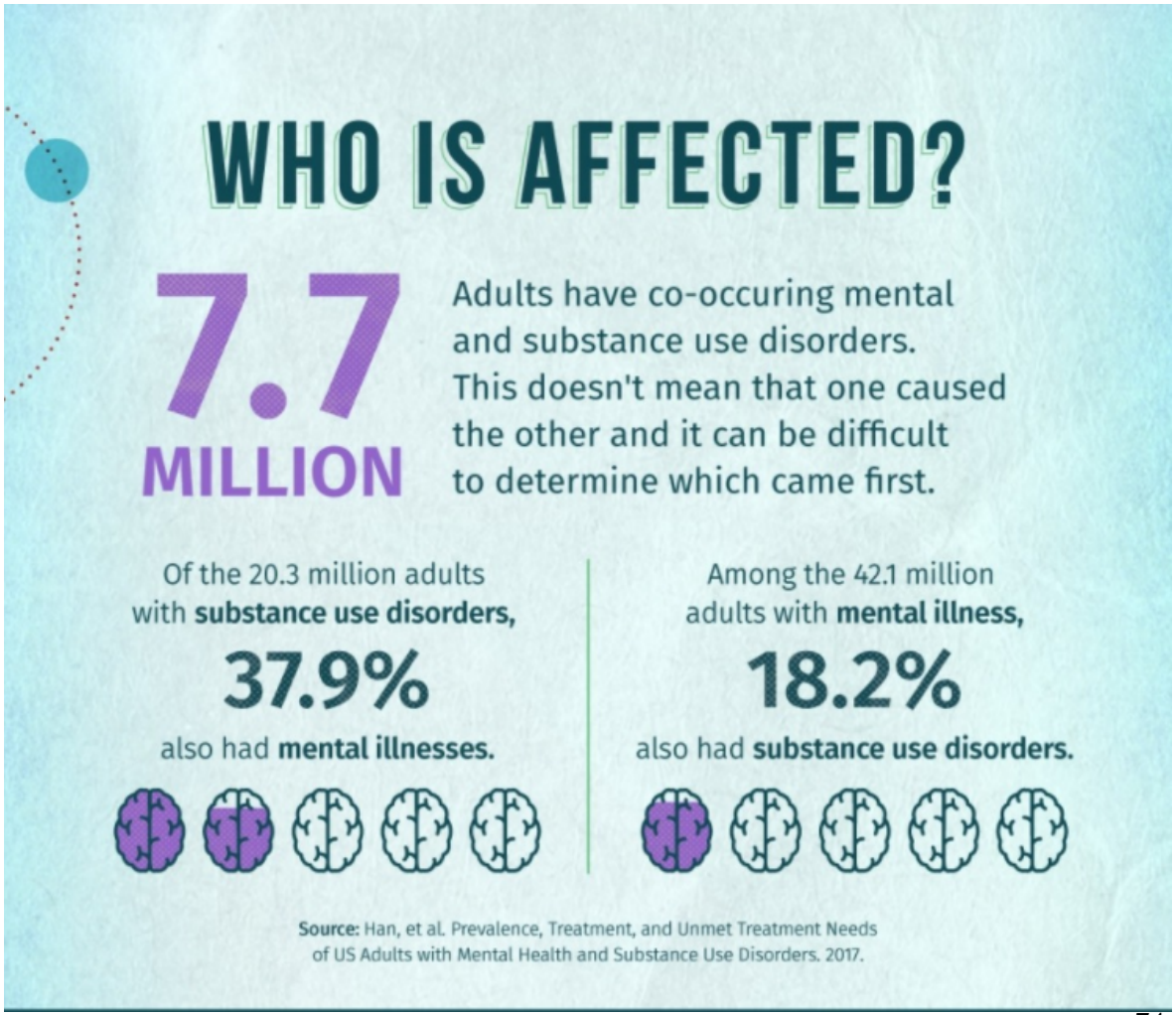
The Fundamentals of Screening and Assessment in the Justice System. https://www.ncsc.org/__data/assets/pdf_file/0024/18825/screening-and-assessment-fundamentals-final.pdf

6 Co-occurring Psychiatric and Substance Use Disorders

Mental Health and Substance Use Disorders

Substance use disorders often co-exist with other psychiatric illnesses, which are referred to as co-occurring disorders, dual diagnosis or co-morbidity. Psychiatric disorders may precede SUDs, which may trigger or exacerbate psychiatric disorders. About half of people who experience a mental illness will also experience an SUD (Ross and Peselow, 2012). In 2018, 38.4 million adults aged 18 or older met criteria for a mental illness, 10.2 million aged 18 or older met criteria for an SUD, and 9.2 million aged 18 or older met criteria for both disorders, and were in the "dual diagnosis" category. In addition to influencing one another, some psychiatric and substance use disorders can be predicted by common underlying factors. The best practice for treating the person diagnosed with an SUD and another psychiatric condition is integrated, rather than sequential or disconnected treatment (Pinals and Fuller, 2020).

Identifying and understanding co-occurring disorders is important because they can result in serious consequences to individuals, families and society. These conditions are especially prevalent among individuals involved in the criminal justice system (Baillargeon et al., 2009). Prevalence rates of mental illness in jail populations average about 17% in men to 24-34% among women, with rates of prevalence varying by illness. Co-occurring disorders may manifest in behaviors that result in probation violations or failures to comply with judicial orders,



such as missing meetings. This section provides information to assist justice professionals to recognize these disorders and associated behaviors and how to address them effectively.

Studies looking at the presence of co-occurring disorders in jails show that of the approximately 17% with serious mental illness, an estimated 72% had a co-occurring SUD, while about 59% of state prisoners with mental illnesses had a co-occurring drug or alcohol problem (Abram, Tepline 2012).

Types of Psychiatric Disorders

Medical and mental health fields use standard terms and criteria for diagnosis for psychiatric disorders derived from the DSM-5. Approximately 15% to 20% of individuals on probation, parolees, and jail and prison inmates suffer from a serious or persistent mental disorder (Marlowe, 2016; Fiscella, 2004). It is important for justice staff to familiarize themselves with the psychiatric disorders that most often co-occur with alcohol and other substance disorders.

The following descriptions are drawn from CSAT's TIP 42 (SAMHSA, 2020):

Personality Disorders

Those suffering from personality disorders have character traits that are persistent and cause impairment in social or occupational functioning and personal distress. Symptoms are evident in their thoughts (ways of looking at the world, thinking about self or others); emotions (appropriateness, intensity and range); interpersonal functioning (relationships and interpersonal skills); and impulse control. People with these disorders are often seen as manipulative, argumentative, difficult, odd, unpredictable and in general, often felt to be willfully difficult, when in fact, they struggle navigating the world. An example of a personality disorder is Borderline Personality Disorder. These individuals typically experience specific negative emotions like vulnerability, hostility, sadness, and anxiety or a nonspecific but intense sense of distress or "feeling bad." This is combined with an inability to monitor and control emotions, alternating chaotic or contradictory ways of relating to self and others, and self-harming or dramatically self-destructive behaviors.

Antisocial personality disorder traits are associated with criminogenic risk factors. Specifically, antisocial thinking patterns, behaviors and peer groups are all part of some of the most challenging criminogenic risk factors. Treatments in correctional settings have been developed to help change thinking patterns and help individuals engage more with prosocial activities and attitudes. SUDs may co-occur with these personality styles.

Psychotic Disorders

The common characteristics of these disorders are symptoms that focus on problems with thinking. These include schizophrenia and schizoaffective disorder, a type of schizophrenia with prominent mood swings. The most prominent (and problematic) symptoms are delusions or hallucinations. Delusions are false, fixed beliefs that significantly hinder a person's ability to function. For example, an individual may believe that people are trying to hurt him/her (paranoid delusion). Hallucinations are false perceptions in which a person sees, hears, feels or smells things that are not real.

Psychotic disorders are seen most frequently in mental health settings and, when combined with SUDs, the substance disorder tends to be severe. Drugs like cannabis, cocaine, or methamphetamine can produce delusions and/or hallucinations as well as drug intoxication.

Because someone with active psychosis makes decisions not based on reality, their behavior can be violent and unpredictable, and treatment is urgently needed. Often, the psychosis impairs one's decision-making capacity and so can affect their competency to stand trial.

Depressive and Bipolar Disorders

Major depression is characterized by sadness, lack of ability to enjoy things, and poor motivation. Severe depression can result in psychotic thinking, inability to concentrate, loss of appetite and sleep. Bipolar disorder requires the occurrence of energetic or

irritable (hypomania) or extreme mania (with psychosis) along with periods of depression. Anxiety often accompanies both conditions. Bipolar disorder in particular tends to have high co-occurrence with SUDs, but major depressive disorder is more common than bipolar disorder.

Anxiety Disorders

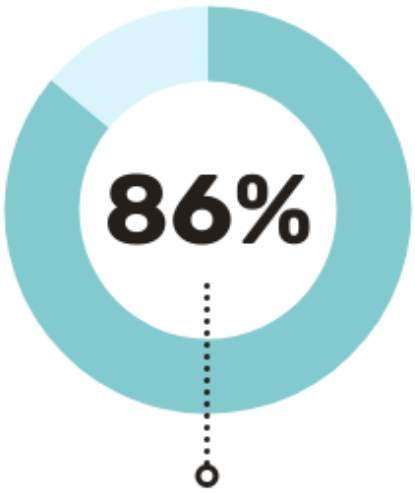
These are quite common, and include generalized anxiety disorder, social anxiety and panic disorder. Anxiety disorders often co-occur with SUDs.

