Session C:

Highlighting JCOIN Early Stage Investigators

Moderator:

Shelley Su

NIDA

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Presentations by:

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2. *Basia Andraka-Christou – J-RIG Grantee/University of Central Florida*
3. *Emily Hennessy – J-RIG Grantee/Massachusetts General Hospital*
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Competing Risk Analysis of Treatment Outcomes among Patients referred for Outpatient Opioid Use Disorder Treatment

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Background

- Several interventions seek to link patients with OUD to non-intensive outpatient treatment centers that provide medications for opioid use disorder (MOUD) treatment
- Treatment modalities that successfully retain patients are likely to have the most beneficial outcomes
- Conversely, the longer a patient remains in treatment, the more likely we are to observe adverse outcomes, including spells that end in treatment discontinuation, incarceration or death
- Studies that do not account for such dynamics do not fully capture the resulting implications of treatment duration on the likelihood of observing successful and unsuccessful treatment outcomes among patients in addiction care

Objective

- Analyze the competing risks of diverse treatment outcomes among patients who are seeking OUD treatment in non-intensive outpatient service settings

- Explore predictive risk-factors for competing outcomes at different points along the treatment trajectory of a patient engaged in outpatient MOUD care

Data

- 2011-2021 data from the Treatment Episode Dataset – Discharges (TEDS-D)

- Discharges of indicated non-pregnant women and men who received OUD treatment at a non-intensive outpatient facility

- Restricted sample to discharges involving patients:
  - 18 years or older
  - Reported using heroin, non-prescription methadone, or synthetic opiates use
  - Discharged from non-intensive outpatient OUD treatment
  - in treatment for at least three days

- Stratified analyses by treatment referral source— criminal legal system involved (CLI) versus not referred by the criminal legal system (non-CLI) — and by gender

Outcomes

- **Outcomes of interest** were based on indicated reasons for discharge:
  - treatment completion
  - treatment discontinuation (treatment drop-out or treatment termination by the facility)
  - treatment facility transfers
  - treatment spells which ended in incarceration
  - spells that ended in death

Predictive Features

- Operationalize **length of treatment** in days for days 1-30. For intervals covering multiple days, used the middle day for analysis

29	29
30	30
31	31 to 45 days
32	46 to 60 days
33	61 to 90 days
34	91 to 120 days
35	121 to 180 days
36	181 to 365 days

- We include many **covariates/features:**
  - Age, race, education, employment status and marital status;
  - Primary use of opioids (heroin, synthetic opiates and non-prescription methadone) ;
  - Secondary use of opioids and other substances;
  - Tertiary use of opioids and other substances;
  - State and year dummy variables;
  - State-specific window of Medicaid expansion

Methods

- Estimated cause-specific piecewise Cox proportional hazards models to understand competing risks of successful treatment completion, unsuccessful outcomes such as discontinuing treatment, incarceration and death, and miscellaneous outcomes such as transferred and other

- Cause-specific hazard model estimated associations between covariates and the rate at which events occur among subjects who are currently event-free

Methods

- Log hazard ratios for each treatment outcome were estimated for three time periods after initiating treatment – 3-14 days, 15-29 days, and 30+ days
- Analyses across all outcomes were stratified by gender and treatment referral source
- Log hazard ratios were estimated adjusting for year of discharge, age, race, education, marital status, MOUD receipt, first indicated treatment episode, substance use, poly-substance use, and whether an individual was discharged in a state with expanded Medicaid eligibility

Results

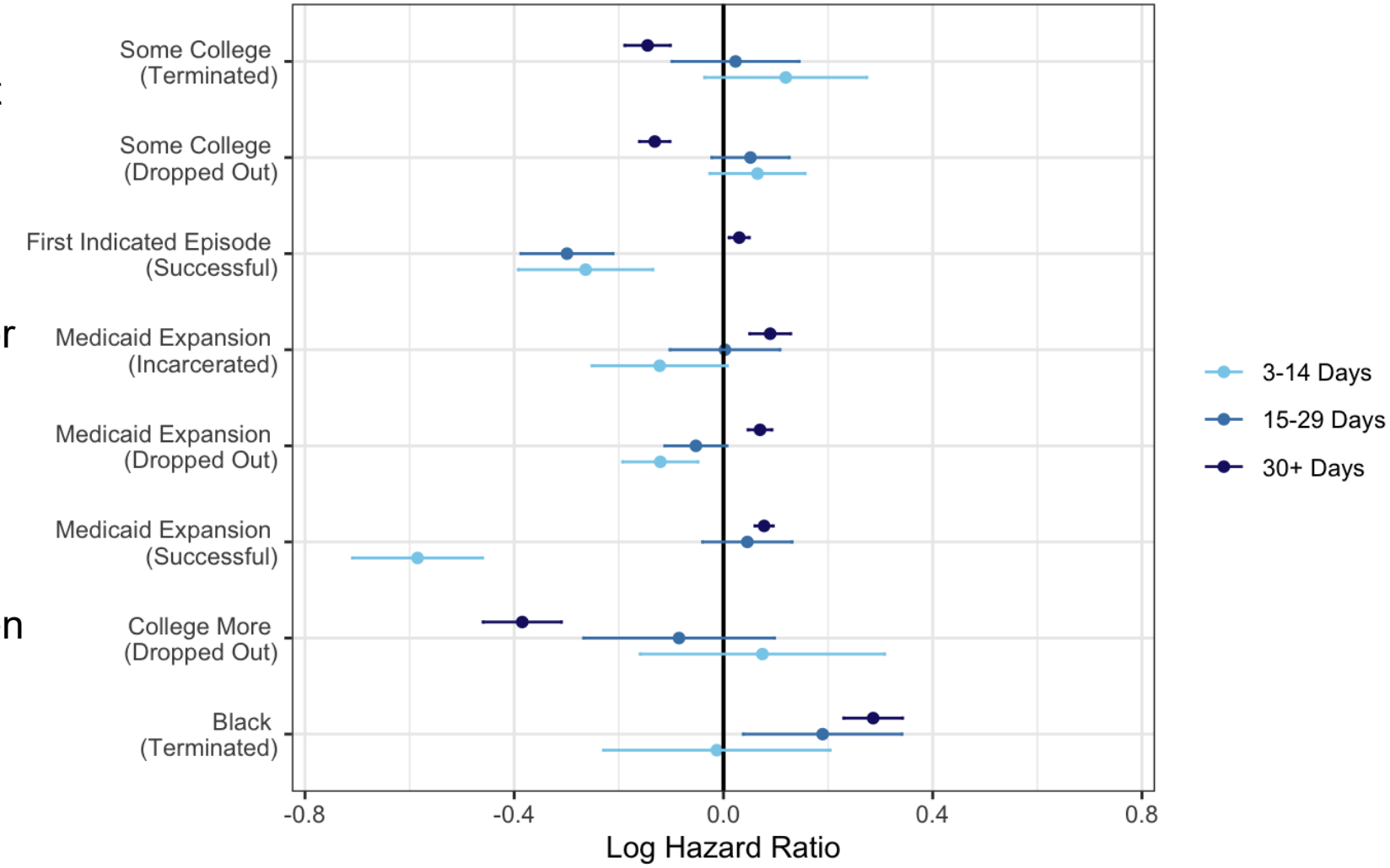
	Men-CLI	Women-CLI	Men-NCLI	Women-NCLI
	(N=162,054)	(N=86,261)	(N=462,601)	(N=348,525)
Age				
18-24	18871 (11.6%)	11123 (12.9%)	35828 (7.7%)	34976 (10.0%)
25-34	**74058 (45.7%)**	**41979 (48.7%)**	**170368 (36.8%)**	**150135 (43.1%)**
35-44	39047 (24.1%)	21636 (25.1%)	116953 (25.3%)	86865 (24.9%)
45-49	11065 (6.8%)	5006 (5.8%)	43391 (9.4%)	26503 (7.6%)
50-54	9060 (5.6%)	3510 (4.1%)	39257 (8.5%)	23045 (6.6%)
55-64	7053 (4.4%)	2294 (2.7%)	38394 (8.3%)	19749 (5.7%)
65+	2900 (1.8%)	713 (0.8%)	18410 (4.0%)	7252 (2.1%)
Race				
White	**137166 (84.6%)**	**79003 (91.6%)**	**369352 (79.8%)**	**297086 (85.2%)**
Black	15760 (9.7%)	4118 (4.8%)	56929 (12.3%)	34590 (9.9%)
AAPI	2396 (1.5%)	1705 (2.0%)	6351 (1.4%)	7156 (2.1%)
Other	6732 (4.2%)	1435 (1.7%)	29969 (6.5%)	9693 (2.8%)
Education				
High School of Less	**128843 (79.5%)**	**61894 (71.8%)**	**344102 (74.4%)**	**236439 (67.8%)**
Some College	28625 (17.7%)	20945 (24.3%)	96623 (20.9%)	94228 (27.0%)
College or More	4586 (2.8%)	3422 (4.0%)	21876 (4.7%)	17858 (5.1%)

Results

	Men-CLI	Women-CLI	Men-NCLI	Women-NCLI
Employment Status				
Full Time	41611 (25.7%)	11345 (13.2%)	90977 (19.7%)	36755 (10.5%)
Part-time	15559 (9.6%)	9255 (10.7%)	36901 (8.0%)	31682 (9.1%)
Unemployed	**64180 (39.6%)**	**37856 (43.9%)**	**188851 (40.8%)**	**153145 (43.9%)**
Not in Labor Force	40704 (25.1%)	27805 (32.2%)	145872 (31.5%)	126943 (36.4%)
Heroin				
No	60598 (37.4%)	38785 (45.0%)	134104 (29.0%)	138394 (39.7%)
Yes	**101456 (62.6%)**	**47476 (55.0%)**	**328497 (71.0%)**	**210131 (60.3%)**
Medicaid Expansion				
No	69881 (43.1%)	40247 (46.7%)	185045 (40.0%)	148301 (42.6%)
Yes	**92173 (56.9%)**	**46014 (53.3%)**	**277556 (60.0%)**	**200224 (57.4%)**
Reason for Discharge				
Treatment Complete	**56946 (35.1%)**	**27639 (32.0%)**	71331 (15.4%)	56736 (16.3%)
Dropped Out	40827 (25.2%)	21280 (24.7%)	**192372 (41.6%)**	**136700 (39.2%)**
Terminated by Facility	17730 (10.9%)	9831 (11.4%)	59904 (12.9%)	45050 (12.9%)
Transferred	21194 (13.1%)	14942 (17.3%)	75519 (16.3%)	67373 (19.3%)
Incarcerated	14120 (8.7%)	6351 (7.4%)	22508 (4.9%)	9243 (2.7%)
Death	967 (0.6%)	351 (0.4%)	5018 (1.1%)	2919 (0.8%)
Other	10270 (6.3%)	5867 (6.8%)	35949 (7.8%)	30504 (8.8%)

