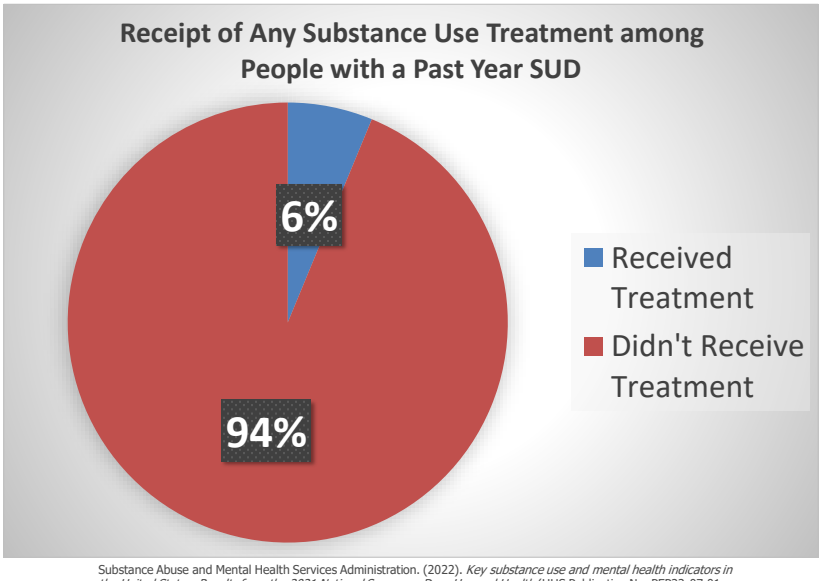
Harm Reduction and Substance Use Treatment

June 24, 2024

1

Receipt of Any Substance Use Treatment among People with a Past Year SUD



Substance Abuse and Mental Health Services Administration. (2022). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report

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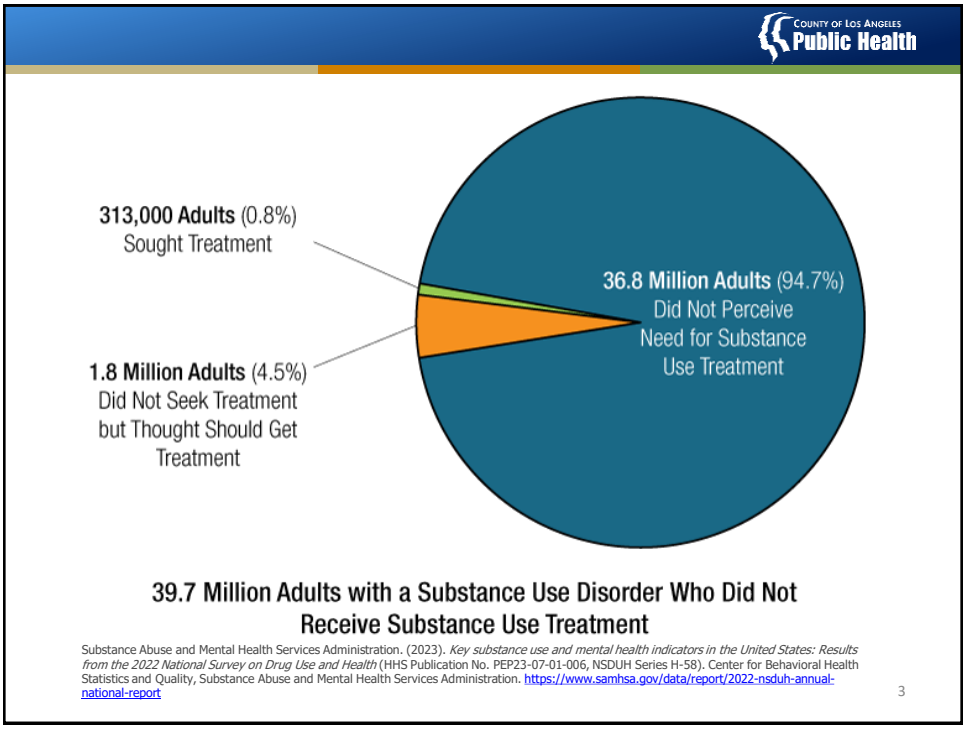
County of Los Angeles Public Health
313,000 Adults (0.8%)
Sought Treatment
1.8 Million Adults (4.5%)
Did Not Seek Treatment but Thought Should Get Treatment
36.8 Million Adults (94.7%)
Did Not Perceive Need for Substance Use Treatment
39.7 Million Adults with a Substance Use Disorder Who Did Not Receive Substance Use Treatment
Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report
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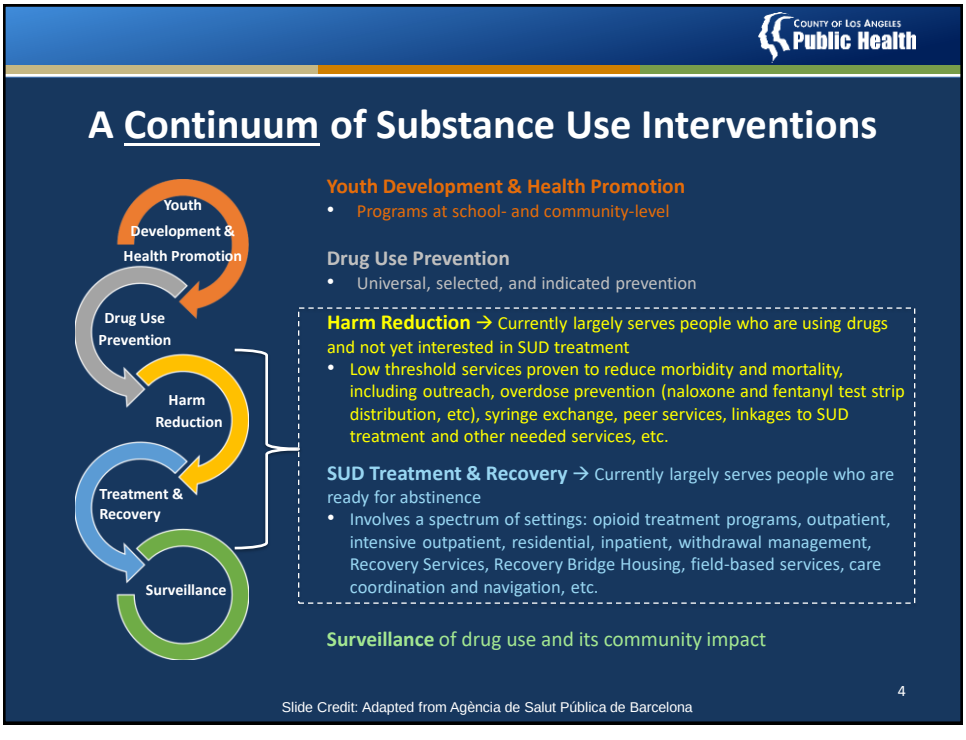
County of Los Angeles Public Health
A Continuum of Substance Use Interventions
Youth Development & Health Promotion
Drug Use Prevention
Harm Reduction
Treatment & Recovery
Surveillance
Youth Development & Health Promotion
• Programs at school- and community-level
Drug Use Prevention
• Universal, selected, and indicated prevention
Harm Reduction → Currently largely serves people who are using drugs and not yet interested in SUD treatment
• Low threshold services proven to reduce morbidity and mortality, including outreach, overdose prevention (naloxone and fentanyl test strip distribution, etc), syringe exchange, peer services, linkages to SUD treatment and other needed services, etc.
SUD Treatment & Recovery → Currently largely serves people who are ready for abstinence
• Involves a spectrum of settings: opioid treatment programs, outpatient, intensive outpatient, residential, inpatient, withdrawal management, Recovery Services, Recovery Bridge Housing, field-based services, care coordination and navigation, etc.
Surveillance of drug use and its community impact
4
Slide Credit: Adapted from Agència de Salut Pública de Barcelona