Post Traumatic Stress Disorder (PTSD)

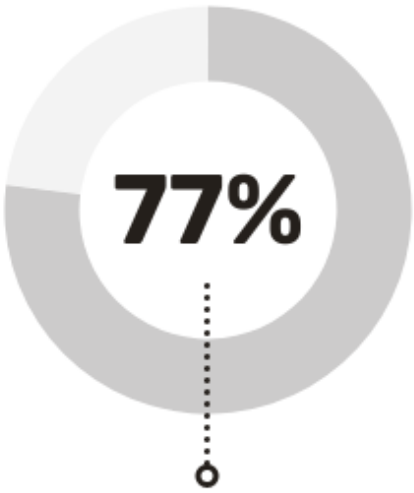
PTSD refers to a mental health condition that some people develop after witnessing or experiencing a life-threatening or unusually violent event. Although PTSD is often associated with military combat, it can have many causes, including domestic violence, abuse or neglect, sexual assault, accidental injury or natural disasters.

The experience of repeated visions of the event or flashbacks, anxiety, irritability and avoidance may begin immediately and for many will fade over time. When these feelings or symptoms do not go away and when they last at least a month and interfere with life activity, a diagnosis of PTSD can be established. For some, the symptoms will not start right away, and this is called delayed onset PTSD.

People who have experienced severe trauma, including witnessing death, nearly dying by gunshot, sexual assault, physical abuse, etc. can develop acute stress disorder, which if it persists become PTSD. These people are hypervigilant, sometimes to the point of appearing paranoid, and can be hyper-reactive. They may also experience flashbacks in which they dissociate and so can perform acts they do not recall. Between 40% and 60% of those with PTSD self-medicate with alcohol and/or drugs to relieve their re-experiencing of traumatic memories or to help sleep. The violent and chaotic upbringing of many involved in the justice system with co-occurring SUDs make trauma-related diagnoses quite common in this population.



Incarcerated women who have reported sexual violence in their life.



Incarcerated women who have reported partner violence.

Dept. of Justice, 2012

Screening and Assessment for Co-occurring Psychiatric Disorders

Screening and assessment for psychiatric and substance use disorders should be conducted at the same time and as early as possible upon the individual's initial involvement with the justice system and throughout involvement. Until it is determined how the individual's psychiatric and substance use disorders relate to one another, the diagnosis may be difficult.

If a co-occurring disorder is undetected, many individuals will not receive appropriate treatment and planning for release strategies will be ineffective.

When defining which screening instruments should be used, consider the following: the time required to administer, cost, mode of administration, staff training required and contextual factors, including:

1. Client characteristics: Age, gender, education and ethnicity

2. Environmental factors such as the setting within the judiciary (i.e. juvenile justice system, family court, criminal justice system, problem-solving courts).

(Meyer, 2019)

Screening for substance use and co-occurring psychiatric disorders is usually administered separately because there are few valid screening tools to screen for both problems simultaneously. The Addiction Severity Index (ASI), Texas Christian University Drug Screen (TCUDS), and Drug Abuse Screening Test (DAST) are a few of the numerous assessments, which have been experimentally validated for use in a prison population (Hiller et al., 2011). The Brief Jail Mental Health Screen (BJMHS), CJ-CODSI, Global Appraisal of Individual Needs (GAIN), Mental Health Screening Form-III (MHSF-III), Modified Mini-Screen (MMS), Checklist 90 Revised (Symptom Checklist 90 Revised (SCL-90-R)), US DOJ Mental Health Screens for Corrections have all been validated for assessing co-occurring mental health disorders in justice system settings.

NIDA's CJ-DATS project team developed the Co-Occurring Disorders Screening Instrument (CODSI), a short screening instrument to identify both alcohol and other drug and psychiatric disorders in a variety of justice settings. At that time, the initial findings supported the efficacy of this measurement as a screening tool for co-occurring psychiatric and substance use disorders. Further research validated this assessment and asserted that the CODSI in conjunction with other screening tools can be exceedingly useful in guaranteeing the comprehensive screening of co-occurring psychiatric and substance use disorders among the prison population.

Screening for traumatic events that can lead to distress or PTSD can be done using screening tools like the Life Event Checklist (LEC) for DSM-5, Adverse Childhood Experiences (ACE), Post-Traumatic Stress Disorder (PTSD) Checklist (PCL) (available in both civilian and veterans versions), Trauma History Screen (THS), Trauma Screening Questionnaire (TSQ).(Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide (SAMHSA, 2019). https://store.samhsa.gov/product/Principles-of-Community-based-Behavioral-Health-Services-for-Justice-involved-Individuals-A-Research-based-Guide/SMA19-5097). Using this type of screening tool can be a springboard for finding, understanding and managing PTSD symptoms events that likely affect the patient in the present.

Part of the challenge in treating co-occurring disorders is that many people performing the assessments are not adequately trained in evaluating SUDs or in treating other mental health and physical conditions that frequently co-occur, particularly in those involved in the justice system. The artificial separation of training for those treating SUDs and those treating other mental health conditions has been a barrier to treating the whole person.

Assessments of individuals who screen positive for co-occurring psychiatric disorders should be performed by a medical professional specially trained in treating both SUDs and psychiatric disorders. This will assure a more comprehensive clinical assessment is performed and appropriate medical intervention conducted. After the assessment is complete, a treatment plan can be developed incorporating a broader network of health professionals to manage treatment.

Examples of brief screening instruments for adults to detect mental health.

- ACE Questionnaire for Adults
- AUDIT-C
- Brief Jail Mental Health Screen
- DAST10
- GAD7
- PCL-C
- PHQ9

Treatment for Co-occurring Psychiatric Disorders

Research supports the effectiveness of programs or services that treat both substance use disorders and psychiatric disorders in an integrated way. If an integrated approach for co-occurring treatment is not available, it is important to treat each disorder at the same time in separate programs with communication across systems (parallel treatment). Individuals with a psychiatric disorder and substance use disorder also tend to have a higher risk for certain general medical conditions such as cardiovascular disease, diabetes, gastrointestinal problems, asthma and a variety of infectious diseases. These conditions may occur as a direct result of the toxic effects of substances, as a result of trauma related to substance use or poor health practices associated with chronic substance use. Treatment for these medical conditions should be coordinated with treatment for psychiatric and substance use disorders.

Quadrants of Care

To understand treatment for co-occurring psychiatric disorders, it is helpful to be aware of the interactions between psychiatric and substance use disorders. The Quadrants of Care is an older but still useful framework developed by the National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors to guide systems integration and resource allocation in treating individuals with co-occurring disorders (Reis, 1993). It can assist justice and medical professionals to understand the manifestation of co-occurring disorders and identify what treatment services are recommended based on the severity of the disorders.

Quadrants of Care

CATEGORY I. Less severe psychiatric disorder and less severe substance disorder

These individuals have low severity substance use and low severity psychiatric disorders. These individuals can be treated in outpatient settings of either mental or substance use disorders treatment programs, or both, with consultation between settings. Some individuals may be managed in primary care settings with consultation from mental health and/or substance use disorder treatment providers.

CATEGORY II. More severe psychiatric disorder and less severe substance use disorder

These individuals have high severity psychiatric disorders usually identified as priority clients within the mental health system and who also have low severity substance use disorders (e.g., in remission or partial remission). These individuals ordinarily receive continuing care in the mental health system and are likely to be well served in an intermediate level mental health program. If marked distress, suicidal ideation, or psychosis is present, more intensive treatment will be called for, such as inpatient or intensive outpatient).

CATEGORY III. Less severe mental health disorder and more severe substance disorder

These individuals have severe substance use disorders and low or moderate severity psychiatric disorders. They are often treated in intermediate level substance treatment programs. They may need coordination with affiliated mental health programs for treatment of the mental disorders. At the start of treatment, a more intensive level of care (residential or intensive outpatient program) may be needed.

CATEGORY IV. More severe psychiatric disorder and more severe substance disorder

These individuals fall into two subgroups. One group includes those with serious and persistent mental illness (SPMI) who also have severe and unstable substance use disorders. The other group includes individuals with severe and unstable substance use disorders and severe and unstable behavioral health problems (e.g., violence, suicidality) who do not meet criteria for SPMI. These individuals require intensive, comprehensive, and integrated services for both their substance use and psychiatric disorders. Treatment can be specialized residential substance use disorder treatment programs in state hospitals, jails or settings that provide acute care such as emergency rooms.

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Resources

General

Women's Pathways to Jail: The Roles and Intersections of Serious Mental Illness and Trauma from the National Institute of Corrections (NIC). https://nicic.gov/womens-pathways-jail-roles-intersections-serious-mental-illness-trauma-2012

Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/Principles-of-Community-based-Behavioral-Health-Services-for-Justice-involved-Individuals-A-Research-based-Guide/SMA19-5097

Suicide and the Opioid Epidemic, National Judicial Opioid Task Force. https://www.ncsc.org/__data/assets/pdf_file/0020/18146/suicideandtheopioidepidemicfinal.pdf

Involuntary Commitment and Guardianship Laws for Persons with SUD, National Judicial Opioid Task Force. http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/350

Comorbidities and Mental Health

Addressing the Larger Mental Health Context of Opioid Use and Misuse: Suicide and the Opioid Epidemic. https://www.ncsc.org/__data/assets/pdf_file/0020/18146/suicideandtheopioidepidemicfinal.pdf

Anxiety Disorders from the National Institute of Mental Health (NIMH). https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

Co-Occurring Disorders and Other Health Conditions from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/co-occurring-disorders

Comorbidity: Substance Use Disorders and Other Mental Illnesses DrugFacts from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses

Comorbidity: Addiction and Other Mental Illnesses from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf

First-Episode Psychosis and Co-Occurring Substance Use Disorders from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/First-Episode-Psychosis-and-Co-Occurring-Substance-Use-Disorders/PEP19-PL-Guide-3

2019 National Survey on Drug Use and Health (NSDUH) Releases from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases

Understanding Anxiety Disorders Caregiver: Get the Facts from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/Understanding-Anxiety-Disorders-Caregiver-Get-the-Facts/SMA16-5009

Understanding Anxiety Disorders Young Adult: Get the Facts from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/Understanding-Anxiety-Disorders-Young-Adult-/SMA16-5010

Living Well with Serious Mental Illness from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/serious-mental-illness

Models

Forensic Assertive Community Treatment (FACT): A Service Delivery Model for Individuals With Serious Mental Illness Involved With the Criminal Justice System from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS), Four Quadrant Model Resources from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/integrated-health-solutions

7 Treating the Problem

Identifying a treatment program that is appropriate for and available to an individual can be challenging. Once an appropriate program is identified, sanctions and incentives can be useful methods for the justice system to employ to increase the likelihood the individual will follow through on the referral and remain engaged. If treatment is not available, it is important to have medical and justice personnel work collaboratively to identify best approaches. For more information on treatment of alcohol and other drug problems, see SAMHSA National Registry of Evidence-Based Programs and Practices: https://www.samhsa.gov/ebp-resource-center.