Results: Men referred for treatment by the criminal legal system

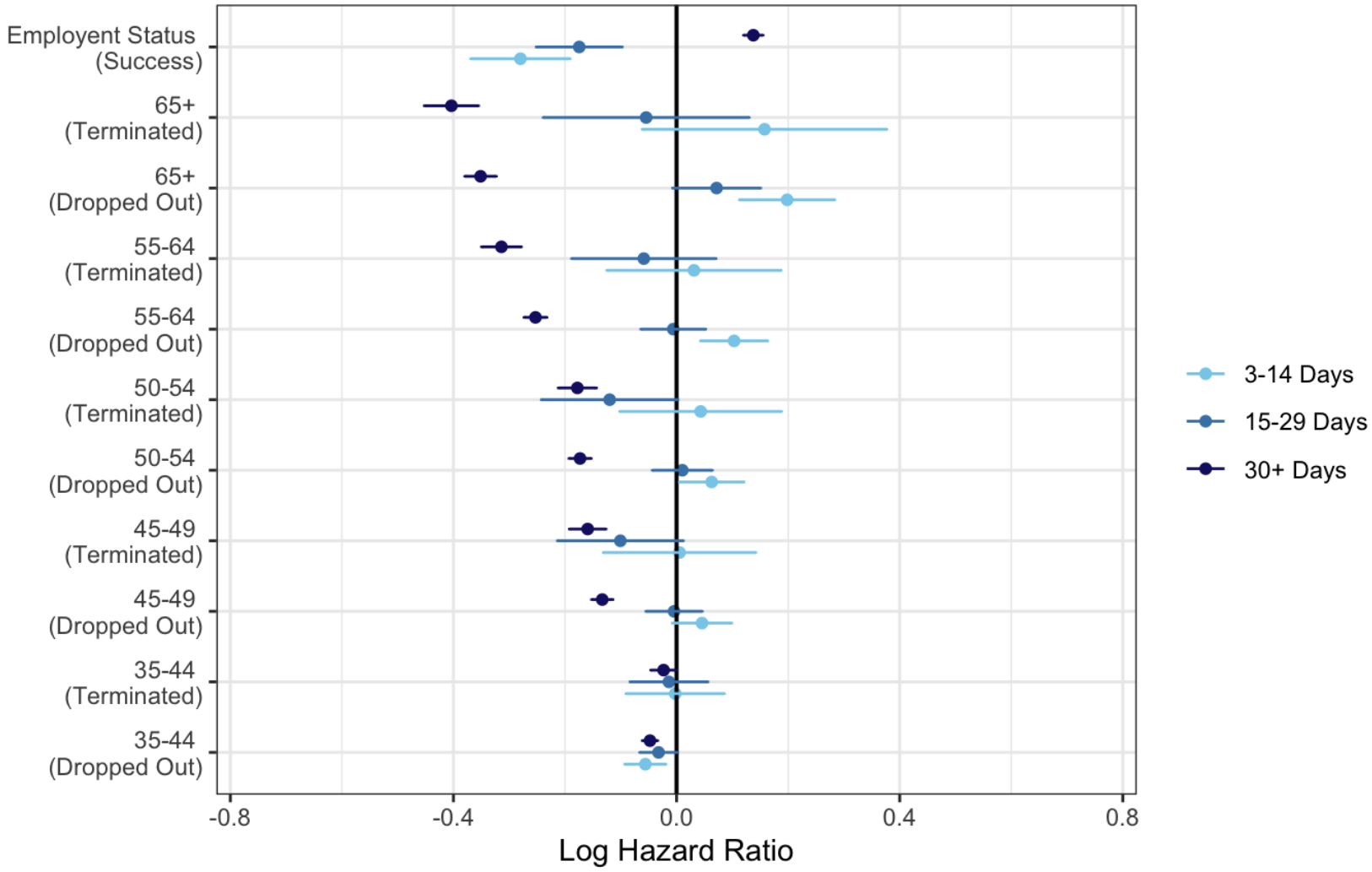
- Plot shows association between covariates and outcomes at different points along the treatment trajectory
- **College education** associated with lower likelihood discontinuing treatment for patients in treatment for longer than 30 days
- **Black race** associated with higher likelihood of terminating treatment
- Mixed results for association between Medicaid expansion and outcomes



Results: Men referred for treatment by sources other than the criminal legal system

For patients in treatment for longer than 30 days:

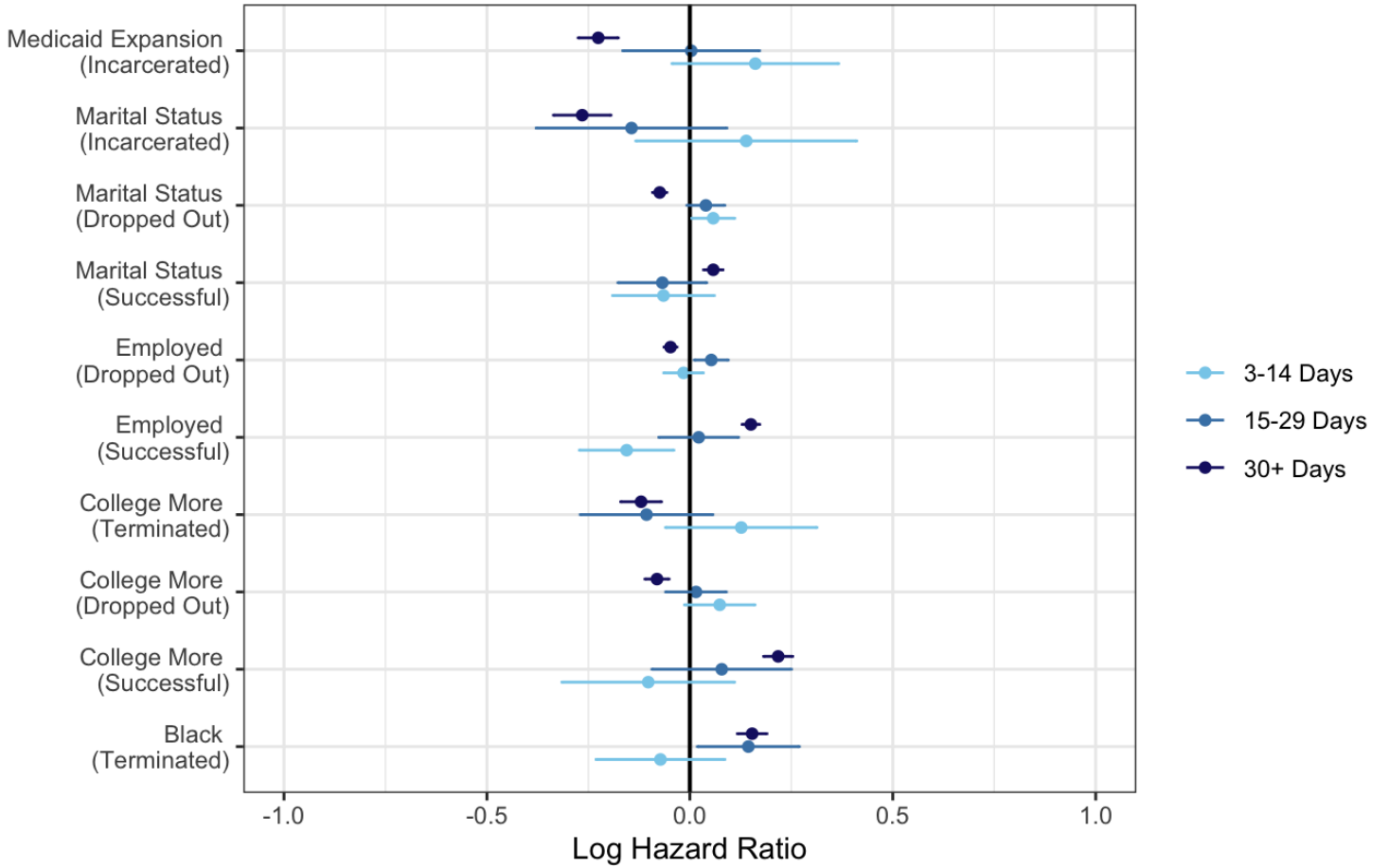
- Being **employed** associated with higher likelihood treatment completion for patients in treatment for longer than 30 days
- **Increasing age** associated with lower likelihood of treatment discontinuation



Results: Women referred for treatment by sources other than the criminal legal system

For patients in treatment for longer than 30 days:

- **Marital Status** associated with
  - higher likelihood of treatment completion
  - lower likelihood of incarceration and treatment discontinuation
- **College education** associated with
  - higher likelihood of treatment completion
  - lower likelihood of treatment discontinuation
- **Employment status** associated with
  - higher likelihood of treatment completion
  - lower likelihood of treatment discontinuation
- **Medicaid expansion** associated with lower likelihood of incarceration



Discussion

- Strong observed associations between select covariates and treatment outcomes. Moreover, these associations are different at different time-points in the trajectory of non-intensive outpatient OUD treatment

- Many known-protective-factor covariates such as, employment status and education, were positively associated with successful OUD treatment outcomes and negatively associated with unsuccessful outcomes — but only for patients who remained in outpatient OUD treatment for thirty days or longer

- Associations of Medicaid expansion with both successful and unsuccessful treatment outcomes reveal interesting patterns that underscore possibilities of patient selection effects

Discussion: Medicaid Expansion

- Some OUD patients at the margin of eligibility or of treatment engagement, were more likely to initiate or engage OUD treatment after their state expanded Medicaid

- Inflow of patients into non-intensive outpatient settings may also have induced resource constraints for treatment centers

- Combination of previously unobserved patients now entering treatment and, of potential failures to complement expanded treatment eligibility with required additional supports, could be associated with increased likelihood of observing adverse outcomes post-expansion

Limitations

- Can only provide predictive associations, conditional on length of treatment duration
- TEDS-D is a discharge-level rather than patient-level dataset
- After treatment duration exceeds 30 days, TEDS-D codes treatment duration as a categorical variable; so, we cannot ascertain with granularity how the relationship between covariates and treatment outcomes changes specifically when treatment exceeds 30 days
- Limited statistical power to explore COVID years separately

Conclusion

- From a methodological perspective, our competing risks model suggests that accounting for treatment duration can improve predictive accuracy regarding the likelihood of successful and unsuccessful treatment outcomes

- Strong observed associations between select covariates and treatment outcomes which vary at different time-points in the trajectory of non-intensive outpatient OUD treatment

- Results also suggest that policymakers must ensure outpatient treatment centers — where most patients seek OUD treatment — have adequate resources to ensure that patients not just enter but also remain in treatment long enough to complete treatment and promote successful recovery

Thank You!