4

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Harm Reduction Services

Harm Reduction Supplies Access

Syringe Exchange & Disposal

Naloxone and Test Strips

Medications for Addiction Treatment

Drop-In Centers

Linkage to Ho using Services

Pharmacy Access

Referrals for Needed Services

- GOAL → Meeting people where they are, both figuratively and literally
  - While brick and mortar locations are needed, mobile services that go out to people who are unlikely to go to brick and mortar locations are also needed

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Stages of Change

Precontemplation → Contemplation → Preparation → Action → Recovery Maintenance

Harm reduction programs

- Initial engagement
- Harm reduction supplies
- Skills development to reduce risks
- Linkage to health care and social services
- Outreach: street teams
- Low-threshold medications for addiction treatment

Recovery is Possible!

- Of those in the U.S. with a history of substance use disorder, 75% are in recovery

Harm Reduction is Essential

- Harm reduction is practiced all across health care settings and services
- In the context of the worst overdose crisis in history, harm reduction reduces mortality risks, increases treatment access and access to other health and social services, and supports recovery

Treatment programs

- Biopsychosocial treatment for substance use (including medication services, individual and group therapy)
- Linkage to other medical and social services
- Crisis care

Aligning Services with Readiness is Essential

- Addiction is chronic and recurrent, and not all people are at the same stage of readiness to change.
- Only focusing on individuals in some stages of change as opposed to ALL stages of change limits service reach and impact → We need the widest service net possible

6

Slide Credit: Adapted from Agència de Salut Pública de Barcelona

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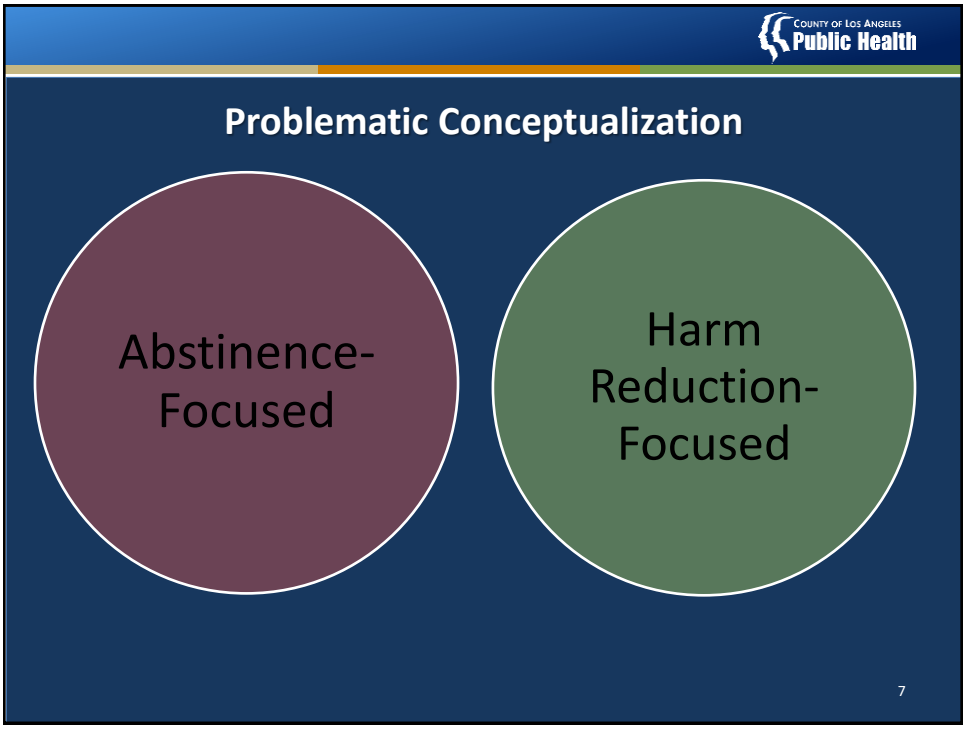
County of Los Angeles Public Health
Problematic Conceptualization
Abstinence-Focused
Harm Reduction-Focused
7

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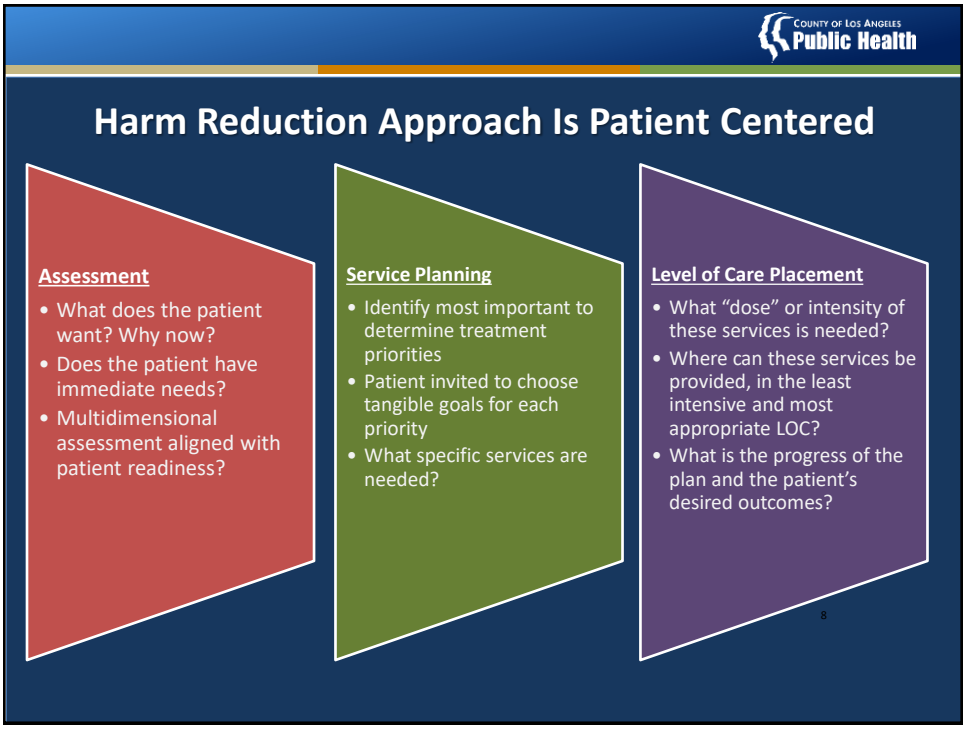
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Harm Reduction Approach Is Patient Centered
Assessment
• What does the patient want? Why now?
• Does the patient have immediate needs?
• Multidimensional assessment aligned with patient readiness?
Service Planning
• Identify most important to determine treatment priorities
• Patient invited to choose tangible goals for each priority
• What specific services are needed?
Level of Care Placement
• What "dose" or intensity of these services is needed?
• Where can these services be provided, in the least intensive and most appropriate LOC?
• What is the progress of the plan and the patient's desired outcomes?
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SAMHSA ADVISORY