Treatment for a chronic illness, such as an SUD, requires a continuum of care, helping patients stabilize, enter remission from symptoms, and establish and maintain recovery. Many effective treatments exist and individuals can obtain recovery and live successful and fulfilling lives. Some individuals require medication-based treatment, such as for opioid use disorder, for varying lengths of time. Prescribing medication to treat opioid use disorder should be a clinically driven decision between the patient and their clinician on an individual basis. Further, outpatient counseling, intensive outpatient treatment, inpatient treatment or a long-term therapeutic community should be provided if possible with medication-based treatment for opioid use disorder, but if counseling is not available, medication should be provided. Other support services may include housing assistance, educational opportunities, or the provision of childcare or mutual-help groups.

Drug for a Drug?

Many oppose the use of medication to treat OUD thinking it replaces one drug of use with another. When used as directed, methadone and buprenorphine reduce cravings and withdrawal. They prevent relapse without a "high." They can stabilize behavioral changes indicative of addictive disease and restore normal social function. Therefore, MOUD is the gold standard for treatment of opioid use disorder.

The National Academies of Sciences, Engineering, and Medicine 2019 report "Medications for Opioid Use Disorder Save Lives."

Recommendations include:

1. Opioid use disorder is a treatable chronic brain disease.
2. FDA-approved medications to treat opioid use disorder are effective and save lives.
3. Long-term retention on medication for opioid use disorder is associated with improved outcomes.
4. A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.
5. Most people who could benefit from medication-based treatment for opioid use disorder do not receive it, and access is inequitable across subgroups of the population.
6. Medication-based treatment is effective across all treatment settings studied to date. Withholding or failing to have available all classes of FDA-approved medication for the treatment of opioid use disorder in any care or criminal justice setting is denying appropriate medical treatment.
7. Confronting the major barriers to the use of medications to treat opioid use disorder is critical to addressing the opioid crisis.

Referrals for treatment services are routinely ordered by courts. For treating opioid use disorders, research demonstrates FDA-approved medications are the most effective treatment (buprenorphine, methadone and XR-naltrexone are all FDA approved medications). Even if counseling is not available, medications should be provided. Without medication for OUD, it is difficult for individuals to stay engaged in therapy and participate in other recovery supports.

When it comes to treating a person with an SUD there is no "one size fits all" even when medications are used. Following a full assessment there should be a discussion with the patient about what medication is best for them. With patient input, a decision should be made as to which medication should be initiated. Treatment may be lengthy as an individual engages in various aspect of recovery (housing, employment, parenting). Patients are emotionally and environmentally susceptible to cravings for an undetermined amount of time. Consequently, there is no defined time limit to continuing medication. Some patients do better on one medication and might need to be switched between medications to determine which one is most effective for them. Changes to medication should ideally be done with careful monitoring and health provider support.

A Continuum of Care

Evidence-based treatment for SUDs is an effective approach to addressing this public health and public safety need. While some individuals involved with the justice system may receive "treatment," the nature and quality vary with no assurance it is effective or grounded in science. This section explains what "treatment" is and what components are necessary for it to be most effective. Resistance to the use of medications such as buprenorphine/XR-buprenorphine, methadone, XR-naltrexone for treating OUD is medically unjustified and potentially harmful. Requiring individuals in the justice system to discontinue or change a medication regimen that was previously successful is ineffective and more likely to be associated with poor outcomes, a lower likelihood of resuming treatment after release from custody and recidivism (Sacks, 2007).

Rhode Island Department of Corrections Medications for Opioid Use Disorder (MOUD) Model

Rhode Island was one of the first states to incorporate MOUD state-wide in 2015 for those in prison and throughout their incarceration, as well as provide treatment after release.

Individuals were given option between methadone, buprenorphine and XR-naltrexone. The program resulted in a 60.5% reduction in overdose deaths following release *(Green, Clarke , Brinkley-Rubinstein L, et al., 2017).* The Rhode Island program has become a model for other corrections facilities throughout the country.

Find more information via a video series at https://vimeo.com/351044274.

NIDA Treatment Recommendations:

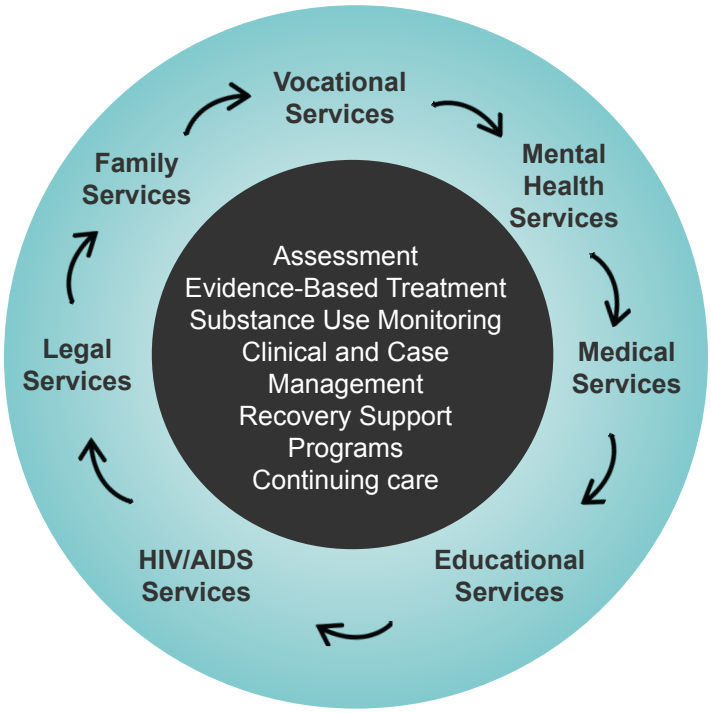
The National Institute of Drug Abuse (NIDA) recommends treatment for a minimum of 90 days for individuals with SUDs involved in the criminal justice system.

Individuals with severe SUDs and co-occurring psychiatric disorders typically need longer treatment and more comprehensive services. Treatment must be provided long enough to produce consistent behavioral changes.

The Medical, Societal and Financial Benefits of Treatment

Financial, social and health impacts of alcohol and other drug problems are often catastrophic. Evidence-based treatment has been shown to save lives and money by:

1. Reducing substance use
2. Reducing crime
3. Decreasing incarceration
4. Improving health
5. Improving family functioning
6. Decreasing injury
7. Increasing employment



Treatment Saves Money

Annual costs vary by substance, with tobacco resulting in an economic burden of over $300 billion; alcohol use, $224 billion; and problematic substance use resulting in $600 billion annually. Economic analysis suggests that the cost of medications for addiction treatment for SUDs may be as low as 20% of the cost of incarceration and that treatment programs can produce a savings between $4 to $7 for every dollar spent in reduced drug-related crime, criminal justice costs and theft.

Source: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services. 2018

The National Institute on Drug Abuse (NIDA) (2018) has developed 13 principles of effective treatment for substance use disorders for criminal justice populations:

1. Addiction is a complex but treatable disease that affects brain function and behavior.
2. No single treatment is appropriate for every one.
3. Treatment needs to be readily available.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug mis use.
5. Remaining in treatment for an adequate period of time is critical.
6. Behavioral therapies— including individual, family, or group counseling—are the most commonly used forms of drug misuse treatment.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
9. Many drug-addicted individuals also have other psychiatric disorders.
10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug misuse.
11. Treatment does not need to be voluntary to be effective.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
13. Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.

Components of Effective Treatment

Treatments for SUDs are designed not only to reduce substance use, but also to reduce recidivism and improve health and social functioning.

The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

NIDA: https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction

Numerous approaches are used for treatment, varying in content, duration, intensity, goals, location, provider and target population. The most effective treatments combine a variety of bio- psycho-social services.

Barriers to Treatment

Many gaps in our nation's capacity to treat SUDs and OUD in particular exist with more in rural and underserved populations than in urban areas. A number of common barriers exist, including:

1. Access to and availability of evidence-based treatment;
2. Associated stigma for individuals who use substances;
3. Inability to pay for insurance (including Medicaid) for treatment;
4. Stigma against medication-based treatment for opioid use disorder;
5. Lack of sober living housing that allows individuals to have medications for treatment;
6. Rural communities with limited transportation—or no public transportation.

Access to MOUD in Rural Communities

People with OUD living in rural communities often face barriers to accessing MOUD, including fewer transportation and treatment options compared with those available in urban areas, according to a 2017 study conducted by Maine Rural Health Research Center.

Action Steps to Adopt Innovative Treatment Models

Many states and local jurisdictions have implemented innovative treatment models that have shown promise in saving lives by connecting patients to MOUD treatment. Local leaders can help advance these initiatives and access to MOUD by taking action to:

1. Facilitate the establishment of treatment in specialty and primary care settings in the community or region.
2. Educate the local community and leadership on the value of MOUD.
3. Assess and leverage local and regional resources to implement programs.
4. Adapt treatment delivery models to address community-specific needs, including needed provider training.
5. Support state leaders in their efforts to address the opioid crisis.