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Collaborations between problem-solving courts and MOUD providers

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Funding

This study was funded under the JCOIN cooperative agreement (MPI Taxman and Rudes) funded through the National Institute on Drug Abuse (NIDA) by the National Institutes of Health (NIH). The author(s) gratefully acknowledge the collaborative contributions of NIDA and support from the U2CDA050097 award. The contents of this article are solely the responsibility of the author(s) and do not necessarily represent the official views of NIDA, NIH, or participating sites.

Background

Lifesaving MOUD is underutilized by problem-solving (PSC) court clients

- PSCs mandate and monitor treatment in lieu of incarceration or to facilitate parent-child reunification
- Opioid use disorder (OUD) is very common among PSC clients (DeVall et al., 2023)
- Medications for opioid use disorder (MOUDs) are the most effective OUD treatments (Larochelle et al., 2018; Santo et al., 2021; Wakeman et al., 2020)
- Unfortunately, only between 5% and 14% of PSC clients with OUD receive MOUD (Farago et al., 2022; Krawczyk et al., 2017)

Known barriers to MOUD use among PSC clients

- Internal context:
  - Court staff negative attitudes toward MOUD
  - Court staff attitudes toward MOUD providers
  - Policies prohibiting MOUD
- External context:
  - MOUD cost
  - Transportation
  - Lack of MOUD providers in the community
- Bridging factors:
  - Lack of collaborations between courts and MOUD providers
  - Lack of court team liaisons to MOUD providers

(Ahmed at al., 2022; Andraka-Christou & Atkins, 2020; Andraka-Christou et al., 2022; Csete & Catania, 2013; Farago et al., 2022; Matusow et al., 2013; Pivovarova et al., 2023)

Court-MOUD provider collaborations are important

PSCs do not directly provide tx, but they provide referral and monitoring

- All Rise best practice standards recommend that PSCs partner with providers for treatment delivery and coordination (All Rise, 2023)
- Courts strongly prefer to send clients to treatment partners (Andraka-Christou et al., 2024)

We need more information about the frequency, quality, and development of court-MOUD provider relationships

- Qualitative work suggests such collaborations are rare (Csete & Catania, 2013; Pivovarova et al., 2023)
- Statewide survey of Florida found that only 50% of PSC staff said their court's tx partner "encourages" buprenorphine or methadone for OUD (Andraka-Christou et al., 2022)

Study aim

(1) To explore the frequency of court-MOUD provider collaborations

(2) To identify factors that affect PSC staff willingness to collaborate with MOUD providers and the prevalence of such collaborations

Part of larger study identifying MOUD decision-making factors in PSCs

Barriers exist to court-MOUD provider collaboration formation

Court staff side:

- Stigma toward MOUD
- Stigma toward MOUD providers (e.g., “not trustworthy”)

MOUD providers:

- Concern that PSCs are punitive
- Concerns that PSCs mandate harmful practices (e.g., arbitrary tapering of MOUD)

Both:

- Ineffective communication
- Lack of understanding each others’ goals

(Andraka-Christou et al., 2024; Pivovarova et al., 2023, Csete et al., 2013)

Methods

Sequential exploratory mixed methods

Interviews

Recruitment: emails to court staff from FL OSCA, our team, and an expert in the field

Virtual focus groups (per court) or interviews from 2022-2023

1-2 hours in length

Topics: Collaboration benefits, formation, and preferences

Audio-recorded, transcribed

Iterative categorization (mixed deductive-inductive qualitative analysis approach) to identify themes

Surveys

- Recruitment: emails to staff from FL OSCA, experts in the field, and our team (using publicly available contact info)
- Data collection during early 2024 (online pilot testing during 2023)
- Online Qualtrics instrument developed based on interview data
    - Current collaborations
    - Experimental “vignette” approach:
        - **Within subjects’ randomization:**
            - *Willing to communicate regularly v. not willing*
            - *Frequent drug testing v. infrequent*
            - *Offers counselling v. does not*
        - **Across subjects’ randomization:**
            - *Methadone v. Buprenorphine*
            - *Accepts Medicaid v. does not accept Medicaid*

Results

Interview participants

6 focus groups and 8 individual interviews

- Total *n* = 54 staff
- From 33 PSCs (13 unique PSC teams)
- Most in Florida (93%), with remainder from 4 other states
- Adult drug courts - most common court type (39%)
- Court coordinators- most common role (39%)

Demographic data (only provided by 28 of 54 participants)

- Mostly female (n=19; 68%)
- Mostly non-Hispanic (n=25; 89%)
- Mostly white (n=22; 79%)
- Most had graduate degrees (n=16; 57%)

Themes: Collaborations develop in a variety of ways

- **Existing tx partner starts offering MOUD:** “I think we were already working with them and then they started offering MAT, so then we incorporated that into what we do.” – Focus group 1, court coordinator
- **Court encourages existing partner to offer MOUD:** “[W]e started saying, ‘Listen, we need to be able to provide this [MOUD]. You're our provider in this county.” – Interviewee 2, court coordinator
- **Court intentionally seeks MOUD provider as partner:** “[W]e wanted the grant of 150,000 a year, but it required us to be open to providing medically-assisted treatment programs … Our drug court team had to say, all right, well, who in [city name] has a doctor who will provide services to our folks who, 90% time will have no money to pay that doctor or the shots or whatever it is they need?” – Interviewee 4, Judge

Themes: Collaboration benefits clients

- **One-stop-shop:** “The benefit that I probably stated over and over is they still offer a gamut of services and one program. Otherwise, they would have to go to different providers.” – Interviewee 7, court coordinator
- **Faster access:**
  - “We can give you referrals faster. It's easier.” – Interviewee 6, court coordinator
  - “We're able to set appointments during court.” – Interviewee 2, court coordinator
- **Lower cost:**
  - “So, with using the provider that we contract with, we cover the cost of the MAT.” – Interviewee 3, court coordinator
  - “I have some state problem-solving court dollars that I can utilize for MAT services. Those are contract-based funding sources. So, I would have to be contracted with that provider to be able to pay them.” – Interviewee 2, court coordinator

Themes: Collaborations benefit PSC

- **Improved efficiency:** “I think that it allows us to provide that service efficiently and then I think that it also benefits clients and us by just knowing what type of substance they're using, if they're using it appropriately or appear to be using it in compliance.” – Interviewee 5, court coordinator
- **Especially if all treatment is offered in one place:** “: “If their treatment can occur comprehensively at one entity, the more streamlined it is for us to gather the information.” – Focus group 1, court coordinator

Themes: Prefer collaborating with MOUD providers who…

- **Communicate (patient info):** “So, ideally a good provider is somebody who has timely communication. So, letting us know when a participant misses an appointment, if they fail a uranalysis, if there is potential risk that the person is abusing their medication. So, timely communication is key.” – Interviewee 3, court coordinator
- **Communicate (educate the court):** “So if they're able to educate us and bring us up to speed with that area, I think that would be an excellent partnership.” –Focus group 4, court coordinator
- **Offer comprehensive services:** “Do they have the continuum care? That is huge for us.” (Interviewee 7, court coordinator)
- **Accept Medicaid:** “The ones who obviously will take Medicaid or the different state insurances that people might need in order to afford things like Vivitrol.” – Interviewee 6, court coordinator
- **Have experience with court system:** “[Partnering MOUD provider] was also the clinic that partnered with the state as far as that pilot program. So we already knew that there was a good reputation there. There was already some knowledge from the clinic as far as how accountability courts worked.” – Interviewee 3, court coordinator

Themes: Prefer collaborating with MOUD providers who…

- **Adjust treatment based on drug screens:** “I think another red flag might be, we've had in instances where the court becomes aware of a change of a patient's behavior, and MAT doesn't seem to adjust for that. So if the person is on a take-home methadone program, they begin using, and that protocol remains the same.” (Focus group 5, attorney)
- **Follow standards set by external agency:** “[W]e would want to make sure that they're licensed, that they're verified, that they would meet [Administration of Courts] standards for a community partner.”

Survey respondents

55 PSC staff from across 15 states

Respondent characteristics (not all provided):

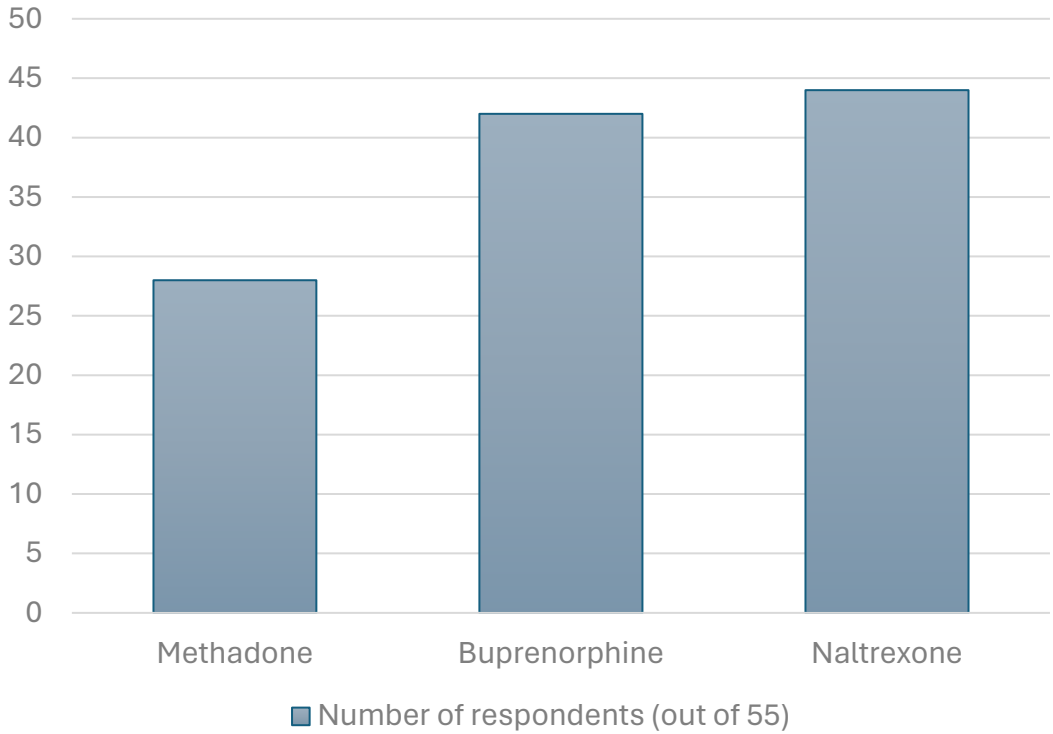
- Primarily from Florida (25%)
- Rural courts (53%); Urban courts (42%)
- Adult drug courts most common court type (46%)
- Court coordinators were the most common role (62%)