Substance Abuse and Mental Health Services Administration

DECEMBER 2023

ADVISORY: LOW BARRIER MODELS OF CARE FOR SUBSTANCE USE DISORDERS

Principles and Components of Low Barrier Models of Care

http://store.samhsa.gov/product/advisory-low-barrier-models-care-substance-use-disorders/pep23-02-00-005

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SAMHSA Principles of Low Barrier Models of Care

- Person-centered care
- Harm reduction and meeting the person where they are
- Flexibility in service provision
- Provision of comprehensive services
- Culturally responsive and inclusive care
- Recognize the impact of trauma

http://store.samhsa.gov/product/advisory-low-barrier-models-care-substance-use-disorders/pep23-02-00-005

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SAMHSA Components of Low Barrier Models of Care

- Available and accessible
- Flexible
- Responsive to patient needs
- Collaborative with community based organizations
- Engaged in learning and quality improvement

http://store.samhsa.gov/product/advisory-low-barrier-models-care-substance-use-disorders/pep23-02-00-005

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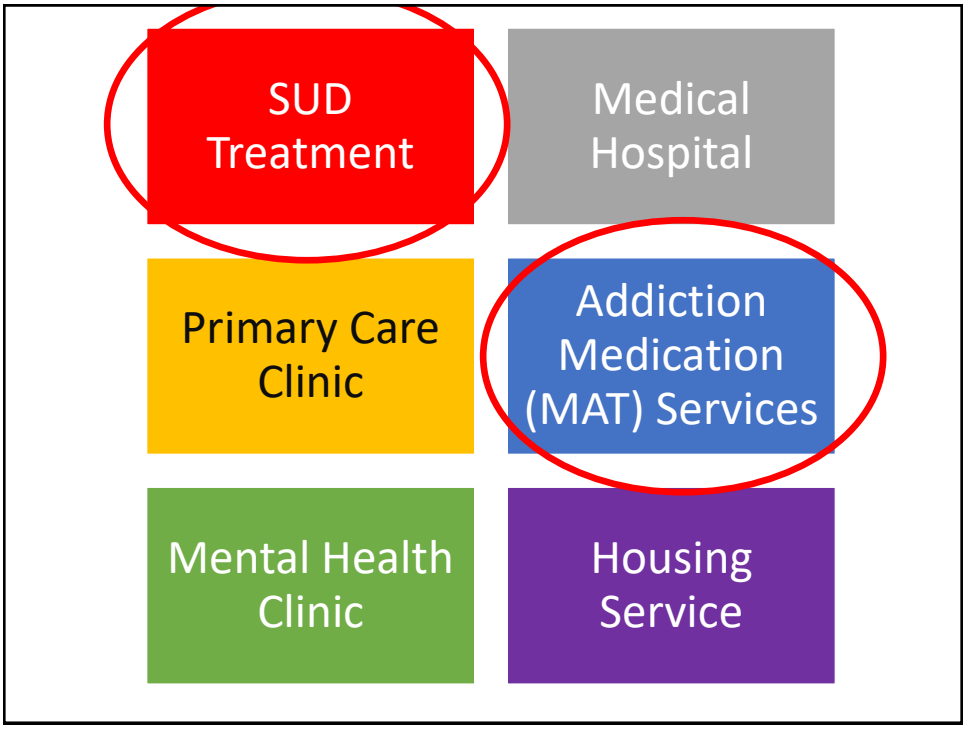

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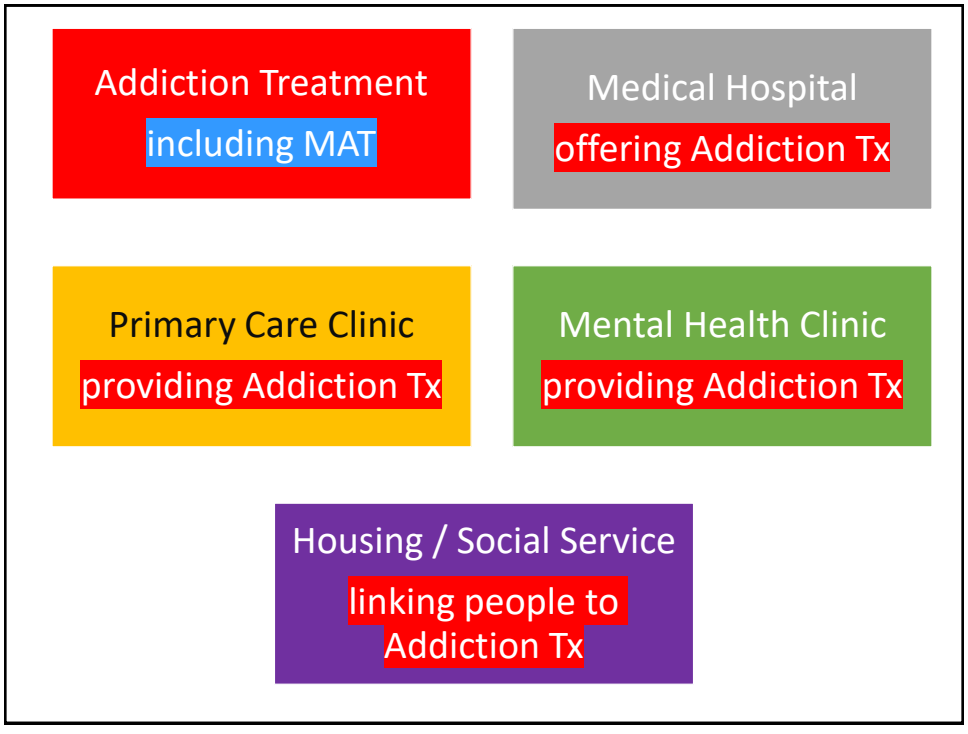

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Barrier Level	Requirements and Approach [35,36,37,38,39,40]	Requirements and Approach (medication only)	Availability [41,42,43,44,45]
Low Barrier Care	• No service engagement conditions or preconditions. • Visit frequency based on clinical stability. • Ongoing substance use does not automatically result in treatment discontinuation. • Client's individual recovery goals prioritized. • Reduction in substance use and engaging in less risky substance use as acceptable goals.	• Medication at first visit. • Home initiation permitted. • Various medication formulations offered. • Individualized medication dosage. • Rapid re-initiation of medication after short-term disruption.	• Treatment available in non-specialty SUD settings. • Other clinical and non-clinical services incorporated into SUD treatment settings. • Same-day treatment availability, no appointment required. • Extended hours of operation. • Telehealth and in-person services available.
High Barrier Care	• Requirements for current or previous engagement with specific services. • Visit frequency based on a rigid, pre-determined schedule. • Treatment discontinuation due to ongoing substance abuse. • Treatment goals imposed. • Abstinence as the primary goal for all clients, all the time.	• Two or more visits before medication. • Clinic initiation required. • Limited medication formulation options. • Uniform maximum dosage. • Induction required to restart medication.	• Treatment only available at specialty SUD programs. • Non-integrated or limited-service offerings. • One or more day wait to initiate treatment, appointment required. • Traditional hours of operation. • Services only available in-person.