Engaging in Treatment

Research indicates that an individual's motivation, internal or external, to reduce substance use improves treatment outcomes. Legally mandating treatment has been shown to increase completion rates in drug court settings where criminal conviction and incarceration may be the alternative outcome. Studies on civil commitment of SUDs are lacking. Coercion is not always necessary; criminal involvement leading to criminal court-mandated treatment may provide a needed incentive for individuals in the criminal justice system with substance use problems to access and benefit from treatment. While judges cannot mandate a specific treatment, they can mandate screening and, based on an evaluation, require the participant to engage in recommended treatment. Support groups can be extremely helpful for a person with an SUD, but they should not considered treatment, rather a supplement to support the evidence-based treatment provided by a clinician.

Evidence-Based Approaches to SUD and Mental Illness Treatment for Adults

Evidence-based practices are defined as interventions that have shown consistent scientific evidence of producing preferred client outcomes. The National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) offer the following evidence-based practices for SUDs.

Elements of Evidence-Based, Effective Treatment. Does it Have…

- **Cognitive Behavioral Interventions**—involves using awareness and skill building activities with clients.

- **Community Reinforcement Approach (CRA)**—connecting the client with other needed agencies and services in the community.

- **Motivational Enhancement Therapy**—using motivational interviewing strategies and interventions that are based on a "stages of change model."

- **12-Step Facilitation (TSF)—**a structured, individualized approach for introducing clients to a 12-step program. This can result in better meeting attendance for a longer period for many. *Note: individuals should be given the option to participate, but if they do not find 12 step helpful or prefer not to participate, they should not be mandated. It is not treatment but support.*

- **Contingency Management**—behavioral contracting where clients have opportunities to earn rewards for specific desirable behaviors. Data demonstrates that some stimulant users respond well to this approach, stay in treatment longer, make measurable progress and have better treatment outcomes.

- **Pharmacological Therapies**—research supports medications for alcohol use disorders (disulfiram, naltrexone, acamprosate, gabapentin, topiramate), opioid use disorders (methadone, buprenorphine and injectable naltrexone) and smoking (nicotine replacement products, varenicline and bupropion) help stabilize a person's life when their alcohol or drug use is out of control.

- **Systems Treatment**—refers to treating clients in their natural social environment. Couples therapy, family therapy and multi-systemic family therapy are all examples of systems treatment models. There is substantial evidence indicating that clients whose families are engaged in the treatment process show improved outcomes. Systems treatment appears to be especially effective with young people.

- **Integrated Dual Disorders Treatment**—helps people recover by offering mental health and substance use treatment services together in one setting. The same clinicians (or team of clinicians) with the client develop an individualized treatment plan, which addresses both the psychiatric and substance use disorders. A wide range of services should be provided as an individual's needs change over the course of treatment.

- **Individualized treatment**—(also known as patient-centered care) is offered depending on the stage of recovery a person is in. Examples of services include basic education about the illnesses, case management to help with housing, money management, relationships and specialized counseling specifically designed for individuals with co-occurring disorders. This is a comprehensive and long-term approach to treatment. Services are offered in a positive and supportive atmosphere. Ultimately, the goal of integrated dual disorders treatment is to help people learn to manage both their mental illness and SUDs so that they can pursue meaningful life goals.

Motivation to Change

The Stages of Change Model is a research-based clinical guide that explains stages of change and why some populations have a difficult time becoming and remaining abstinent.

There are five stages: precontemplation, contemplation, preparation, action and maintenance. Moving through the Stages of Change successfully requires accomplishing specific tasks at each stage (https://www.ncbi.nlm.nih.gov/pubmed/17574798).

The Stages of Change Model can assist individuals with SUDs in their recovery process. Information about treatment readiness should be used to determine whether external pressure is required for treatment retention and if so, how much. Thus, more pressure may be indicated for individuals who are not otherwise treatment ready, but diversion from the legal system or other approaches that employ less pressure may be needed in cases when the individual is treatment ready. While individuals in the legal system may not be able to choose from a variety of treatment options, referral to treatment should try to include consideration of individual needs.

Stages of Change

Precontemplation	At this stage, the individual does not believe a problem exists and is not interested in engaging in treatment. The individual must become concerned about the problem and interested in treatment in order to do so, the individual needs evidence of the problem and its consequences.
Contemplation	In the contemplation stage, an individual recognizes that a problem exists and considers treatment. While considering treatment, the individual must complete the tasks of analyzing the balance of risks and rewards of treatment. They need support and information to understand treatment options as they make decisions about treatment.
Preparation	When an individual is in the preparation stage, they are ready to begin treatment but need help finding appropriate treatment. While preparing for treatment, an individual must create an effective and acceptable treatment plan. Justice and health professionals may work with the individual to develop the treatment plan.
Action	At the action stage, an individual begins treatment and must reaffirm his or her commitment to the treatment plan and follow up with treatment providers to determine if the plan needs to be revised. Ongoing support from justice and health professionals, family and community may help the individual sustain his or her commitment.
Maintenance	The major characterization of the maintenance stage is continued commitment to sustaining new behavior. In this stage, justice and health professionals should develop a continuing care plan with the patient, including relapse prevention. Even if relapse does occur, justice and health professionals need to reassess the patient, evaluate the triggers, and determine the best course of action for the patient and his/her support network.

Detoxification/Withdrawal Management

Detoxification (more currently referred to as withdrawal management) is a precursor to treatment for people who have been identified as being physically dependent on a substance. Medically supervised withdrawal management is often needed to counteract withdrawal complications from alcohol, benzodiazepines and barbiturates. Withdrawal from opioids can be medically dangerous and require medication. Withdrawal from cocaine and methamphetamine may be accompanied by psychiatric instability and require supervision as treatment is initiated.

The need for detoxification should be assessed and patients referred for medical care when indicated.

Forced, unmedicated, unsupervised withdrawal is dangerous and potentially lethal. Thus, assessment of detoxification needs should be incorporated in justice settings, coupled with medical input and involvement as needed.

Withdrawal management in some cases may require hospital or inpatient facility for medical care. However, it can often be successfully managed in an ambulatory setting. The manifestations of withdrawal can range from mild dysphoria to life-threatening complications. Three common methods alleviate the potentially dangerous effects of withdrawal: (1) the dose of the substance used is slowly tapered or (2) a long-acting pharmaceutical medication similar to the drug is administered and then tapered, or 3) medications to treat symptoms of withdrawal are used while the patient's condition is monitored. The process typically requires three to five days; however, the length of time varies depending on the individual, the individual's co-morbid medical conditions, the substance the patient is withdrawing from and the severity of their SUD.

While withdrawal management treats the acute physiological effects of decreasing or eliminating substance use, it does not address the longer-lasting psychological, social, and behavioral problems associated with SUDs. As a result, detoxification does not typically produce lasting behavioral changes necessary for sustained recovery. It is important to remember that those with opioid use disorder, once they have undergone detoxification, will have lost their tolerance to opioids, and if they return to their prior level of use, are at high risk of overdose. The period while the patient is being detoxified can be a teachable moment. Clinicians can actively encourage treatment and point out the likely improvement in circumstances, avoidance of discomfort, and return to a healthy lifestyle.

Stages of Treatment Setting

Treatment services can be provided across a variety of settings/levels. Treatment usually takes place in four primary settings or locations: (1) Inpatient, (2) Residential, (3) Intermediate, and (4) Outpatient. These settings correspond to "levels of care." The level of care should correspond to the severity of an individual's substance problem and not a criminal charge, conviction or ruling. One tool to determine clinically appropriate treatment settings for SUDs are the American Society of Addiction Medicine (ASAM) Placement Criteria (https://www.asam.org/asam-criteria/about). This tool scores six aspects of a patient's status (withdrawal risk, medical risk, psychological risk, readiness for change, relapse potential and recovery environment) to determine what is the appropriate level of care needed.

Treatment Modalities

"Treatment modality" refers to the specific activities used to relieve biologic symptoms and establish behavior change. A variety of treatment modalities are used to treat alcohol and other drug use disorders; however, all generally fit into one of two categories: (1) behavioral and (2) pharmacological.

Pharmacological Treatment

Understanding that prolonged use of alcohol and other drugs can change the structure and function of the brain helps explain why pharmacological (i.e., medication) treatment can have an important role in the treatment of SUDs.

VA/DoD Clinical Practice Guideline

The Veteran's Administration released the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders, a validated tool considered the gold standard for treating SUDs. These guidelines are applicable to any patient with an SUD and is not specific to those in the military and is available at no cost. It covers SUDs and co-occurring psychiatric disorders. https://www.healthquality.va.gov/guidelines/MH/sud/

The VA's Chronic Pain Guideline describes the critical decision points in the Management of Opioid Therapy (OT) for Chronic Pain and provides clear and comprehensive evidence based recommendations incorporating current information and practices for practitioners. https://www.healthquality.va.gov/guidelines/Pain/cot/

While society seems to have accepted that there are a number of medication treatments for nicotine use disorder—nicotine gum to help people stop smoking cigarettes, for example—there is less acceptance of using medications for alcohol use disorder or opioid use disorder. Research supports the use of medications when accompanied with behavioral therapy for treating alcohol and other drug use disorders and is considered the gold standard of care for treating opioid use disorder. However, if counseling is not available, it remains imperative to provide medication. There is a subset of patients who will do well without behavioral treatment.

The primary principles of medications for opioid use disorder (MOUD), are to decrease craving, stabilize withdrawal symptoms, interrupt repeated drug use and allow individuals to remain substance free.

Because justice-involved patients often suffer from other SUDs in addition to opioid use disorder, other co-occurring psychiatric disorders, trauma, unemployment, etc., they need a comprehensive, integrated treatment plan delivered by a health professional certified to prescribe medications and a team experienced in the clinical use and management of MOUD and behavioral treatments.