Survey findings (preliminary, descriptive)

Court has access to MOUD via collaborating provider(s)

MOUD	n	% respondents
Methadone	28	51
Buprenorphine	42	76
Naltrexone	44	80
Total courts in sample = 55		

Court has access to MOUD via collaborating provider(s)

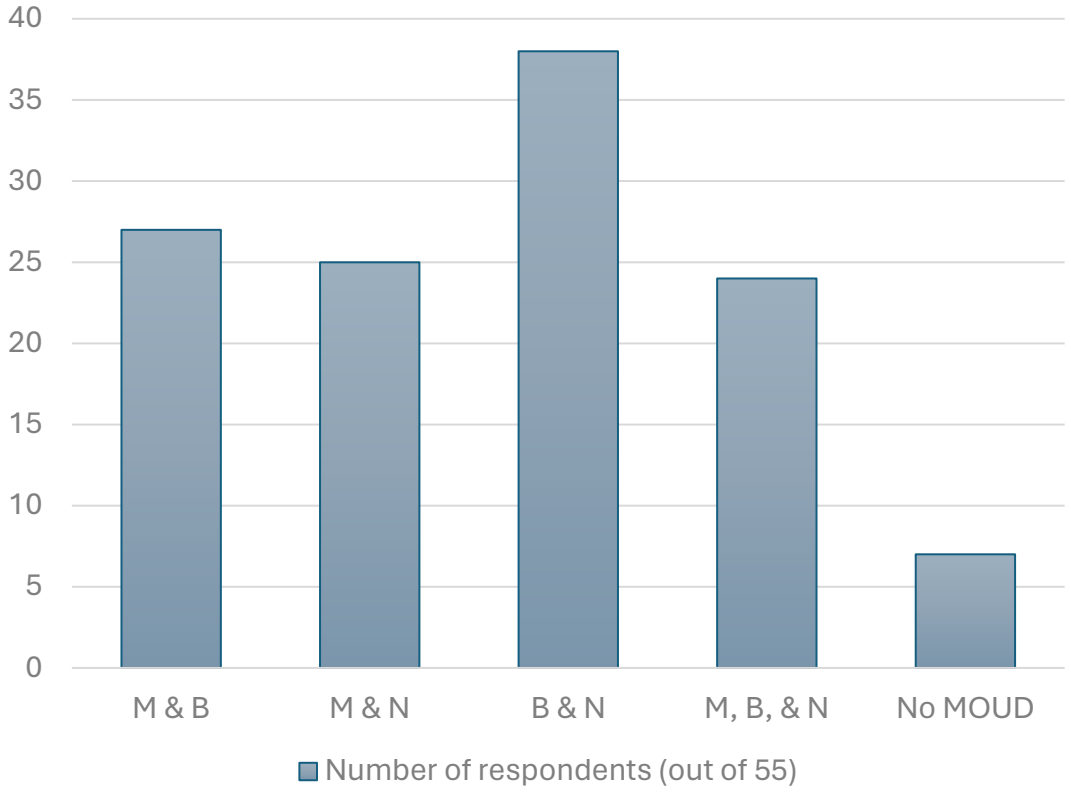


Survey findings (preliminary, descriptive)

Court has access to MOUD via collaborating provider(s)

MOUD	n	% respondents
Methadone & buprenorphine	27	49 %
Methadone & naltrexone	25	45 %
Buprenorphine & naltrexone	38	69 %
Methadone, buprenorphine, & naltrexone	24	44 %
No MOUD	7	13 %
Total courts in sample = 55		

Court has access to MOUD via collaborating provider(s)



Discussion

Key findings

- Court staff recognize the benefits of collaborating with MOUD providers
- Court staff want to collaborate with providers who:
  - Have indicators of quality of care (from courts' perspective)
  - Help the court do its job (i.e., monitor)
- Having no MOUD collaborators was rare (13%)
- But fewer than half (44%) had **access to all three MOUDs** via collaborators; and only half (51%) collaborated with a **methadone** provider

Interventions are needed to increase court-MOUD collaborations

- Very few interventions focused on court-MOUD collaborations have been developed and tested
  - Opioid Intervention Courts (O'Grady et al., 2024)
  - Clinical Organization and Legal Agency Alliance Building (Pivovarova et al., 2024)
- Draw from fields like implementation science and organizational psychology

Limitations

- Generalizability?
- Court staff who opted into the study may be more likely to have positive attitudes/policies toward MOUD than “typical” staff
- Lack of provider perspectives
- Lack of court client perspectives

Next steps

Analyze experimental survey data

Integrate qualitative and quantitative results

- Do quantitative results **confirm** our qualitative findings?
- Provide **context** for quantitative results from qualitative results

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Questions? Comments?

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HARVARD MEDICAL SCHOOL
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The Recovery Capital Model in a Drug Court Setting: Results from Pilot and Feasibility Studies

Emily A. Hennessy (Presenter)
David Best, Leeds Trinity University, Leeds, UK

June 2024

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Acknowledgements

This study was funded under the JCOIN cooperative agreement (MPI Taxman and Rudes) funded through the National Institute on Drug Abuse (NIDA) by the National Institutes of Health (NIH). The author(s) gratefully acknowledge the collaborative contributions of NIDA and support from the U2CDA050097 award. The contents of this article are solely the responsibility of the author(s) and do not necessarily represent the official views of NIDA, NIH, or participating sites.

Overview of Presentation

1. **Background**
2. **Methods**
3. **Results: Feasibility & Pilot studies**
4. **Summary**

Background

Recovery and Justice-Involvement: Building Recovery Capital

- Recovery capital – strengths-based, ecological model of resources to use for recovery and examining recovery progress
- Growth in recovery capital often initiated through community programs to create supportive scaffolding
    - Individuals in the criminal legal system often experience barriers to community programming
- Opportunity to assess growth in a variety of domains over time: REC-CAP – a recovery-capital oriented system of measurement, planning, and engagement

REC-CAP Assessment

1. Quality of Life & Satisfaction
2. Barriers to Recovery
3. Service Involvement & Needs
4. Recovery Strengths
5. Assessment of Recovery Capital (ARC)
    - Personal - Coping & Life Functioning, Physical Health, Psychological Health, Recovery Experience, Risk Taking
    - Social - Citizenship, Housing & Safety, Meaningful Activities, Social Support, Substance Use & Sobriety
6. Recovery Group Participation
7. Outside Support
8. Commitment to Sobriety
9. Goals (open-ended)

REC-CAP Summary (in REDCap)

Recovery Capital Score Summary

Overall Recovery Capital: -1.23

This is a measure of your overall level of positive recovery capital (resources to use in your journey) and barriers to recovery capital (things getting in the way of your journey) on a scale of -100 to 100.

Resources to use in your journey	61.27
Things getting in the way of your journey	-62.5

Social Recovery Capital Score: 72%

Moderate social recovery capital

Other Support Score: 42.86%

This indicates you have low other support

- Moderate emotional support from others
- Moderate help from others
- Moderate resources from others
- Moderate advice from others

Community Recovery Capital Score: 64.29%

Moderate community recovery capital

Personal Recovery Capital Score: 60%

Low personal recovery capital

Quality of Life and Satisfaction Score: 63.8%

Based on the results of previous studies, your score of 63.8 would be classified as low.

Here is an overview of your scores in this section and average scores from other people in long-term recovery for comparison.

	Overall Score: Quality of Life and Satisfaction	*Physical Health*	*Support Satisfaction*	*Housing Satisfaction*	*Psychological Health*	*Quality of Life*
Your Scores	**63.8**	15	16	8	14.8	10
Average Scores	**78.20**	15.43	16.09	16.29	15.87	14.52

Recovery Planning Map

Recovery Strength Subdomains

Personal Capital

- *Global Health, Psychological*
- *Global Health, Physical*
- *Risk Taking*

Aims

1. To understand needs and barriers to improve the REC-CAP implementation process with drug treatment courts
2. To examine client outcomes

Methods

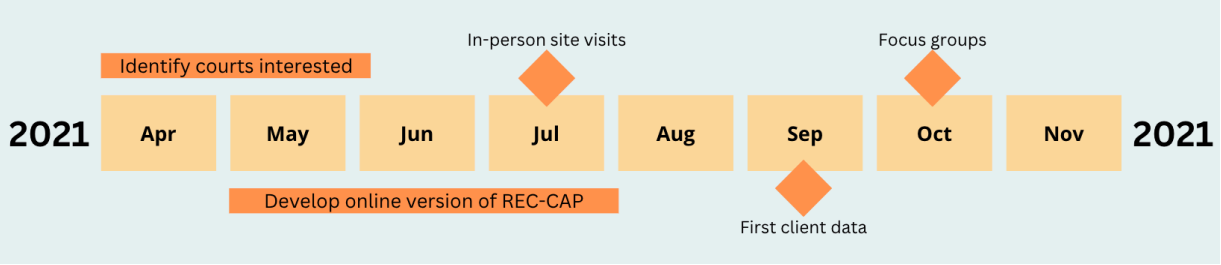
Partnership with two drug treatment courts

- David Best identified key stakeholders in MA and Rhode Island courts
  - Phased program – 4 phases, approximately 1 year long for entire program
  - Client censuses ranging from 10-15/year
  - One probation officer assigned to the program

Feasibility and Pilot Studies

Phase I

- Virtual meetings, week-long site visit and training, court session observation, ongoing technical assistance
- Adapted REC-CAP
- Staff completed adapted Texas Christian University Work Experience and Workshop Evaluation Surveys and participated in focus groups
- Focus group data analyzed using the qualitative description approach, followed by member checking