Jakubowski, A., Fox, A. (2020). Defining Low-threshold Buprenorphine Treatment. J Addict Med. 2020 Mar/Apr;14(2):95-98. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC7075734

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ASAM Clinical Considerations for Engagement and Retention of Non-Abstinent Patients in Treatment

(Draft)

Core dilemma: patients are denied admission and/or discharged from substance use treatment for exhibiting symptoms of the disease for which they need treatment

American Society of Addiction Medicine. Clinical Considerations for Engagement and Retention of Non-Abstinent Patients in Treatment. May 2024 (Draft). http://bit.ly/EngagementASAM

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ASAM Clinical Considerations for Engagement and Retention of Non-Abstinent Patients in Treatment

(Draft)

1. Cultivate patient trust by creating a welcoming, nonjudgmental, and trauma-sensitive environment
2. Do not require abstinence as a condition of treatment initiation or retention
3. Implement clinical strategies to optimize patient engagement and retention
4. Only administratively discharge patients from treatment as a last resort
5. Seek to re-engage individuals who disengage from care

American Society of Addiction Medicine. Clinical Considerations for Engagement and Retention of Non-Abstinent Patients in Treatment. May 2024 (Draft). http://bit.ly/EngagementASAM

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ASAM Clinical Considerations for Engagement and Retention of Non-Abstinent Patients in Treatment

(Draft)

6. Build connections to people with SUD who are not currently seeking treatment
7. Cultivate staff buy-in
8. Prioritize retention of front-line staff
9. Align program policies and procedures with the commitment to improve engagement and retention of all patients, including non-abstinent patients
10. Measure progress and strive for continuous improvement of engagement and retention

American Society of Addiction Medicine. Clinical Considerations for Engagement and Retention of Non-Abstinent Patients in Treatment. May 2024 (Draft).
http://bit.ly/EngagementASAM

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SAMHSA Six Pillars of Harm Reduction

- Led by people who use drugs and with lived experience of drug use
- Embraces the inherent value of people
- Commits to deep community engagement and community building
- Promotes equity, rights, and reparative social justice
- Offers most accessible and noncoercive support
- Focuses on any positive change, as defined by the person

http://www.samhsa.gov/find-help/harm-reduction/framework

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SAMHSA Core Practice Areas for Harm Reduction

- Safer Practices
- Safer Settings
- Safer Access to Healthcare
- Safer Transitions to Care
- Sustainable Workforce and Field
- Sustainable Infrastructure

http://www.samhsa.gov/find-help/harm-reduction/framework

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Better Blending Treatment & Harm Reduction

- **We know recovery is a continuum, but the separation and programmatic divide between treatment and harm reduction services is often wide and needs to be addressed to better match the continuum of SUD services with client experience.**

- **Better integrating treatment and harm reduction services within agencies is both a cultural and operational issue, with the cultural issue being the more challenging to address.**
  - Achieving this goal will require addressing this from both angles and will require agency-level interventions on top of what SAPC focuses on given that agencies have different cultures and agency leadership know their culture best.

- **Ingredients for culture change at the agency-level**
  1. Knowing what we're dealing with – Opening the door for discussions to explore staff thoughts/feelings around this topic (e.g., individual/supervision/staff meetings, office hours, etc.) --> **ESSENTIAL FOCUS!**
  2. Leadership making the end goal clear – Aligning the agency and staff
  3. Evaluating progress – How do we know when treatment and harm reduction service are more integrated?
  4. Adjusting approaches as needed – Our evaluations will allow us to modify our interventions to more effectively achieve this integration

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About SAPC

- The Department of Public Health's Division of Substance Abuse Prevention and Control (DPH-SAPC) oversees the most diverse and comprehensive continuum of SUD services in California.

SUBSTANCE ABUSE SERVICE HELPLINE 24/7 1.844.804.7500

CENS Client Engagement and Navigation Services

CORECenter Connecting to Opportunities for Recovery and Engagement

- SAPC is committed to innovative, equitable, and quality-focused substance use **prevention**, **harm reduction**, **treatment**, and **recovery services**.

DPH-SAPC Contracted Provider Network*

Prevention	Treatment	Harm Reduction	Recovery Bridge Housing
29 provider agencies	86 provider agencies	7 provider agencies	23 provider agencies
133 site locations	394 site locations	12 site locations	123 site locations
69,552 served	33,800 served	10,866 served	3,200 served

*For persons served, all numbers are annual

SAPC Website: ph.lacounty.gov/sapc/

SAPC Strategic Plan - 2023-2028: ph.lacounty.gov/sapc/docs/providers/SAPC-Strategic-Plan-2023-2028.pdf

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Thank You!

SAPC website:
http://publichealth.lacounty.gov/sapc

SUBSTANCE ABUSE SERVICE HELPLINE 24/7 1.844.804.7500

RecoverLA.org *(try it out on your mobile browser!)*

SAPC's filterable Service & Bed Availability Tool:
http://sapccis.ph.lacounty.gov/sbat

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SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

DECEMBER 2023

ADVISORY: LOW BARRIER MODELS OF CARE FOR SUBSTANCE USE DISORDERS

Introduction

Despite robust evidence demonstrating the effectiveness of medications and psychosocial treatment interventions for substance use disorders (SUDs), less than 10 percent of people who need treatment have sustained access to care. In 2021, only 22.1 percent of people with a past year opioid use disorder (OUD) reported receiving medications for the treatment of their opioid misuse, and only 6.3 percent of people with a past year illicit drug or alcohol use disorder reported receiving any substance use treatment.[1] SUDs continue to pose a significant public health challenge. Most people who could benefit from treatment do not receive it due to systemic barriers and access issues which are even greater for historically underserved communities.

Low barrier care is a model for treatment that seeks to minimize the demands placed on clients and makes services readily available and easily accessible. It also promotes a non-judgmental, welcoming, and accepting environment. In this way, low barrier models of care meet people where they are, providing culturally responsive and trauma informed care that is tailored to the unique circumstances and challenges that each person faces.[2,3] This facilitates engagement in treatment: one recent study of a low barrier bridge clinic serving individuals with opioid, alcohol, stimulant, sedative/hypnotic, and cannabis use disorders, found that 70 percent of clients were engaged in treatment, which is higher than national averages.[4] Another study of low barrier buprenorphine offered at a syringe services program revealed a nearly three-fold increase in buprenorphine use (from 33 to 96 percent) and substantial declines in the use of other opioids (from 90 to 41 percent) between clients' first and sixth visits.[5] Other research reveals that low-barrier care is cost-effective, reducing the need for emergency department visits and hospitalizations.[6]

Key Messages

- Low barrier care reduces requirements and restrictions that may limit access to care and increases access to treatment for individuals with substance use disorders. This approach meets individuals where they are and helps provide culturally sensitive care tailored to the unique circumstances and challenges that each person faces.
- Research demonstrates the potential effectiveness of low barrier care in improving treatment engagement and outcomes for individuals with substance use disorders.[4] Low barrier care can reduce the use of harmful substances and lower the need for emergency department visits and hospitalizations.
- Some approaches to substance use disorder treatment may be perceived by people who use drugs as punitive, leading to stigmatization and limited treatment engagement. Low barrier care provides a non-judgmental, welcoming, and accepting environment that encourages individuals to seek help without fear of stigma or discrimination.
- Policymakers and stakeholders must work to identify and address any inhibitors to low barrier care, including funding and reimbursement, workforce development, and regulatory policies.
- Low barrier care can increase access to treatment and improve recovery-based outcomes for individuals and communities affected by substance use disorders.[6]

This Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory outlines the principles and components of low barrier care and how low barrier care may be leveraged to overcome substantial gaps in access, while also engaging individuals in treatment. Low barrier care for SUDs is a critical way to address the overdose epidemic and other substance use challenges. By removing barriers to care and providing evidence-based services in a non-judgmental, welcoming, and accepting environment, low barrier models of care can help to improve recovery-based outcomes for individuals and communities affected by substance use and use disorders. [2]

Principles and Components of Low Barrier Models of Care

Low barrier models of care promote engagement and retention by placing the patient at the center of planning and decision making. Accordingly, low barrier models include flexible scheduling and walk-in services, a non-punitive approach to ongoing substance use, decreased stigma about SUD compared to traditional care settings, and incorporation of patient goals and choice into medication decisions. The following principles and components of low barrier care highlight a patient-centered approach to care that meets the person where they are and engages them in treatment in a compassionate and person-centered manner.