Behavioral Therapy

Because of the significant behavioral problems often resulting from SUDs, behavioral therapies can help patients: (1) identify and avoid triggers to use, (2) control urges, (3) develop refusal skills and (4) build healthy social supports. Psychotherapy including behavioral therapy, also referred to as “talk therapy,” engages people in treatment, modifying their attitudes and behaviors related to SUDs and increasing their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for substances resulting in relapse. Moreover, behavioral therapies can enhance the effectiveness of medications by helping individuals remain in treatment, continue to take their medications and maintain their recovery.

Commonly Used Behavioral Therapies for SUDs:

Acceptance and Commitment Therapy (ACT) is an action-oriented approach to psychotherapy that stems from traditional behavior therapy and cognitive behavioral therapy. Clients learn to stop avoiding, denying, and struggling with their inner emotions and instead accept that these deeper feelings are appropriate responses to certain situations that should not prevent them from moving forward in their lives. With this understanding, clients begin to accept their issues and hardships and commit to making necessary changes in their behavior, regardless of what is going on in their lives, and how they feel about it.

Cognitive-Behavioral Therapy (CBT) focuses on thoughts and thought processes in addition to behaviors. The patient and therapist decide together on the treatment goals and plan. CBT is based on social learning theory, which assumes that how a person initiates substance use is how they learn to continue use. Therefore, the therapist will teach and reinforce skills and strategies the individual can use after treatment to identify and avoid cues and modify the patient's behavior through urge control techniques. CBT seeks to help patients recognize, avoid, and cope with situations in which they are most likely to use substances.

Community Reinforcement Approach (CRA) is based on the understanding that environmental factors can play a significant role in encouraging and discouraging substance use. CRA uses social, recreational, familial, and vocational reinforcement to support the individual's recovery process. CRA integrates several treatment components, including: (1) building the client's motivation to quit, (2) helping the client initiate sobriety, (3) analyzing patterns of use, (4) increasing positive reinforcement, (5) learning new coping behaviors, and (6) involving significant others in the recovery process. This approach can also be effective when combined with family therapy and motivational interviewing. The overall philosophy of CRA is to treat substance use by helping people discover healthy lifestyle alternatives that are more rewarding and fulfilling.

Contingency Management (CM) is a systematic reinforcement of desired behaviors using incentives and sanctions (negative reinforcement). Positive consequences for abstinence may include vouchers that can be exchanged for access to additional services or privileges. Negative behaviors, such as unfavorable reports from a parole officer, could result in withholding vouchers.

CM can be used in variety of ways, including reinforcement of medication compliance and reinforcement of treatment attendance and has had particular effectiveness with some stimulant use disorders.

Matrix Model (MM) was developed as an outpatient treatment for stimulant use. It provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) patients in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, and become familiar with self-help programs. Patients are monitored for drug use through urine testing.

Motivational Interviewing (MI) is a directive client-centered counseling approach for eliciting behavior change by supporting clients to explore and resolve ambivalence. MI is more focused and goal directed than other counseling techniques. Motivational interventions are effective across numerous substances such as alcohol, tobacco, opiates and other drugs.

Medications Used for Substance Use Disorder Treatment *(see chart pages 108-111)*

While currently there are no medications for treatments approved by the FDA for SUDs with stimulants, hallucinogens, methamphetamines or cannabis, effective medications are approved for alcohol, nicotine and opioid use disorders. FDA-approved medications for alcohol use disorder include acamprosate, naltrexone (oral and injectable) and disulfiram. The main FDA-approved medication for nicotine use disorders are nicotine replacement products, varenicline and bupropion.

Some medications, like naltrexone, are used for both alcohol and opioid use disorder. The major pharmacological properties of medications used to treat SUDs are: (1) agents that activate the same receptors as targeted by the misused drug, (2) agents that block the same receptor as targeted by the misused drug, (3) agents that modulate circuits affecting the actions of the misused drug, or (4) medications that make use of the misused drug aversive. Medications that activate opioid receptors are called agonists or partial agonists. Medications that block opioid receptors, like naltrexone, are called antagonists. Naltrexone also blocks the effects of endogenous opioids, and thus modulates alcohols rewarding effects, reducing heavy drinking. Disulfiram causes the accumulation of a toxic metabolite of alcohol metabolism, making drinking aversive.

Multisystemic Therapy (MST)

MST is an intensive family-based treatment for serious antisocial behavior in adolescents and their families. The primary goals of MST are to reduce rates of antisocial behavior in the adolescent, reduce the number of out of home placements and empower families to resolve future difficulties. Research indicates MST reduces long-term rates of delinquency and antisocial behavior. Research shows that when pharmacotherapy is used in conjunction with psychotherapy, patients have improved outcomes relative to either pharmacotherapy or psychotherapy alone.

Treatment Retention

Staying in treatment is important not only to the health of individuals with an SUD but also to public safety. A number of factors influence whether an individual will stay in treatment: 1) treatment readiness, 2) treatment appropriateness, 3) pressure from an outside source like the justice system or an employer, 4) family involvement in treatment, and 5) treatment effectiveness. In many studies, treatment retention is the proxy for treatment success.

Inmates treated with MOUD prior to release are more likely to engage in post-release treatment, stay in treatment longer and stay alive.

Attention to Individual Needs

Referring an individual to treatment that appropriately addresses their needs improves the likelihood that the individual will successfully complete treatment, saving lives and limited resources. Access to clinical expertise can help the justice system provide individuals and their families with the appropriate resources to address their problems, improving medical and legal outcomes.

Treatment should be modified to meet the individual's specific needs. Severity of the SUD, psychiatric disorder, criminal history, gender, culture, socioeconomic status, ethnicity, language, literacy and physical or cognitive ability may affect how an individual responds to treatment and should be considered during clinical assessment and throughout treatment.

MEDICATIONS FOR ALCOHOL USE DISORDER

Acamprosate (Campral)

Dosing: Acamprosate is usually taken three times daily.

Treat: Alcohol use disorder

After alcohol use has ceased, an unpleasant physical condition, known as protracted abstinence syndrome, can develop. Acamprosate works to reduce the discomfort of protracted abstinence syndrome, increasing the likelihood that individuals will remain abstinent and sustain their recovery longer because they no longer feel the urge to drink alcohol to relieve their discomfort. Acamprosate is an effective treatment among motivated and abstinent populations. Research has found acamprosate reduced the quantity and frequency of drinking and increased abstinent days, particularly among motivated patients (Witkiewitz et al., 2012).

Disulfiram (Antabuse)

Dosing: Disulfiram is usually taken once daily.

Treats: Alcohol use disorder

Approved by the FDA for the treatment of alcohol use disorder in 1949, this is used primarily by patients who are not currently drinking in order to avoid using alcohol. This medication discourages drinking by producing unpleasant physical effects, such as vomiting, chest pain, blurred vision, mental confusion, breathing difficulty, red face and anxiety when even small amounts of alcohol are consumed. Numerous meta-analyses have shown, with reasonable consistency, that disulfiram is effective in promoting abstinence from alcohol (Skinner et al., 2014). The efficacy for disulfiram is improved significantly with supervised administration. Disulfiram is an important component of treatment when abstinence is the goal.

Naltrexone (Revia, Vivitrol, Depade)

Treats: Alcohol use disorder and opioid use disorder

A synthetic opioid antagonist (blocker) with few side effects, naltrexone is FDA-approved for treatment of alcohol and opioid use disorders. Naltrexone has no addictive potential. Daily treatment with 50mg/day of naltrexone in conjunction with therapy has been shown to produce a greater reduction in alcohol use than CBT alone (Anton et al., 2003). Adherence to daily naltrexone administration, like disulfiram, is a common problem. However, a long-acting injectable (LAI) or depot (28 days) form of naltrexone, brand name Vivitrol, was approved by the FDA in 2006 for treatment of alcohol use disorder. It may be especially helpful for those with AUD in whom medication adherence is challenging.

As with naltrexone use for alcohol use disorder, poor compliance with oral naltrexone has resulted in disappointing treatment results and the long-acting injectible is encouraged.

MEDICATIONS FOR OPIOID USE DISORDER

Methadone

Dosing: Once daily orally administered at a regulated center.

Treats: Opioid use disorder

- Methadone is only dispensed in specially regulated clinics called Opioid Treatment Programs (OTPs).

- Methadone is appropriate for women with opioid use disorder who are pregnant or breastfeeding.

Methadone is a synthetic opioid agonist that can alleviate cravings and withdrawal symptoms. It is FDA-approved for the treatment of opioid use disorder, highly regulated, and only prescribed in federally licensed clinics and hospitals. Methadone maintenance treatment (MMT) is an effective, evidence-based approach for treatment of individuals in the criminal justice system, particularly when combined with counseling. The Key Extended Entry Program (KEEP) at New York City's jail facilities at Rikers Island was the first MMT program in the U.S. for incarcerated individuals with heroin use disorders. Individuals enrolled in KEEP received a stable dose of methadone in jail and were referred to community MMT programs. The KEEP program increased enrollment and retention in treatment after release from Rikers. More recent retrospective analysis supports the assertion that methadone treatment among individuals with a criminal conviction reduces illicit substance use and overall mortality (Russolillo et al., 2018).

MMT use in prisons and re-entry programs remains limited but has significantly improved engagement in treatment for opioid use disorder and reduced overdose risk for at least 12-months after release (NIDA: Methadone Maintenance Treatment During Incarceration Has Long-Term Benefits. April 2019: https://www.drugabuse.gov/news-events/nida-notes/2019/04/methadone-maintenance-treatment-during-incarceration-has-long-term-benefits).

One of the barriers to MMT involves concern over how long a patient should remain MMT. Research has shown that use of methadone for eight months or longer reduces recidivism and other health problems, including reduced rates of HIV. MMT is administered to stabilize individuals and enable them to be abstinent of other opioids, which allows individuals to make lasting behavioral changes.

Buprenorphine/XR-Buprenorphine

Dosing: Taken one to three times daily orally or once monthly as an injectable.