Phase II

- Information sheet to share data
  - Existing clients and new clients
- Original system + node-link mapping to create goals
- Historic “control” cohort from administrative data*

Results: Feasibility and Pilot Studies

Feasibility: 27 clients completed the REC-CAP

- Staff felt REC-CAP provided important information about clients' strengths and barriers
- Helped staff guide clients in creating action plans – adding to staffing forms for reporting to the Judge
- Staff indicated their use of REC-CAP improved their work experience and could improve some operating procedures and structures

"Some of these conversations are very difficult for these people because they've never had these questions asked in this way" - Court 1

"Seeing [clients] reflect on some of their history was very impactful" and helped to create a structured dialogue which allowed them to more personal with clients - Court 1

Using REC-CAP at a first client meeting might lead them to "paint a rosy picture" of their experiences resulting in inaccurate baseline scores

- Court 2

Pilot: Client Characteristics

13 clients have completed at least one REC-CAP; 11 have completed at least two

- 92% male
- 62% white, 23% black; 23% Hispanic
- Mean age = 43 years (range 35-56 years)

Pilot REC-CAP Outcomes

Court 1

- 9 client completions, all agreed to share data with research team
- Wide range of recovery capital during court entry (range = 7-71)
    - Represents combination of both high negative recovery capital (**many barriers**) and high positive recovery capital (**many supports**)
- Negative recovery capital decreased for most clients after their initial assessment
    - Resulted in increased overall recovery capital for the later phases (range = 36-83)

Court 2

- 5 client completions, 4 agreed to share data
- Lower recovery capital during earlier phases (range = 41-60)
    - Represents lower positive recovery capital (fewer resources) rather than high negative recovery capital
- Recovery capital scores increased for the later phases (range = 86-96)

Limitations

- Low court census
- Transition/turnover among court staff
- Challenges related to who administers initial REC-CAP and follow-up REC-CAP

Summary

Massachusetts General Hospital
Founding Member, Mass General Brigham

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Thank you!

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RECOVERY RESEARCH INSTITUTE

Minneapolis Addiction Recovery Initiative (MARI) Safe Station: A Year-End Process Evaluation

Julie M. Krupa, Nathan Koranda, Jeremiah Fairbanks, Sheila Specker, Jaymie Mark, & Christine Klein

NIH HEAL Initiative and Helping to End Addiction Long-term are service marks of the U.S. Department of Health and Human Services.

Acknowledgments

- Grant No. 15PBJA-21-GG-04594-COAP awarded by the Bureau of Justice Assistance

- Partners:
  - Twin Cities Recovery Project, Minneapolis Fire Department, YourPath Health, Cordata Healthcare, Koranda O'Tool Paramedics, Inc. (KOPI)

Introduction

- Substance use disorder (SUD) and the criminal legal system
  - 1 million drug/narcotic offenses (2022)
  - Not designed to address SUD

- Role of diversion/deflection
  - Provide services before, or outside of, point of arrest
  - Community-based interventions
  - Program outcomes

- MARI Safe Station seeks to reduce substance use-related harm

Minneapolis Overdose Statistics

58.8% increase from 2019 to 2020

44.2% increase from 2020 to 2021

Opioid Overdose Deaths, 2010-2022

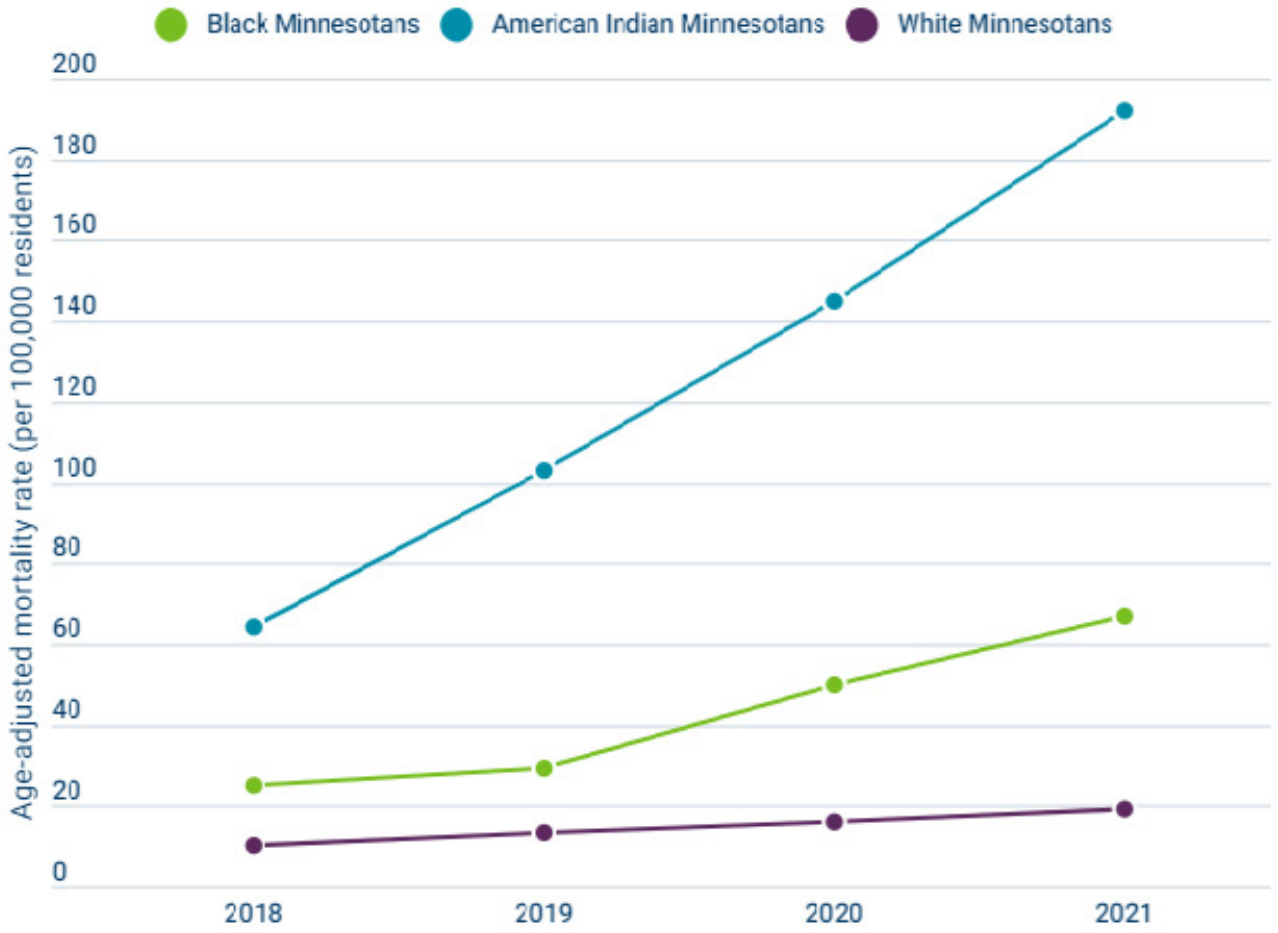
Source: Minnesota death certificates. Received from Minnesota Department of Health. Drug Overdose Dashboard: https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html

Minneapolis Overdose Statistics

In 2021, **American Indian Minnesotans were 10x** as likely to die from a drug overdose than white Minnesotans

Black Minnesotans were more than 3x as likely to die from drug overdose than white Minnesotans

Opioid Overdose Death Rates by Race



Source: Minnesota death certificates. Received from Minnesota Department of Health. Drug Overdose Dashboard: https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html

MARI Safe Station

- Self-referral program for individuals with SUD
- Recovery connection between fire department and service provider
- Educate fire personnel on addiction
- Connect individuals with SUD to peer recovery coaching
  - Focus on underserved populations

- Launched in April 2023 in Minneapolis, MN
  - One fire station

Current Study

Describe the program services, activities, policies, and procedures to inform implementation