Principles

1. **Person-centered care:** Treatment works best when the focus is on how to empower each client to achieve their goals. This requires being present to the individual, asking about, listening to, and respecting clients' experiences, wishes, and autonomy, as well as providing individualized care to meet their needs. Cultivating a culture of person-centered empowerment within organizations and systems is especially needed given the pervasive stigma against people with SUDs. In the context of low barrier care for SUDs, it is crucial to support a client's preferences for short-term versus long-term medication use (e.g., withdrawal management) as part of a patient-centered approach to treatment. This includes providing psychosocial education so that individuals understand the risks and benefits of their decisions. Respecting individual autonomy and through a shared decision-making and informed consent process can enhance treatment adherence, promote a sense of autonomy, and improve overall outcomes. Long-term medication use may offer stability and continuous support for clients, whereas short-term use can be instrumental in managing withdrawal symptoms and initiating the recovery process. By ensuring effective informed consent via shared decision-making and tailoring treatment plans to align with clients' unique needs and preferences, healthcare providers can foster a therapeutic alliance, optimize treatment efficacy, and ultimately contribute to a more successful and sustainable recovery.[13]

EXAMPLE: New York Harm Reduction Educators

New York Harm Reduction Educators (NYHRE), serving Manhattan and the Bronx in New York City, prioritizes meeting people where they are and supporting clients in their self-defined recovery process. NYHRE offers case management, naloxone, syringe access, and other supports and services regardless of whether clients continue using drugs or express interest in medication. NYHRE is increasing the number of hours that medication prescribers are available and incorporating additional services for co-occurring mental disorders to better serve their population.

2. **Harm reduction and meeting the person where they are:** Harm reduction, a cornerstone of the Department of Health and Human Services' Overdose Prevention Strategy,[1] is a practical and transformative approach that incorporates public health strategies – including prevention, risk reduction, and health promotion- to people who use drugs, so that they

might live healthy and purpose-filled lives. What that looks like can vary for each client. For example, abstinence from all substances may not be a feasible or desired goal for every client at a given point in time. Other behavior changes – including reductions in substance use and engaging in less risky substance use practices – can meaningfully improve health outcomes and can be appropriate treatment goals. Similarly, recovery is determined by the person. It is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. In a low barrier setting, services and interventions are provided in a non-judgmental, welcoming, and accepting environment, which is designed to encourage individuals to seek help without fear of stigma or discrimination.[7] Low barrier care recognizes that recovery is a journey that is unique to each individual, and therefore, emphasizes the need to provide interventions that are tailored to the unique needs and circumstances of each person.[8]

3. **Flexibility in service provision:** Low barrier models of care prioritize patient-centered care and adapt to the individual's specific needs, preferences, and circumstances by offering walk-in services, providing multiple levels of care within a single program, and using evidence-based practices to support a variety of recovery goals.[9,10]
4. **Provision of comprehensive services:** Low barrier care models often incorporate a whole health approach that encompass a range of medical, behavioral, and social services to address the multifaceted needs of individuals with SUDs, including access to medications for opioid use disorder (MOUD) and medications for alcohol use disorder (AUD), counseling, case management, peer support, mental health care, education, housing support, mental health screening and referral or co-occurring enhanced treatment, and vocational services.[9] The provision of these services may be performed onsite, or through referrals.
5. **Culturally responsive and inclusive care:** The burden of SUDs has been disproportionately experienced by people from racially and ethnically marginalized communities. Addressing these disparities requires proactive and community-involved efforts to improve access to care for communities that have been underserved, including mitigation of the upstream factors that reinforce inequities in health status, healthcare access, healthcare quality, and health outcomes. Low barrier care also emphasizes diversity, striving to provide care sensitive to the unique needs and experiences of each individual, including those belonging to marginalized populations, such as people of color, rural communities, lesbian, gay, bisexual, transgender, questioning, intersex and asexual (LGBTQIA+) individuals, people with disabilities, and those experiencing homelessness.[11,12]
6. **Recognize the impact of trauma:** Many individuals with an SUD have experienced trauma at some point in their lives. Trauma-informed care can improve patient engagement, treatment adherence, and health outcomes as it recognizes the long-lasting, negative impacts of trauma. Key principles of a trauma-informed approach include attention to (1) safety, (2) trustworthiness and transparency, (3) peer support, (4) collaboration and mutuality, (5) empowerment, voice, and choice, and (6) cultural, historical, and gender issues.[13]

Components of Low Barrier Models of Care

In low barrier models of care, providers accommodate clients' preferences to the maximum extent possible while also working collaboratively with clients to determine recovery goals, recognizing that recovery is unique to the person. Key elements of low barrier models are availability, flexibility, responsiveness, a collaborative approach to the needs and interests of the individual, as well as promoting a culture of learning and evaluation.

Available and Accessible

Embedding SUD treatment, related services and supports across the healthcare system is critical to improving treatment engagement. Relatedly, socioeconomic factors can make it difficult for some clients to access treatment (e.g., unreliable transportation, employment, childcare responsibilities, prior authorizations). These are key considerations to increasing access to treatment for the entire population with SUDs and can be actualized through the use of telehealth technology, integrated care platforms and mobile medical units.

This model would ensure that:

- Treatment is available outside of specialty SUD settings, including in emergency departments, primary care, specialty health care (e.g., obstetrics/gynecology), syringe services programs, crisis stabilization facilities, and mobile units.[14,15]
- Other clinical (e.g., primary care, mental health care) and non-clinical services (e.g., syringe access, peer support services, case management) are incorporated into specialty SUD treatment settings.[16]
- Individuals can receive services on the same day without an appointment.[6,14]
- Clinics have extended hours of operation.[16]
- Telehealth and in-person services are available.[17] This is especially important for individuals in remote or underserved areas, eliminating transportation barriers.

EXAMPLE: Meharry Addiction Clinic

Meharry Addiction Clinic (MAC), part of the Meharry Medical College and located in North Nashville, TN, emphasizes the importance of building strong relationships between staff and clients, and community and providing person-centered care. MAC does not discharge clients for ongoing substance use and they provide harm reduction services – naloxone, fentanyl test strips, and syringe access – to all clients with OUD. To reduce barriers to their services, MAC is implementing a mobile addiction clinic and increasing their outreach to emergency departments, faith-based organizations, and Black community members.

Flexible

Low-barrier models adapt to the individual's specific needs, preferences, and circumstances, offering walk-in services, providing multiple levels of care within a single program, and using evidence-based practices to support a variety of recovery goals. Rigid requirements and expectations imposed on clients can deter them from seeking, initiating, or sustaining treatment.