Treats: Opioid use disorder

- Buprenorphine is an opioid partial agonist. Sold alone, formerly Subutex®, or combined with naloxone (Suboxone® or Zubsolv®)

- It is described as a "partial agonist" because it simultaneously activates and blocks the opioid

receptors in the brain so that other opioids have limited effects. This results in a “ceiling effect” that makes it safer than agonist medications, like methadone, that when taken in high doses. could lead to overdose.

- Certain buprenorphine products approved by FDA for the treatment of OUD can be prescribed by providers who have received a waiver associated with their DEA registration. Providers who prescribe for more than 30 patients, require additional training.

- Buprenorphine can be administered within OTPs without a waiver and administered in hospital settings, including the emergency department.

- Buprenorphine containing products can be filled at retail pharmacies.

- Buprenorphine and methadone are currently the treatment of choice in pregnant women. Naltrexone is currently being evaluated for treatment during pregnancy.

Buprenorphine is a partial opioid agonist that can, like methadone, alleviate craving and withdrawal symptoms and is FDA-approved for the treatment of opioid use disorder. While methadone may not be prescribed in a prescriber’s office for the treatment of opioid use disorder, buprenorphine/naloxone and buprenorphine alone is available by prescription. Providers who prescribe buprenorphine for treating OUD do not have to be addiction specialists but must be specifically trained in treating OUD and the administration of buprenorphine for opioid use disorder before they are able to prescribe. Physicians, advanced practice providers and PAs are available for licensure.

There are several preparations of buprenorphine: (1) Buprenorphine combined with the opioid antagonist naloxone. The presence of naloxone is designed to deter misuse of the medication by intravenous injection but does not interfere with treatment when taken sublingually. (2) Buprenorphine monoproduct is also available. It was primarily used in the treatment of pregnant women, however there is strong evidence the combination product is safe in pregnancy. (3) A monthly long acting injectable form of buprenorphine.

Naltrexone (Vivitrol, Depade)

- **Naltrexone** is a non-addictive opioid “antagonist” that occupies the opioid receptor without activating it and therefore blocks the effects of other narcotics.

- A person must have stopped taking opioids for 7-10 days prior to receiving oral or injectable naltrexone to avoid a serious form of withdrawal called “precipitated withdrawal.”

Naltrexone blocks the effects of opioids like heroin and prevents the euphoric effects of other opiates. If other opiates are used while on naltrexone, the individual experiences no effect so patients will need alternatives to opioid analgesics for pain control. Naltrexone is effective in preventing relapse and re-incarceration. A recent study found that among individuals with a previous criminal conviction, injectable naltrexone doubled the average time to relapse, and individuals receiving naltrexone had a 50% lower rate of relapse than those receiving placebo.

It is important to note the pharmacology of the three medications approved by the FDA and their use should be tailored to the individual's needs. One patient might do well with buprenorphine and another may find naltrexone or methadone more beneficial to their recovery (Green, Clarke, and Brinkley-Rubinstein, 2018).

Oral naltrexone and injectable naltrexone are opioid antagonist medications that work by blocking access of opioids to the *mu*-opioid receptor. Patients taking injectable naltrexone receive a monthly injection, which reduces cravings for heroin/opioids and also blocks the brain's opioid receptors so the patient would not feel any euphoric effects should they use heroin or oral opioids. Naltrexone cannot be administered to a patient until he or she has been totally withdrawn from opioids (a procedure known as detoxification) and has been opioid-free for at least seven days. Naltrexone prevents relapse and can also be used by patients who have been in treatment and have tapered off buprenorphine as an added protection against relapse. It is important to warn patients discontinuing this medication; they are at increased risk of overdose if they attempt to use opioids due to the loss of tolerance. The oral medication is taken daily and compliance is poor.

Naloxone

Naloxone (Narcan®) is an opioid antagonist much shorter-acting than naltrexone, and is given by injection or nasal spray. It is used to reverse an opioid overdose. For more information, visit: https://www.drugabuse.gov/publications/medications-to-treat-opioid-addiction/naloxone-accessible#.XkGwlvwQHxE.mailto

Naloxone should be readily available in courts, and court officials should be trained to administer it. Individuals should be given naloxone and immediately connected to addiction treatment, as they continue to be at high risk of overdose and death.

Treating Women

All individuals with SUDs, women included, should be placed into treatment programs with the appropriate structure and level of intensity based on their medical needs and severity.

While most clinical programs have been developed specifically for men, the number of women entering the justice system has significantly increased. Though the women prison population is growing faster than the male prison population, few treatment programs have been developed specifically for women offenders. Many of the programs that do exist for women in jails and prisons are modified from treatment models developed for male offenders. Research has shown that women are more likely than men to have a psychiatric disorder and trauma-related problems co-occurring with their SUD. They are also more likely to be affected by poverty, physical or sexual trauma, unstable social supports and medically related problems like HIV.

Research of women in jail-based SUD treatment programs suggests that such programs should be designed to meet individual needs wherever possible. Setting aside enough time for the assessment and diagnosis of co-occurring disorders and proper assessment of the cognitive abilities and background of individual women is essential to delivering effective treatment. As stated previously, maintaining continuity of care for those with an SUD when moving between justice settings or exiting the system is vital in preventing recidivism. Treatment for women may present the additional challenge of concurrently providing care for children. Involvement of social and/or family support whenever possible is ideal, as these factors have been found to reduce rates of criminal recidivism and substance use following release.

Treatment for Pregnant Women with Opioid Use Disorder

In February 2018, SAMHSA released the new Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants (https://www.samhsa.gov/resource/ebp/clinical-guidance-treating-pregnant-parenting-women-opioid-use-disorder-their-infants). The clinical guidance provides reliable, useful and accurate information for treating mothers with opioid use disorder and their children.

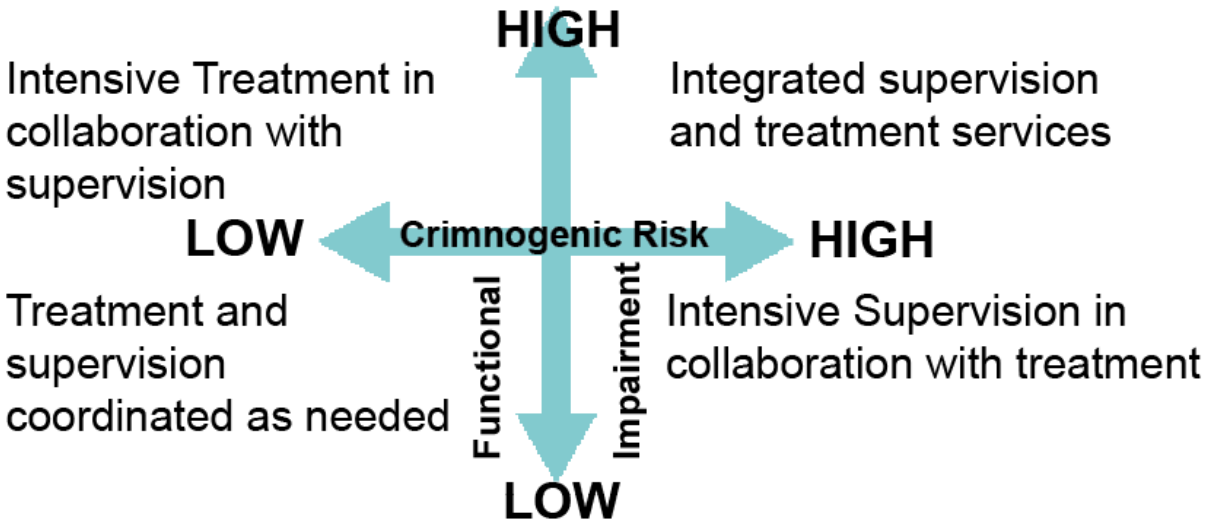
The guidance consists of 16 fact sheets on prenatal, infant and maternal postnatal care that are directed at healthcare professionals. The evidence-based practices found in SAMHSA's guidance can inform judges, court administrators, executive branch leaders, legislators, behavioral health treatment providers, community supervision agencies, medical experts, prescription drug monitoring program managers, regulatory agencies and child welfare representatives, among others. Non-medical professionals, including judges, can potentially affect treatment decisions for pregnant women with opioid use disorder and can further complicate the care of women and their infants if those non-medical professionals do not understand the best practices laid out in this guidance (National Judicial Opioid Task Force).

Neonatal Opioid Withdrawal Syndrome In the United States, the prevalence of opioid use among pregnant women more than quadrupled from 1999 to 2014. An infant is born with neonatal opioid withdrawal syndrome (NOWS) approximately every 15 minutes in the United States. The use of medications for OUD have shown to reduce length of hospital stay, severity of symptoms to the infant and risks during pregnancy and the newborn. Newborns with NOWS require specialized care and typically have longer hospital stays after birth and increased healthcare costs.

Infants born to mothers whose OUD is treated with buprenorphine have less severe NOWS than those treated with methadone (SAMHSA 2021).

Continuum of Care

When supervised treatment is completed, continuing care is critical to success. When possible, it is important to arrange for continuing care beyond treatment and re-entering into the community. Sometimes it can take as little as a phone call to a physician/health provider or hospital to confirm the availability of local resources. It is important to be aware of the resources in the community. Continuing care is important because many problems become more apparent or reappear only when an individual returns to the community following inpatient treatment or incarceration. Helping individuals develop skills such as learning to handle situations that could lead to relapse; learning how to live substance-free in the community; and developing a substance-free peer support network are key when it comes to treating substance use issue. An important aspect of continuing care is relapse prevention. Relapse prevention plans provide ways to avoid exposure to triggers and high-risk situations and how to manage these situations if they are unavoidable. High-risk situations, like family conflict or being in places and/or with people where previous substance use occurred, trigger the brain to crave the substance.