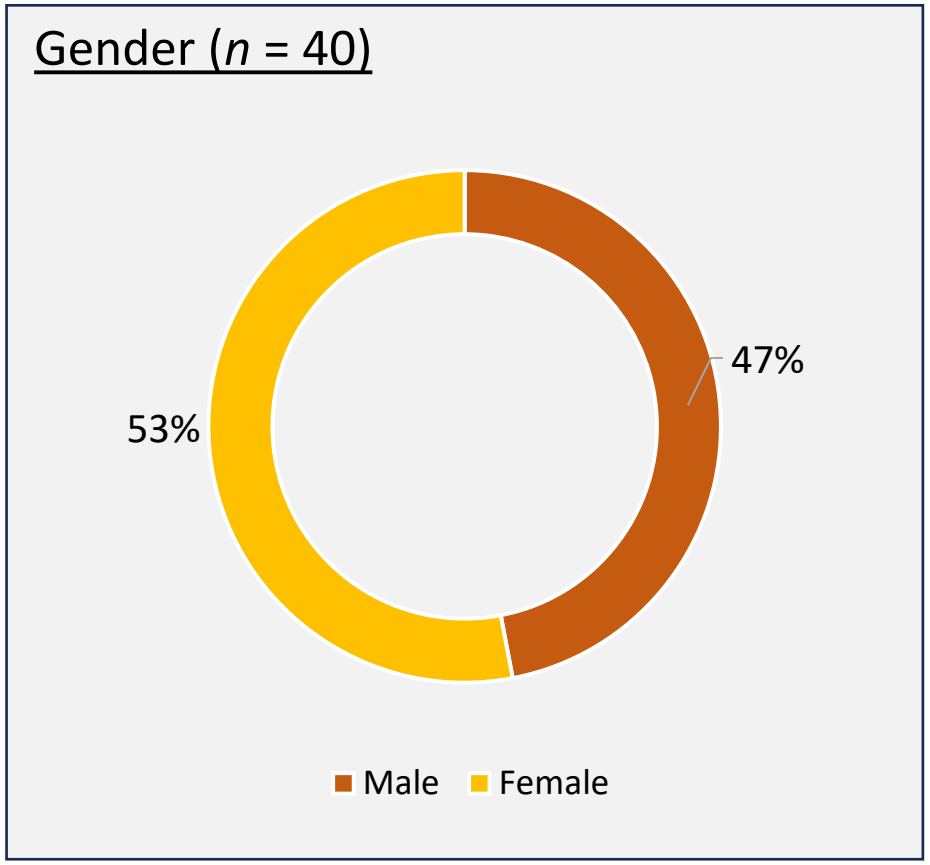
April 2023 – December 2023

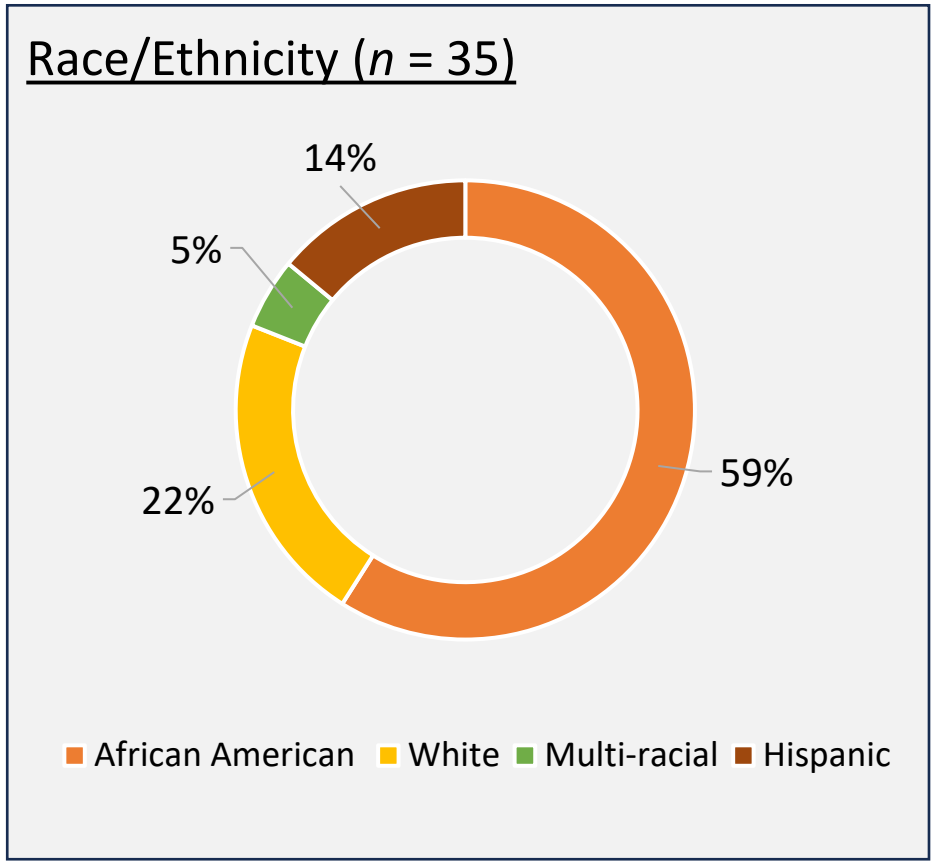
Methodology:

- Document review of proposal, policies, operational documents
- Observations at stakeholder meetings (bi-weekly – monthly)
- Participant data
  - Descriptive statistics
  - Data completeness
  - Behavioral health service cascade
- Outreach activities

Participant Demographics

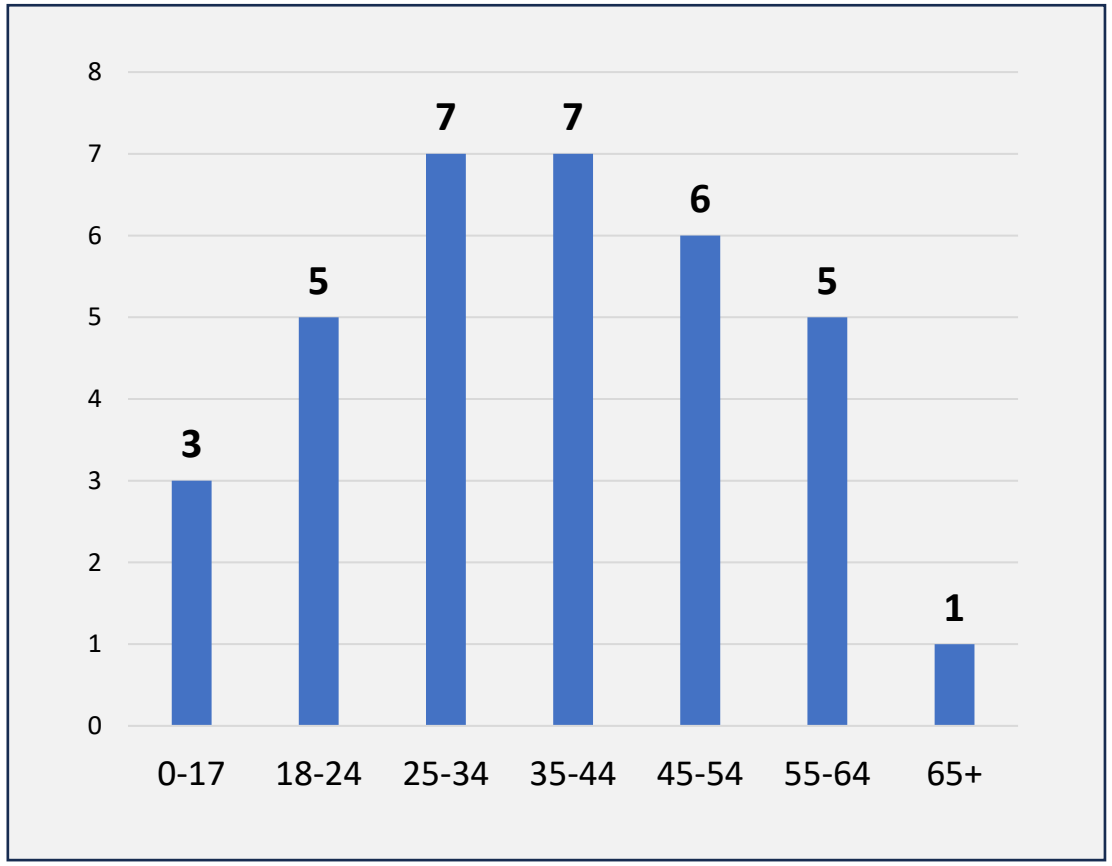
Total enrollments = 40



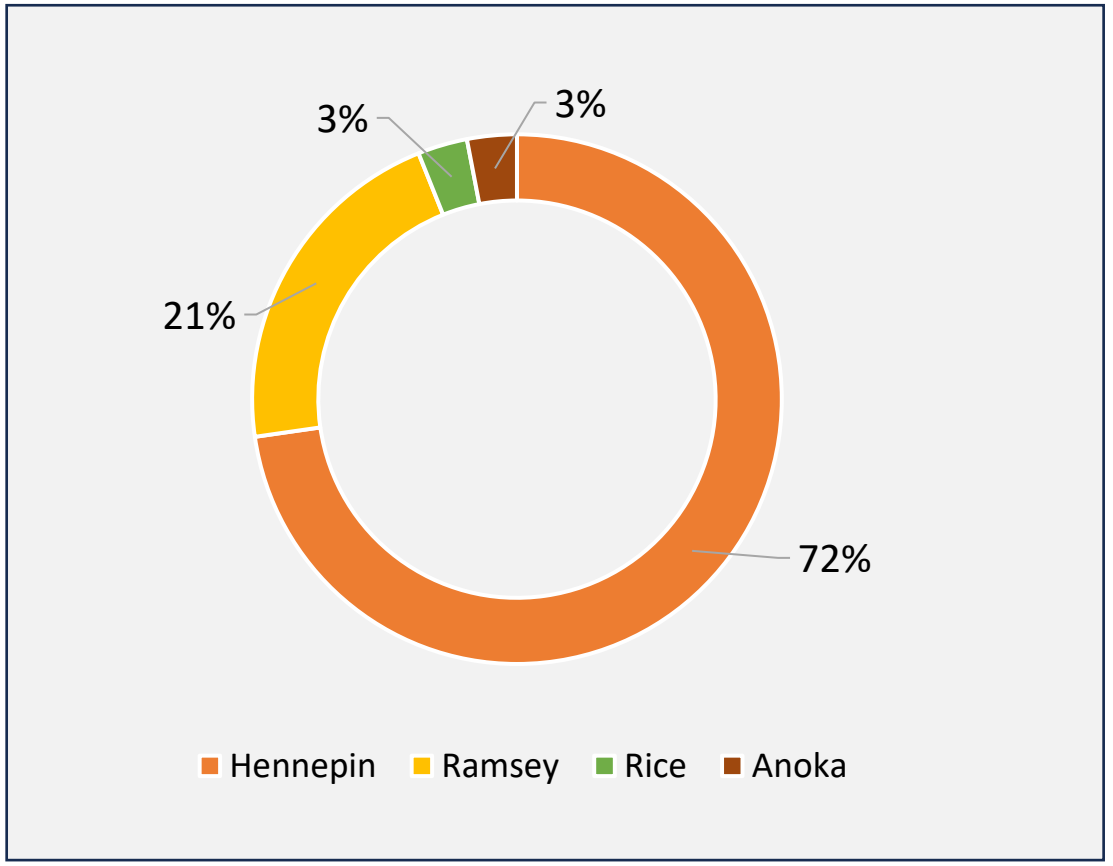


Participant Demographics

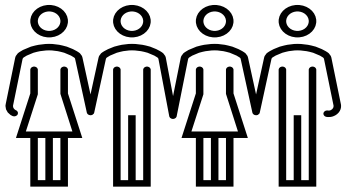
Age (*n* = 34)



County (*n* = 29)