- Treatment engagement conditions or preconditions should not be placed on the patient. This includes requirements that individuals receive multiple services simultaneously; demonstrate complete adherence with scheduled intake appointments; complete additional testing prior to starting medication or receiving dose increases; receive treatment for co-occurring conditions (e.g., mental disorders); or provide consent to co-occurring treatment providers before SUD treatment initiation are required conditions of treatment.[18,19]
- Medication is provided at the first visit if the patient chooses. Additionally, the provision of medication is not contingent on a positive urinary drug screen or active withdrawal.[14,20]
- Home initiation of medications is offered.[14,17]
- Various formulations of medications are offered.[14]
- Medication dosage and duration of therapy are individualized.[16]

- Medication is rapidly re-initiated if person chooses when there is a short-term treatment disruption.[14]
- If desired by the individual, counseling can teach new ways to make healthy choices and handle stress. While counseling should be offered to patients, the provision of medication should not be contingent upon participation or engagement in a set counseling schedule.
- The use of toxicology results to prioritize client safety, rather than punishment, helps to establish trust, promote transparency, and facilitate a more effective therapeutic alliance, ultimately enhancing treatment outcomes and mitigating potential adverse outcomes. In other words, the results of tests are not used to restrict services.

Responsive

Recovery is a highly personal process that occurs via many pathways. Each person with a SUD will have a different approach to cultivating and sustaining recovery. People with SUDs benefit from comprehensive services to support them on their path to recovery, and low barrier care does not preclude offering a full range of services to the individual in a person-centered manner. Indeed, practitioners in low barrier settings play a vital role in providing a full continuum of support, which includes community-based services, family support, and peer support, all of which ensure those with SUDs have access to whole person care.[16]

- Visit frequency is based on clinical stability, not an organization-wide schedule (except for interventions that employ specific visit schedules by design, such as contingency management).[14]
- Ongoing substance use, whether by self-report or demonstrated through specimen testing, does not automatically lead to treatment discontinuation or a reduction in medication dose.[14,16]
- Being prescribed medications for mental health conditions does not automatically preclude MOUD, nor should programs mandate those receiving MOUD provide consent to release information to their mental health prescriber as a contingency of continued SUD treatment.
- Providers support clients in determining their recovery goals based on what feels right for them, including medication choice.[16]
- Reducing substance use and harm mitigation are considered acceptable goals.[14,16]
- Peer services or nonclinical professionals with lived experience in recovery from SUD are available to support people on their recovery journeys by providing education about how to care for and strengthen recovery, help advocate for people in recovery, share resources, and provide mentorship.
- Providers should work with patients and their care team to determine what services are needed to support their growth in the four domains of recovery (health, home, purpose, and community).[21]
- Families should be involved based on the wishes of the individual.
- Clinic staff use outreach and follow-ups to encourage treatment adherence and attendance.[22]

Collaborative

To address the complex needs of individuals with SUD, low barrier care programs often partner with other community organizations, including:

- Primary care providers;[23]

- Mental health services;[24]
- Housing agencies;[25]
- Social services;
- Transportation services;
- Offices of employment; and
- Peer support networks.[26]

Engaged in learning and quality improvement.

Adequate training and education of healthcare providers and staff members in low barrier care principles, evidence-based treatment practices, signs and symptoms of co-occurring disorders, recovery-oriented care, and harm reduction strategies are crucial to delivering effective care for people with SUDs.[20] It is also important to foster program evaluation and feedback mechanisms, as these underlie quality improvement activities.[27] Implementing these strategies can involve:

- Enhancing knowledge about the latest evidence-based interventions for SUDs, including medications, counseling, and recovery support services.[20,28]
- Providing information on the principles and benefits of harm reduction approaches, such as overdose prevention, and syringe services programs.[29]
- Offering cultural competence training to better understand and address the diverse needs of clients from various cultural, racial, and ethnic backgrounds, as well as the LGBTQIA+ community.[30]
- Encouraging continuing education and professional development opportunities for staff and providers, including conferences, webinars, and workshops related to SUDs and low barrier care.
- Collecting and analyzing data on treatment outcomes, client satisfaction, and accessibility of services, using standardized measures and tools.[31]
- Incorporating feedback from clients, staff, and community partners to identify strengths and weaknesses of the low barrier care model and to inform service improvements.[32]
- Conducting regular reviews of clinical practices and policies to ensure alignment with the latest research evidence and best practices in the field.[33]
- Establishing a culture of continuous quality improvement, where staff and providers are encouraged to learn from successes and challenges, and to adapt and innovate in their approaches to care.[34]

These components facilitate a comprehensive, integrated approach to care, while also enhancing the effectiveness of treatment and support services. In this way, comprehensive implementation of low barrier care requires systemic policy and practice transformation at every level. SAMHSA is committed to supporting the treatment provider and harm reduction communities in achieving this transformation.

Exhibit 1: A Comparison of Low-Barrier and High-Barrier Care

Barrier Level	Requirements and Approach [35,36,37,38,39,40]	Requirements and Approach (medication only)	Availability [41,42,43,44,45]
Low Barrier Care	• No service engagement conditions or preconditions. • Visit frequency based on clinical stability. • Ongoing substance use does not automatically result in treatment discontinuation. • Client's individual recovery goals prioritized. • Reduction in substance use and engaging in less risky substance use as acceptable goals.	• Medication at first visit. • Home initiation permitted. • Various medication formulations offered. • Individualized medication dosage. • Rapid re-initiation of medication after short-term disruption.	• Treatment available in non-specialty SUD settings. • Other clinical and non-clinical services incorporated into SUD treatment settings. • Same-day treatment availability, no appointment required. • Extended hours of operation. • Telehealth and in-person services available.
High Barrier Care	• Requirements for current or previous engagement with specific services. • Visit frequency based on a rigid, pre-determined schedule. • Treatment discontinuation due to ongoing substance abuse. • Treatment goals imposed. • Abstinence as the primary goal for all clients, all the time.	• Two or more visits before medication. • Clinic initiation required. • Limited medication formulation options. • Uniform maximum dosage. • Induction required to restart medication.	• Treatment only available at specialty SUD programs. • Non-integrated or limited-service offerings. • One or more day wait to initiate treatment, appointment required. • Traditional hours of operation. • Services only available in-person.

This table was adapted from a table developed by Jakubowski and Fox.[35]

A Brief Implementation Example

Implementing low barrier models of care into primary care settings, including Federally Qualified Health Centers (FQHCs), involves a comprehensive approach that addresses the various components of patient-centered care, including availability, flexibility, responsiveness, collaboration, and a culture of learning. Below, are some important examples of required elements in promoting low barrier models of care in primary care settings:

- **Establish a multidisciplinary care team**: Assemble a team of healthcare professionals, including physicians, nurses, counselors, marriage and family therapists, social workers, and peer support specialists, to provide comprehensive care to patients with substance use disorders.[46]

- **Integrate SUD screening and assessment**: Incorporate routine SUD screening and assessment into primary care settings using validated tools, such as the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST).[47]
- **Involve people with lived experience**: Meaningfully engage people in recovery and family members in the planning, delivery, and evaluation of services. Include people in recovery in leadership and board roles.
- **Train primary care providers**: Provide training and education for primary care providers on the fundamentals of addiction medicine, evidence-based treatment options, and the use of medications for SUD, such as buprenorphine.[48]
- **Develop collaborative care protocols**: Establish protocols that outline communication and coordination processes among primary care providers, behavioral health specialists, and other community-based service providers.[49]
- **Offer flexible treatment options**: Provide various treatment options, including medications, counseling, and harm reduction services, which cater to the individual needs and preferences of patients with SUDs.[50]
- **Eliminate service engagement preconditions**: Ensure that treatment initiation is not contingent on factors such as strict adherence to scheduled appointments or the requirement to receive treatment for co-occurring conditions before initiating SUD treatment.[50]
- **Address stigma**: Provide ongoing education and training to staff members to challenge misconceptions about addiction and promote empathy and understanding towards individuals with SUDs. This can help reduce stigma and create a welcoming, non-judgmental environment.[51]
- **Establish referral networks**: Develop strong partnerships with local mental health, social services, and housing organizations to facilitate access to additional support and resources for patients, thereby fostering a comprehensive continuum of care.[48]
- **Evaluate and continuously improve**: Regularly assess the effectiveness of the low barrier care model through the collection and analysis of patient outcomes, satisfaction, and engagement data. Use the insights gained to refine and enhance service delivery.[49]

Through careful implementation of these steps, primary care settings can successfully implement low barrier models of care, fostering an accessible and patient-centered environment for individuals with SUDs.