(Prins and Osher, Council of State Governments Justice Center, 2009)

Community Support Systems

Community support groups or mutual help-groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) are not treatment modalities nor do they claim to be. They are organizations that can support individuals in their recovery and help them re-establish healthy connections. Not all individuals will choose this approach, while many others find it extremely helpful for their recovery. Spiritual approaches can provide powerful tools for some individuals to achieve and maintain abstinence. Treatment providers can suggest clients consider the spiritual leaders of their choice for additional counseling, and treatment programs can also accommodate 12-step groups that do not explicitly endorse any one religion or even a religious approach at all, e.g., Smart Recovery. It should be noted that not all support groups accept the use of medications for treatment as part of recovery, therefore when referring someone to a support group it is important that they consider the use of medications for treatment as part of recovery.

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Resources

General

Addressing the Unique Challenges of Opioid Use Disorder in Women https://www.cdc.gov/grand-rounds/pp/2017/20170117-opioid-overdose.html

Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice/SMA18-5065

Treatment of Opioid Use Disorder, National Judicial Opioid Task Force. https://www.ncsc.org/information-and-resources/resource-centers/resource-centers-items/opioids-and-the-courts/resource-center

Treating Pregnant Women with OUD, National Judicial Opioid Task Force. https://www.ncsc.org/__data/assets/pdf_file/0021/18156/treating_pregnant_women_with_oud.pdf

Promising Strategies in Providing OUD Treatment to Rural, Frontier and other Underserved Communities, National Judicial Opioid Task Force. https://www.ncsc.org/__data/assets/pdf_file/0019/17614/oud-txt-in-rural-areas-final.pdf

Directory of Single State Agencies (SSA) from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/sites/default/files/ssadirectory.pdf

Federal statutes, regulations, and guidelines from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines

How to remain optimistic when treating addiction from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/how-to-remain-optimistic-when-treating-addiction/

Myths and Misconceptions: Medication-Assisted Treatment for Opioid Addiction from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/resource/myths-and-misconceptions-medication-assisted-treatment-for-opioid-addiction/

Raising the Curtain on Recovery from the National Council for Behavioral Health. https://www.thenationalcouncil.org/BH365/2017/06/29/raising-curtain-recovery/

Behavioral Health Treatments and Services from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/find-help/treatment

Early Serious Mental Illness Treatment Locator from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/esmi-treatment-locator

TIP 36: Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/tip-36-substance-abuse-treatment-for-persons-with-child-abuse-and-neglect-issues/SMA12-3923

Patient Wants to Stop Taking Buprenorphine from the Providers Clinical Support System (PCSS), a SAMHSA

funded initiative. https://pcssnow.org/education-training/training-courses/patient-wants-to-stop-taking-buprenorphine/

Recovery Housing: Best Practices and Suggested Guidelines from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/resource/ebp/recovery-housing-best-practices-suggested-guidelines

The National Reentry Resource Center - https://nationalreentryresourcecenter.org/

Evidence-Based Practice Resource Center from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/ebp-resource-center

ASAM Criteria: https://www.asam.org/asam-criteria/about

VA/DoD Clinical Practice Guidelines for the Management of Substance Use Disorders – https://www.healthquality.va.gov/guidelines/MH/sud/

VA/DoD Clinical Practice Guidelines for the Management of Opioid Therapy (OT) for Chronic Pain - https://www.healthquality.va.gov/guidelines/Pain/cot/

Alcohol
Support and Treatment Resources from the National Institute on Alcohol and Alcoholism (NIAAA). https://www.niaaa.nih.gov/alcohols-effects-health/support-treatment

Alcohol Treatment Navigator from the National Institute on Alcohol and Alcoholism (NIAAA). https://alcoholtreatment.niaaa.nih.gov/

Detox
TIP 45: Detoxification and Substance Abuse Treatment from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA15-4131

Treatment Programs and Approaches
Module 2: Alcohol and Drug Use Disorders from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/module-2-alcohol-and-drug-use-disorders/

TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA15-4426

Certification of Opioid Treatment Programs (OTPs) from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program

Family Planning in Addiction Treatment Settings from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/resource/family-planning-in-addiction-treatment-settings/

Module 4: Medication and Behavioral Treatment of Substance Use Disorders from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/module-4-medication-and-behavioral-treatment-of-substance-use-disorders/

TIP 63: Medications for Opioid Use Disorder from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://medicine.yale.edu/edbup/resources/TIP_63_338482_284_42920_v1.pdf

Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface
Providers Clinical Support System (PCSS), a SAMHSA funded initiative - www.pcssNOW.org

Safer Injection Practices from the Boston Medical Center, OBAT Training and Technical Assistance Team. https://www.bmcobat.org/news/2019/11/new-video-from-our-experts-safer-injection-practices/

TIP 27: Comprehensive Case Management for Substance Abuse Treatment from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215

TAP 34: Disaster Planning Handbook for Behavioral Health Treatment Programs from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/TAP-34-Disaster-Planning-Handbook-for-Behavioral-Health-Treatment-Programs/SMA13-4779

TIP 39: Substance Use Disorder Treatment and Family Therapy from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/treatment-improvement-protocol-tip-39-substance-use-disorder-treatment-and-family-therapy/PEP20-02-02-012

Principles of Drug Abuse Treatment for Criminal Justice Populations - A Research-Based Guide from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide/principles

Treating Patients with OUD Can Be Incredibly Rewarding from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/treating-patients-oud-can-be-incredibly-rewarding/

Uncomfortable treating patients with OUD? From the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/uncomfortable-treating-patients-with-oud/

Rethinking Drinking: What Counts as a Drink? From the National Institute on Alcohol and Alcoholism (NIAAA). https://www.rethinkingdrinking.niaaa.nih.gov/#:~:text=In%20the%20United%20States%2C%20a,an%20alcoholic%20drink%2Dequivalent).

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MAT in Corrections
Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/Adult-Drug-Courts-and-Medication-Assisted-Treatment-for-Opioid-Dependence/sma14-4852

MAT Inside Correctional Facilities: Addressing Medication Diversion from the Substance Abuse and Mental Health Services Administration (SAMHSA). https://store.samhsa.gov/product/mat-inside-correctional-facilities-addressing-medication-diversion/PEP19-MAT-CORRECTIONS

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Medications

A patient choose buprenorphine for OUD from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/a-patient-chooses-buprenorphine-for-oud/

How does buprenorphine work? (Part 1), from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/how-does-buprenorphine-work-part-1/

How does buprenorphine work? (Part 2), from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/how-does-buprenorphine-work-part-2/

How does buprenorphine work? (Part 3), from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/how-does-buprenorphine-work-part-3/

How does injection naltrexone work? (Part 1), from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/how-does-injection-naltrexone-work-part-1/

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How does injection naltrexone work? (Part 3), from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/how-does-injection-naltrexone-work-part-3/

Medication-Assisted Treatment (MAT) for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit from the National Council for Behavioral Health. https://www.thenationalcouncil.org/medication-assisted-treatment-for-opioid-use-disorder-in-jails-and-prisons/

The Opioid Epidemic (Module 3) from the Providers Clinical Support System (PCSS), a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/module-3-the-opioid-epidemic/

Treatment Approaches for Drug Addiction from the National Institute on Drug Abuse (NIDA). https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction

Understanding Substance Use Disorders (Module 1) from the Providers Clinical Support System, a SAMHSA funded initiative. https://pcssnow.org/education-training/training-courses/module-1-understanding-substance-use-disorders/

8 Supporting Collaboration and Partnership

Developing and Implementing an Integrated Approach

Collaboration between the justice and medical systems ultimately saves money while decreasing substance misuse and associated health and legal problems. The cost of treatment is just 1/5th the cost of incarceration. Numerous research teams have demonstrated that both pharmacological and behavioral therapies are highly effective at reducing SUD and criminal recidivism and improving general quality of life. Research and data support that individuals receive SUD treatment.

Before developing integrated systems, it is important to understand the different perspectives of the justice and medical systems and how their perspectives influence the type and quality of services provided.

The justice and medical systems both aim to protect the general population, whether they are protecting them from crime, health and/or other social problems. An integrated public health-public safety approach blends functions of justice and medical systems to optimize outcomes. An effective collaboration across systems requires developing unified policies, procedures, relationships and shared responsibilities.

Co-chairs of the National Judicial College training, James D. Gingerich, Director State Courts Partnership and Kathryn Cates-Wessel, CEO, American Academy of Addiction Psychiatry.

An Integrated Approach

An integrated public health and public safety approach may take many different forms. There are numerous opportunities for the two systems to integrate, complement and support one another. When an individual enters the justice system, it is critical to screen for and assess alcohol and other substance disorders as well as co-occurring psychiatric disorders and physical health problems. When an individual progresses through the justice system, opportunities for integration with the treatment system continue; the court may refer an individual with SUDs or at risk for developing a disorder to treatment, mental health care, family therapy, 12-Step programs, drug courts, and/or social services, such as housing assistance, job training and job placement.

Building an Integrated System

The development and implementation of integrated services is a huge challenge, requiring unique approaches for different regions and different programs. Judicial leadership is the key component to integrating systems. Judges are the senior partner at the table and can bring stakeholders together to develop collaborative solutions to alcohol and other SUDs in the justice system (Anderegg et al., 2006). Models of support for individuals with the complex interplay of co-occurring conditions and justice involvement are emerging and showing promise.

Challenges for an Integrated System

To be effective, organizations that treat those with SUDs who are involved in the justice system often need to share information about these individuals. Judges are encouraged to consider how to balance information sharing and system coordination against concerns for patient privacy (Boldt, 2007). SUDs are highly stigmatized, and having this knowledge made public can drastically inhibit a person's ability to find employment, find a residence and establish relationships with others.

Linking to Social Services

Because SUDs can often be chronic, relapsing illnesses, it is crucial to develop and sustain an integrated continuum of care among health professionals, medical/treatment providers, justice staff and social service agencies. Linkages to the appropriate social services are essential elements of treatment. Resources should be made available for a range of services, including: educational, vocational, cultural, legal, medical and mental health. Collaboration among community agencies requires careful planning, ongoing communication and adequate resources to develop and maintain relationships. Treatment planning and case management will be easier overall if these relationships already exist and can be called upon as needed.