Participant Needs



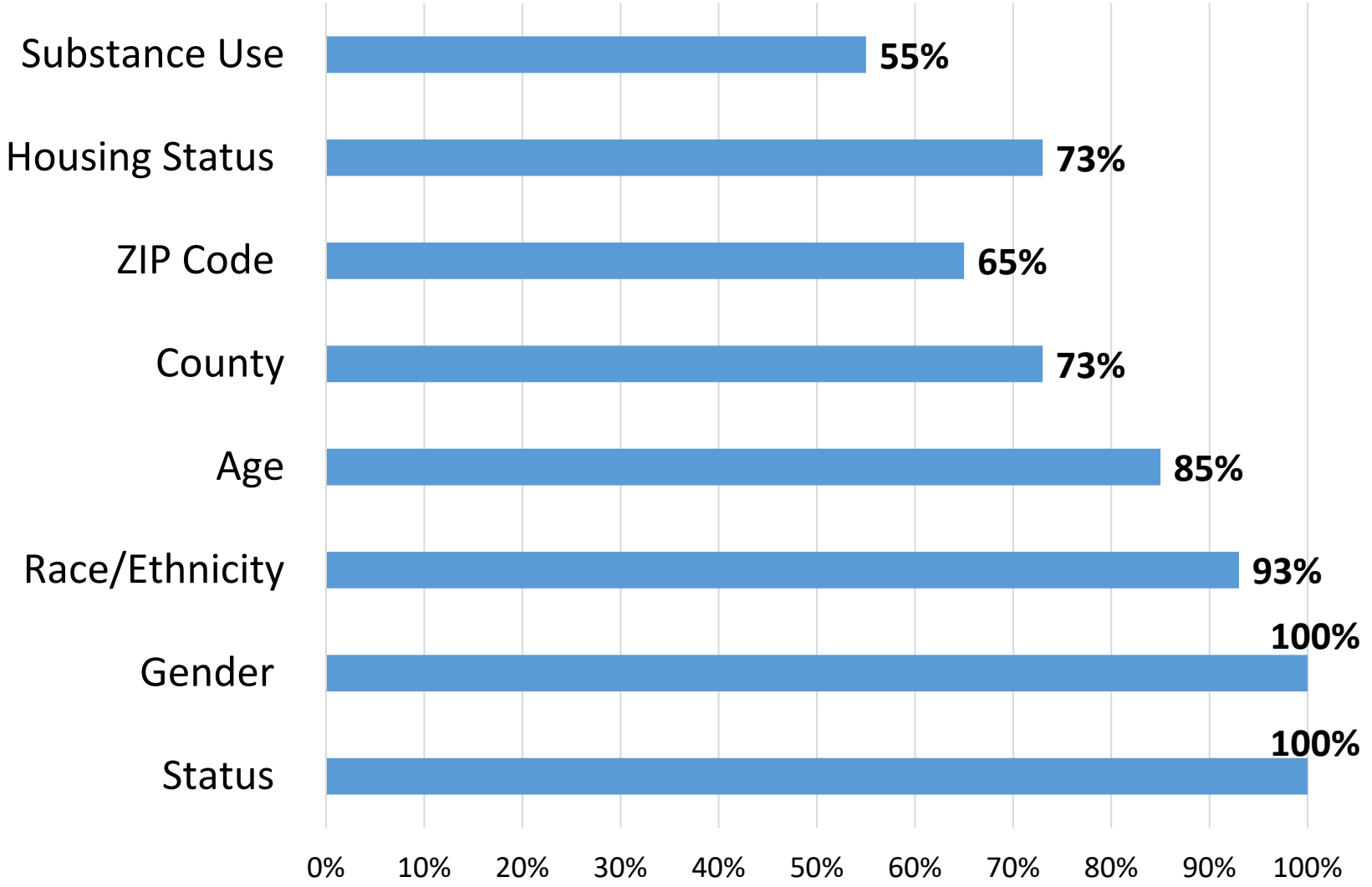
22 participants report substance use

Ranged: **1-6** Substances

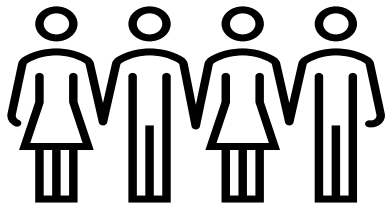
Average: **2** Substances (SD =1.29)

Alcohol	9 (41%)
Cocaine	2 (9%)
Crack-Cocaine	5 (23%)
Fentanyl	2 (9%)
Heroin	2 (9%)
Marijuana/THC	4 (18%)
Methamphetamine	4 (18%)
Methadone	1 (5%)
Opioids	11 (50%)
Other Drugs	1 (5%)
Suboxone	2 (9%)

Data Completeness

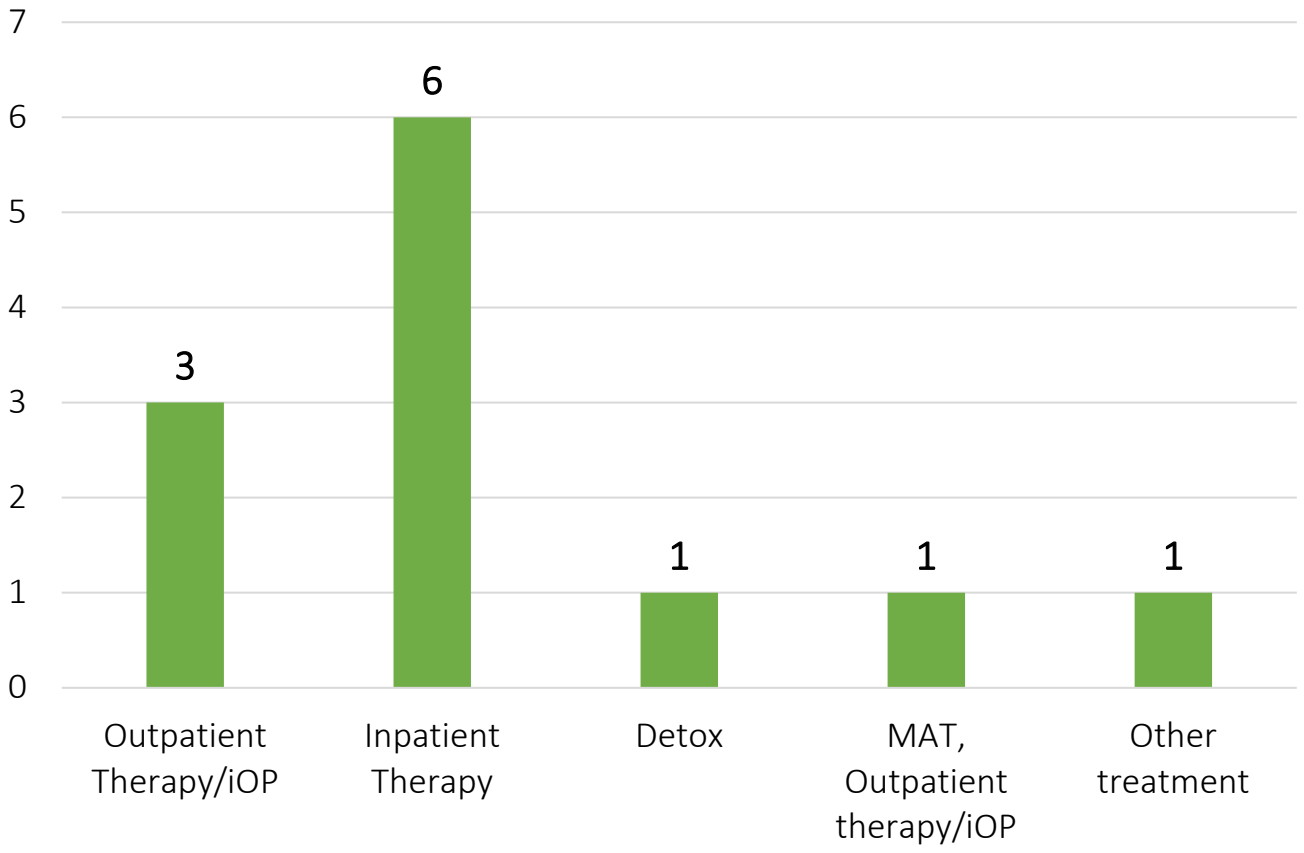


Care Coordination



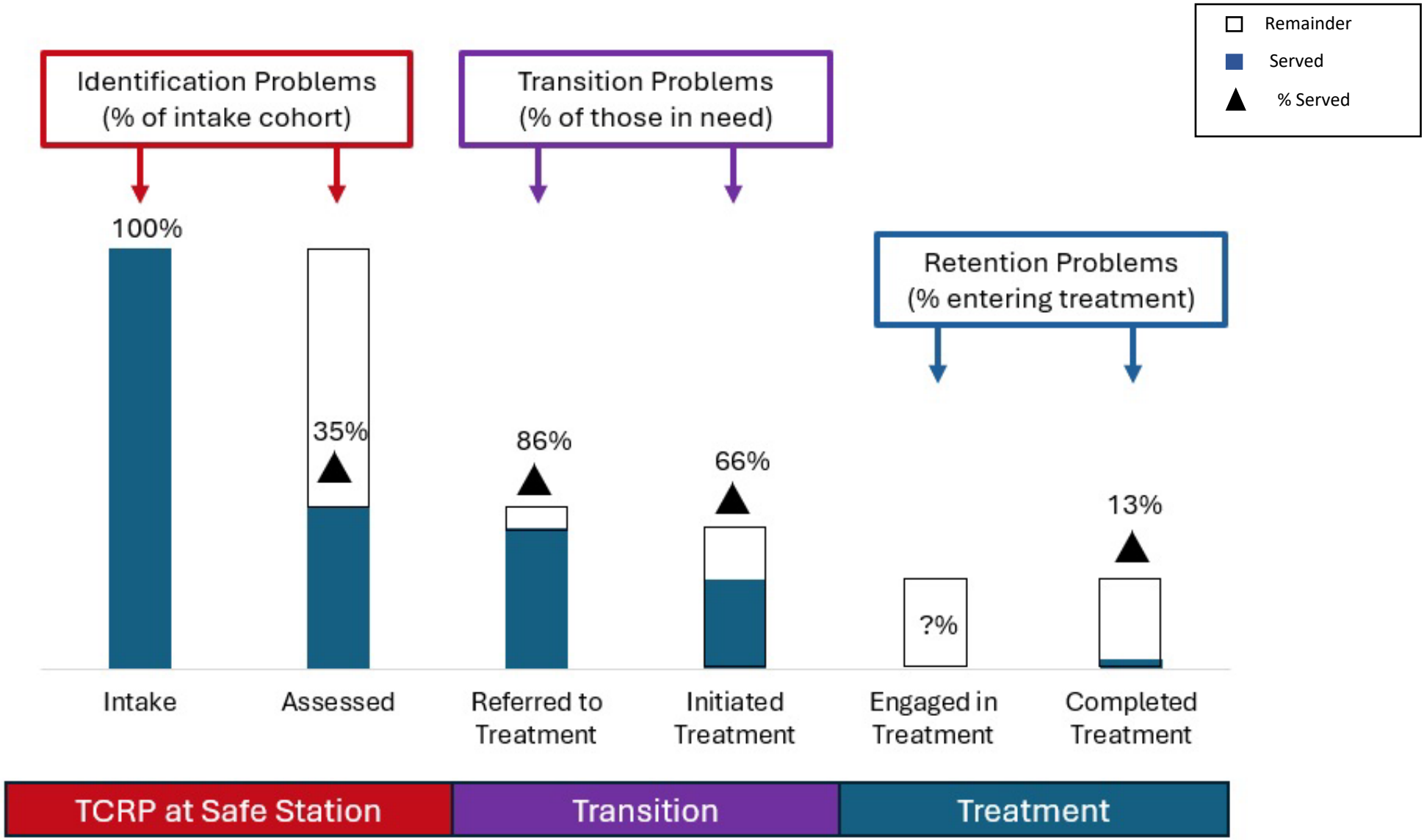
30% of participants were connected to treatment