Providing Comprehensive Patient-Centered Care: Treating The "Whole Person" Through Low Barrier Care

People with SUDs benefit from comprehensive services to support them on their path to recovery, and low barrier care does not preclude offering a full range of services to the individual in a person-centered manner. Indeed, practitioners in low barrier settings play a vital role in ensuring that those with SUDs are offered "whole person" care. This can include addressing concerns that the individual may have about their physical and mental health, financial, or housing needs. Practitioners should consider the following issues when caring for individuals.

- **Treatment decisions are person-centered.** In the context of low barrier care for substance use disorders, it is crucial to support a client's preferences for long-term versus short-term medication use (e.g., withdrawal management) as part of a patient-centered approach to

treatment. By ensuring effective informed consent and tailoring treatment plans to align with clients' unique needs and preferences, healthcare providers can foster a therapeutic alliance, optimize treatment efficacy, and ultimately contribute to more successful and sustainable recovery trajectories. For more information on treating opioid use disorders, see SAMHSA's TIP 63 - Medications for Opioid Use Disorder (https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002). Information on treating stimulant use disorders can be found in TIP 33, available at https://store.samhsa.gov/product/treatment-for-stimulant-use-disorders/PEP21-02-01-004. Information on treating alcohol use disorder is available at: https://store.samhsa.gov/product/prescribing-pharmacotherapies-patients-with-alcohol-use-disorder/pep20-02-02-015. Information on treating co-occurring disorders can be found in TIP 42, available at: https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004?referer=from_search_result.

- **The use of telehealth expands access.** Audio-only and/or audio-visual telehealth technologies can be helpful in reaching individuals in remote settings, or connecting to those people who are reluctant to receive care in physical settings. A growing amount of research has demonstrated the effectiveness of using telehealth in treating OUD with medications. More information about telehealth and treating substance use disorders can be found in SAMHSA's evidence-based guide on 'Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders', available at: https://www.samhsa.gov/resource/ebp/telehealth-treatment-serious-mental-illness-substance-use-disorders.
- **Biological specimen testing is not punitive.** In low barrier care for substance use disorders, the use of biological specimen test results, obtained after appropriate patient education and consent, holds significant value for informing clinical decision-making with respect to client safety, as opposed to punitive applications. By providing objective data on a client's substance use patterns, these tests can guide healthcare providers in adjusting treatment strategies, ensuring appropriate interventions, and monitoring client progress, all while considering the individual's unique needs and risk factors. Utilizing test results to prioritize client safety helps to establish trust, promote transparency, and facilitate a more effective therapeutic alliance, ultimately enhancing treatment outcomes and mitigating potential adverse consequences associated with substance use disorders. Further information about biological specimen testing can be found at: https://store.samhsa.gov/product/TAP-32-Clinical-Drug-Testing-Primary-Care/SMA12-4668.
- **Counseling can help people enhance their coping skills.** If desired by the individual, counseling can teach new ways to make healthy choices and handle stress. The provision of medications for treatment should not be contingent on participation in counseling, but it should be offered as indicated. This is because the combination of counseling and medications has been shown to be of significant benefit to the individual. Practitioners can help patients locate services using SAMHSA's Behavioral Health Treatment Services Locator (https://www.samhsa.gov/find-help/treatment).
- **Peer workers**, or nonclinical professionals with lived experience in behavior change and recovery from SUD, can support people on their recovery journeys. Peer workers support people in or seeking recovery from SUDs by providing education about triggers that can lead to recurrence, advocating for people in recovery, sharing resources, teaching skill-building, and mentoring. For more information about peer workers, see https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

- **People seeking care may also have other health issues**. Practitioners should work with clients to ensure access to additional health services as needed. Indeed, those with SUDs may have physical or mental health conditions that they wish to be addressed. For more information about referral centers in your local area, see https://findtreatment.gov/.
- **Additional Supports**. Additional supports such as family therapy and vocational counseling should be offered to the patient with the understanding that such services may not be accepted immediately, and that engagement might be sporadic. For more information on employment and recovery, see https://store.samhsa.gov/product/Substance-Use-Disorders-Recovery-with-a-Focus-on-Employment/PEP21-PL-Guide-6. Additional information on family therapy can be found at https://store.samhsa.gov/product/importance-family-therapy-substance-use-disorder-treatment/pep20-02-02-016.
- **Caring for people with SUDs is empowering** for the provider and patient. Expanding skills and knowledge through learning about medications to treat SUDs, prescribing buprenorphine to patients with OUD, and engaging with other resources provides a practical way to help a growing number of individuals. In December 2022, the requirement to obtain a special waiver to prescribe buprenorphine was lifted. Now, where state law allows, any practitioner with a valid state license and DEA registration to prescribe Schedule III medications may prescribe buprenorphine. This expands opportunities to provide care and the ability to provide low barrier treatment to those with OUD across different settings. For more information on removal of the Data-Waiver, see https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement.

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Engagement and Retention of Nonabstinent Patients in Substance Use Treatment

Request for public comments, May 2024

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Background

For more than a decade, the United States has been struggling to address an epidemic of overdose deaths. Despite these efforts, the rate of overdose deaths has continued to rise, with the latest available data from 2023 finding over 112,000 deaths within a 12-month period.[5] Many initiatives have focused on improving the quality of addiction treatment, including fostering the adoption of evidence-based interventions. However, the vast majority of people with substance use disorders (SUDs) do not receive any treatment. In 2022, over 48.7 million people in the US met criteria for an SUD, representing more than 17% of the population.[7] Of these, only 14.9% received SUD treatment in the past year.[7] Among those with an SUD who did not receive treatment, 94.7% did not perceive a need for treatment, while 4.5% perceived a need for treatment but did not seek it.[7]

Beyond initiation, ongoing engagement and retention in treatment are some of the most important predictors of SUD outcomes; longer duration of treatment predicts better clinical outcomes. The National Institute on Drug Abuse's Principles of Drug Addiction Treatment notes that individuals progress through addiction treatment at various rates, and positive outcomes are contingent on adequate treatment duration.[8] Yet, data from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set (TEDS) shows that among discharges in 2021, less than 43% of patients completed the treatment episode, 25% of patients withdrew from treatment, and the facility terminated treatment (ie, administratively discharged) for nearly 5% of patients.[9]

Despite the low rates of treatment participation, patients are regularly dissuaded from initiating treatment until they are willing and able to commit to sustained abstinence from all substances. All too often, patients are administratively discharged from SUD treatment programs if they resume substance use.[10-12] **In essence, patients are denied admission**

and/or discharged from treatment for exhibiting symptoms of the disease for which they need treatment. These practices are inconsistent with our understanding of addiction as a chronic disease.[12,13]

Improving engagement and retention is a multifaceted and nuanced challenge. People with SUD often have complex medical and psychiatric comorbidities. Further, intoxication, withdrawal, and SUD can present with significant behavioral challenges, including psychosis, agitation, impulsivity, and compulsive use of substances. Treatment programs are tasked with balancing the needs of each patient with any potential risks to other patients and staff. While challenging, these complexities are part of the disease we are treating. It is incumbent upon us to design treatment programs that maximize engagement and retention in the face of them.