The coordination of treatment with justice planning can encourage participation in treatment and can help treatment providers incorporate correctional requirements as treatment goals.

Action Steps to Create Community Coalitions

Many states and local jurisdictions have implemented successful and innovative working groups, a drug focused taskforce, or a coalition to handle the opioid crisis in their communities. Local leaders can get started by:

1. Identifying areas of concern that could be addressed by community-level prevention, treatment and recovery efforts. Wherever possible, add data to help tell the story.

2. Establishing connections with community, county, region, and state-level stakeholders. Rural communities have a natural partner in county and state agencies.

3. Identify and connect with critical stakeholders in the community affected by substance use disorders such as business- and healthcare-related leaders. Schedule regular meetings to start building an action plan.

4. Seeking opportunities to learn more about and connect with relevant organizations to learn about coalition building and training that could provide continued support.
(Rural Community Action Guide, https://www.usda.gov/sites/default/files/documents/rural-community-action-guide.pdf)

Ideally having healthcare providers collaborate directly with justice staff to evaluate the individual's treatment plan and ensure it meets all requirements is vital. This may include: housing, childcare, medical, psychiatric, social services, vocational and employment assistance.

Planning should incorporate the transition to community-based treatment and links to appropriate post-release services to improve the success of drug treatment and re-entry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention or medications to prevent relapse. Weak inter-organizational cooperation between correctional and treatment programs presents a major threat to effective rehabilitation.

Development of these relationships is imperative but ultimately slow going (Welsh et al., 2015). Because of this, the Institute of Medicine has recommended a number of practices to enhance inter-organizational coordination:

- Use performance measures of the coordination between the systems and within the system, agency, program, and individual levels.
- Provide combined, interdisciplinary training in collaboration and coordination with integrated sessions including personnel from cross-system agencies and programs.
- Coordinate incentives via promotion, salary and budget decisions.
- Provide education and decision support to prosecutors and judges.
- Use information systems to facilitate the movement of information essential to responding appropriately to each individual.

Ayana Jordan, MD, PhD discussed cultural bias with participants at The National Judicial College.

Five Overarching Principles Adopted To Guide The National Judicial Opioid Task Force Direction And Work:

1. At every intersection point, the justice system should lead the way in delivering solutions to the opioid epidemic.

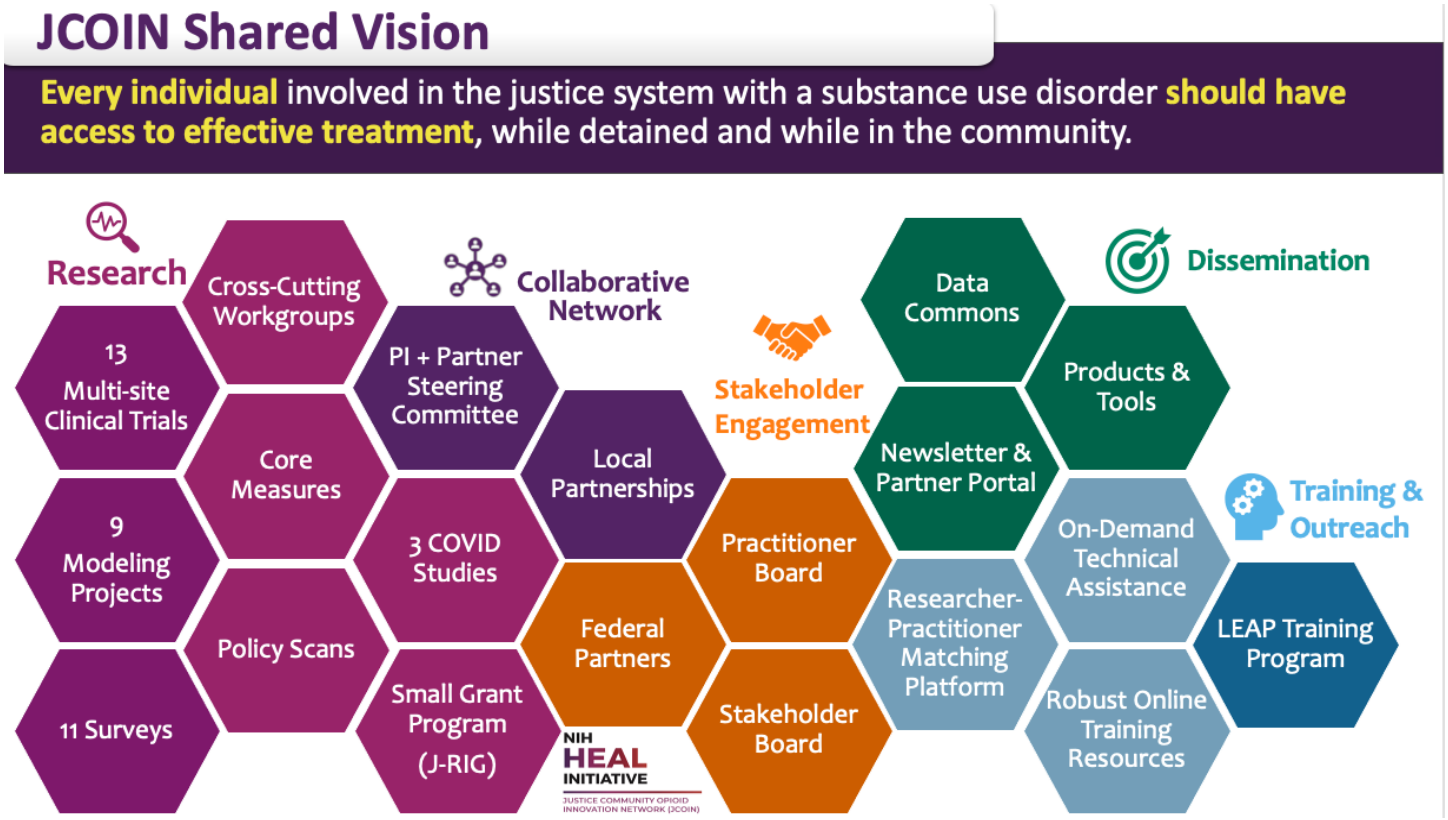
2. Judges should maximize their role as conveners by bringing together government agencies and community stakeholders to address the opioid epidemic and any underlying causes.

3. Courts should ensure that individuals with opioid use disorders receive the treatment they need. Interventions should include a continuum of treatment strategies and support services.

4. Given the inordinate impact of the crisis on children and families, courts must focus attention on this area, with an emphasis on prevention and the expeditious placement of children in a safe, stable environment.

5. Courts should objectively assess performance and support programs and practices that work—through the use of robust data collection, quality-assurance practices, and data-driven decision-making.

The National Institute on Drug Abuse (NIDA)'s Justice Community Opioid Innovation Network (JCOIN) initiative is a federal example of a collaborative effort that partners addiction scientists with justice agencies and community-based treatment/healthcare service providers. JCOIN is part of NIH's Helping to End Addiction Long-term (HEAL) integrated set of research initiatives, designed to provide scientific solutions to the opioid crisis. One of NIH's HEAL initiatives focuses on optimizing effective treatment effects for justice involved individuals. JCOIN's vision is that every individual involved in the justice system with an SUD should have access to effective treatment, whether detained or residing in the community. The following are JCOIN's priority goals: 1) generate new evidence about what works and how to implement effective treatment, 2) become a trusted resource for researchers and practitioners, 3) develop a network of researchers collaborating with practitioners across justice and community-based service settings, 4) build capacity to conduct research in settings, and 5) facilitate translation of research to practice and feedback loops.



Across the country, communities are uniting to create, identify and implement innovative solutions to address SUD needs and, in particular, the opioid crisis. Judges are in a unique position to bring together multidisciplinary teams that can achieve successful outcomes. These teams can provide a structure and process for the development of prevention programs and in response to future problems and issues related to all SUDs.

Judges can take the lead in their communities by creating and participating in local, state, and regional task forces, which are a key step in addressing the overdose crisis. In short, when a judge convenes a community meeting about a social issue affecting their community, people show up.

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RESOURCES

Creating a Local or Regional Judicial Opioid Task Force, National Judicial Opioid Task Force. http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/343

Judicial Leadership in Creating and Leading a Multidisciplinary Team to Address SUDs, National Judicial Opioid Task Force. https://www.ncsc.org/__data/assets/pdf_file/0025/51766/Leading-Change.pdf

OUD: Patients Can and Do Recover, a video from Providers Clinical Support System, a SAMHSA funded grant: https://pcssnow.org/education-training/training-courses/oud-patients-can-and-do-recover/

Reclaiming Futures: www.reclaimingfutures.org/

Rural Community Action Guide https://www.opioidlibrary.org/wp-content/uploads/2020/02/USDA_rural-community-action-guide.pdf

Substance Abuse Treatment for Adults in the Criminal Justice System, SAMHSA's TIP 44: https://store.samhsa.gov/product/tip-44-substance-abuse-treatment-for-adults-in-the-criminal-justice-system/sma13-4056

The Court's Role: Using the Sequential Intercept Model as a Place to Start, National Judicial Opioid Task Force. http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/349

Dedicated to David C. Lewis, MD

David C. Lewis, MD, (1935 – 2020) was a pioneer in the field of medicine who advocated for all physicians and health providers to be educated in the prevention, identification and treatment of substance use disorders. He championed creating a think tank, *Physician Leadership on National Drug Policy*, with surgeon generals, former US secretaries of state and public health leaders to advocate for evidence-based practices and promote the need for physicians to be educated. This group further expanded into becoming the *Physicians and Lawyers for National Drug Policy* with leaders of law working with leaders of medicine. Dr. Lewis' vision and commitment to help those impacted by SUDs supported the early work for the American Academy of Addiction Psychiatry in cultivating law and medicine partnerships that this current resource guide builds upon.