That's **12** people



Note: iOP = intensive outpatient therapy

Behavioral Health Services Cascade



Discussion

- Provide timely feedback on implementation

- Recommendations regarding implementation:
  - Data entry:
    - Standardized procedures for data entry
    - Collect information on recovery capital & quality of life
  - Program operations:
    - Program manager
    - Finalize all policies, procedures, and workflows

- Importance of process evaluations within criminal legal/deflection settings

Implementation Adjustments

Project manager for service provider

Increase in recorded outreach activities

Increase in intakes

Linkage of assessment information to intake information

THE UNIVERSITY OF CHICAGO
CROWN FAMILY SCHOOL OF SOCIAL WORK, POLICY, AND PRACTICE
Advancing a More Just and Humane Society

State Medicaid Initiatives Targeting Substance Use Disorder in Criminal Legal Settings, 2021

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Christina Andrews PhD the Department of Health Services Policy and Management at Arnold School of Public Health, University of South Carolina, Columbia
Amanda J. Abraham PhD, the Department of Public Administration and Policy in the School of Public and International Affairs, University of Georgia
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Colleen M. Grogan PhD, Crown Family School of Social Work, Policy, and Practice

Why are Medicaid Initiatives Important for Criminal Legal Involved Populations Reentry?

- Over 60% of the prison and jail populations has a substance use problem
- More than 600,000 individuals are released from state and federal prisons. Another 9 million cycle through local jails.
- Lack of health care upon release (80 percent reentry without health insurance)
- The likelihood of visiting an SUD treatment outpatient facility within the first 30 days of release increased after implementation of pre-release Medicaid enrollment assistance
- Lack of continuity of care, treatment, and health services initiated during incarceration frequently stops upon release.
  - Higher mortality rates
  - Drug overdose

What Do We Currently Know?

- Medicaid Inmate Exclusion Act of 1965
- Medicaid Inmate exclusion waiver
- Some states have submitted proposals to waive the Medicaid inmate exclusion provision (4 approved in 2023 and 14 pending)
- State Medicaid programs can create MOUD programs from sources other than federal funds (state Medicaid funds, or funding from grants focused on SUD treatment for legal system-involved populations)

Current Investigation

To capture what initiatives states are involved in to assist criminal legal-involved populations with Medicaid upon release.

Methods

Our research team conducted an Internet-based survey of Medicaid programs in the 50 states and the District of Columbia. Each state Medicaid director was emailed a packet that contained a study description, an invitation to participate, and a request to send the survey link to the most knowledgeable staff person or persons. Follow-up emails and phone calls were made to fill in missing data. Forty-six Medicaid programs responded for a survey response rate of 90%.

	Prisons	Jails	Community Corrections
Medication reentry treatment for individuals leaving...	☐	☐	☐
Medication treatment for opioid use disorder for individuals residing in...	☐	☐	☐
Enroll justice-involved persons in Medicaid prior to release (as part of discharge planning) in...	☐	☐	☐
Develop Medicaid-covered care coordination plan (including SUD follow-up treatment plan) as part of discharge planning for justice-involved persons in...	☐	☐	☐
Assign Medicaid application counselors for onsite enrollment at...	☐	☐	☐
Enroll justice-involved persons in Medicaid Health Homes with emphasis on SUD treatment in...	☐	☐	☐
Assign justice-involved persons to a Medicaid Managed Care Plan prior to release from...	☐	☐	☐
Suspend / Reclassify Medicaid enrollees upon entry to enable Medicaid coverage of inpatient expenses and to reactivate coverage upon release from...	☐	☐	☐
Other Medicaid-funded programs for justice-involved populations (please specify): _____	☐	☐	☐

Table 1: Number of U.S. States Adopting Specific Medicaid Covered Criminal-Legal Initiative for Persons with SUD as of 2021

Type of Initiative	Total Number of States Adopting in at Least One Setting	Total Number of States Adopting in Prisons	Total Number of States Adopting in Jails	Total Number of States Adopting in Community Corrections
Any of the 2 Initiatives Related to MOUD* Treatment	**17**	**14**	**14**	**9**
MOUD Pre-release Treatment	16	14	12	8
MOUD Treatment Residing in…	14	12	10	7
Any of the 3 Initiatives Related to Medicaid Enrollment	**17**	**16**	**15**	**11**
Suspend/Reclassify	14	12	13	8
Pre-release Enrollment	13	12	10	5
Onsite Application Counselor	8	7	6	4
Any of the 3 Initiatives Related to SUD Care Coordination**	**11**	**10**	**8**	**4**
Discharge SUD Planning	9	8	5	4
Assign to MCO***	6	6	5	1
Assign to SUD Health Home	2	2	2	2

Notes: *MOUD = Medication for Opioid Use Disorder; ** SUD = Substance Use Disorder; ***MCO = Managed Care Organization.

Results

- Only a handful of states adopted SUD care coordination models for criminal legal involved populations.
- All states (and DC) with SUD Medicaid initiatives for criminal legal involved populations are Medicaid expansion states
- Initiatives were most commonly adopted in prison settings, followed by jails, and then community corrections.
- States most commonly supported the following initiatives:
  - first, provision of MOUD just prior to release (16 states in at least one setting) or during residence in criminal legal settings (14 states in at least one setting);
  - Second, facilitation of Medicaid enrollment through suspension rather than termination of Medicaid enrollment upon entry to a criminal legal setting (14 states in at least one setting) or providing pre-release enrollment into Medicaid (13 states in at least one setting).

Implications

- Medicaid coverage for criminal legal involved populations prior to release (just one of the eight initiatives reported here) is associated with higher health service usage among the population.
- Coordination between these two disparate systems also increases the possibility for continuity of care, and there is some evidence that Medicaid coverage reduces recidivism.
- Given these public health benefits, the lack of state adoption of Medicaid initiatives across criminal legal settings is concerning, and further study of state initiatives targeting this population are crucial.

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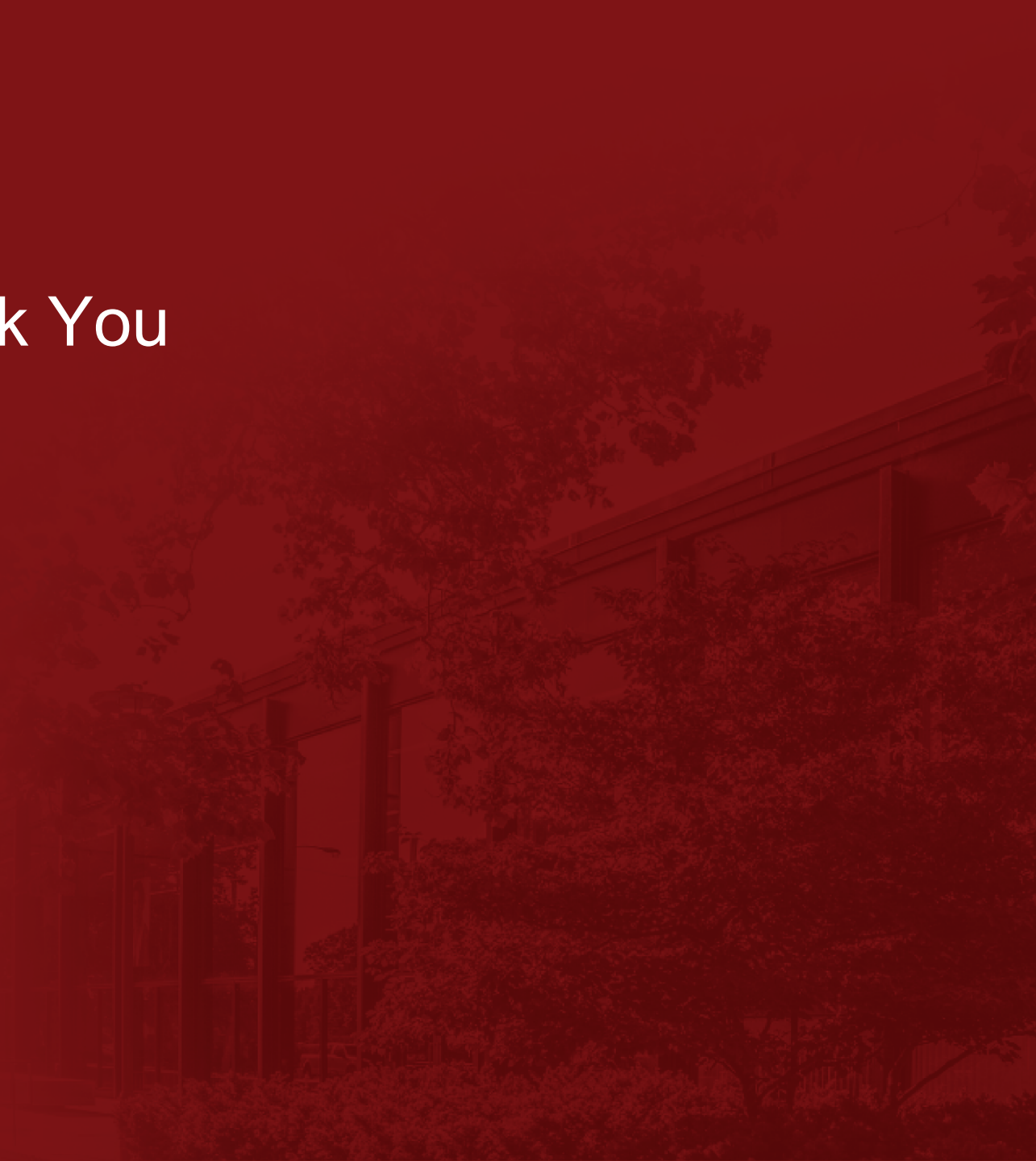
Thank You



Thank you!

The next sessions will begin at 10:30.

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