To improve outcomes, SUD treatment providers and programs need to focus not only on improving care quality but also on reaching those who are not engaged in treatment and increasing retention of those who do engage in care. To do this, we must take a fundamentally different approach by:

- proactively engaging individuals who would benefit from treatment at all stages of readiness for change, including those who are uninterested or ambivalent about receiving treatment; and
- designing programs with the intention of increasing patient retention in the continuum of care.

Purpose

The purpose of this document is to provide SUD treatment providers and programs with guidance and support to:

- address the complexities of patient nonabstinence during treatment,
- reduce administrative discharges, and
- implement strategies focused on lowering barriers to care to improve engagement and retention of nonabstinent patients in the continuum of care.

It outlines ten best practice recommendations for treatment programs to optimize engagement and retention of all patients. This document also includes brief discussions on health disparities in substance use treatment engagement and retention, as well as how policymakers can support implementation of these recommendations.

The intended audience for this document is SUD treatment program administrators, staff, and clinicians, including physicians, nurse practitioners, physician assistants, nurses, behavioral health professionals, and other healthcare and support workers employed by or associated with inpatient or outpatient SUD treatment programs. This document may also be helpful for policymakers, insurers, and individuals who have lived experience with SUD.

Public comments accepted through Monday, June 3 2024 via the online survey form at https://bit.ly/EngagementASAM

Summary of Recommendations

1. Cultivate patient trust by creating a welcoming, nonjudgmental, and trauma-sensitive environment.
2. Do not require abstinence as a condition of treatment initiation or retention.
3. Implement clinical strategies to optimize patient engagement and retention.
4. Only administratively discharge patients from treatment as a last resort.
5. Seek to re-engage individuals who disengage from care.
6. Build connections to people with SUD who are not currently seeking treatment.
7. Cultivate staff buy-in.
8. Prioritize retention of front-line staff.
9. Align program policies and procedures with the commitment to improve engagement and retention of all patients, including nonabstinent patients.
10. Measure progress and strive for continuous improvement of engagement and retention.

Recommendations

Recommendation #1: Cultivate patient trust

1. Cultivate patient trust by creating a welcoming, nonjudgmental, and trauma-sensitive environment.

Initiating addiction treatment can be frightening for someone with an SUD. At its root, addiction ties substance use to circuits in the brain that reinforce behaviors necessary for survival; as a result, the prospect of stopping can feel like a threat to survival. In addition, patients often fear painful withdrawal symptoms. Many people who consider treatment will be ambivalent about engagement. The environment and atmosphere that programs create can send a powerful message to those seeking and engaging in treatment. At its worst, it can convey stigma, judgment, and antipathy; at its best, it can convey compassion, hope, and respect.

Make intake welcoming

At intake, it is vital that patients feel welcomed, comforted, and reassured in their decision to engage in treatment, regardless of their current stage of readiness to change. A welcoming environment can begin cultivating trust in the program and staff and increase the likelihood of a patient engaging and remaining in treatment.[14-16]

To that end, the intake environment should reflect the program's desire to make patients feel welcome. Programs should consider additional ways to make incoming patients feel reassured, such as by incorporating peer support services during intake so patients can see and interact with others who may look like them or with whom they can directly relate.[17]

Programs that operate primarily or solely via telehealth can consider additional factors and strategies to create a welcoming environment and cultivate patient trust. Clinicians and intake staff should ensure their webcam is situated head-on and at eye level. Staff should remain focused during conversation and engage with the camera as opposed to looking off to the side so that the patient will perceive staff as interacting directly with them. Additionally, telehealth programs can consider integrating peer supports before or after telehealth visits, such as through scheduled follow-up calls or access to a peer support call number.

Patients have highlighted the complex, lengthy, and invasive nature of the intake process as a substantial treatment barrier.[3,16,17] Programs should consider how current intake procedures can be streamlined to support improved engagement in treatment. See Recommendation #9 for more discussion. Regulatory requirements can be a significant factor in the length of the intake process. See A Note for Policymakers for more discussion.

Emphasize harm reduction

Another key element of demonstrating compassion and respect for patients is prioritizing harm reduction. Harm reduction interventions—such as distribution of opioid overdose reversal medications, drug checking supplies (eg, fentanyl and xylazine test strips), and sterile smoking and injection supplies—convey that the program and/or clinician:

- is realistic about the possibility of continued use,
- values the patient's life and health, and
- has hope for the patient's long-term outcomes.

This type of compassion and respect plays a significant role in building a therapeutic relationship, which is vital to long-term treatment engagement and success.

All programs should have naloxone on-site. In addition, programs should either directly provide or coordinate with local harm reduction programs to support patient access to naloxone and other harm reduction supplies such as condoms, sterile syringes, safer smoking supplies, and drug checking supplies (where permitted by law).[13] Programs should also incorporate education on safer use of substances as part of their services.

ENVIRONMENTAL CONSIDERATIONS

When designing a treatment program, consider the following:

- How does your program welcome people into your facility?
- Does your facility provide a comfortable home-like environment with soft lighting and warm colors?
- What is the messaging on your program's signs and printed materials?
    - Is the language and imagery nonstigmatizing and nonjudgmental?
    - Is the language and imagery welcoming to diverse patients and respectful of diverse cultures?
- How would your program's environment be experienced by someone coping with trauma?
- Is your program's setting welcoming to patients across diverse cultures, races and ethnicities, sexual orientations, and gender identities?
- What is the existing diversity among your program's staff?
    - Do your staff reflect the diversity of the populations your program serves?

Consider the facility environment

A program's aesthetic environment should aim to be soothing and considerate of patients who may feel uneasy or have been impacted by trauma. Environmental considerations such as color, lighting, and decoration (eg, plants, pictures, wall hangings) are easily overlooked but have the potential to improve patient comfort and, thus, promote engagement and retention in care.

Access to basic supplies for comfort and hygiene—such as tissues, water, coffee, and snacks—is also important in creating a welcoming environment. The washroom should have soap, hygiene products, tissues, paper towels or hand dryers, and other necessities for the populations served (eg, diapers in a program focused on serving families).[13,16]

Consider seeking input on the treatment setting—including the intake environment—and ways to enhance patient comfort and trust from patients or others with lived experience. Directly asking patients about how the setting could better meet their needs or increase their sense of safety can present opportunities for therapeutic discussion and demonstrates a commitment to the population served.

Communicate with compassion and respect

It is critical that all staff consistently behave and communicate with patients in a culturally humble and trauma-sensitive manner—that is, with compassion and respect and without judgment. Many people with SUD have had interactions with the healthcare system, including the addiction treatment system, that left them feeling stigmatized and judged. Such interactions can drive people away from the care that they need. Staff should be attuned to patients' fears of hostility and judgment and proactively seek to allay them.

Stigma and judgment can also be conveyed through nonverbal cues and body language. Staff should be aware of how their body language can convey compassion and respect. In addition, they should be well-prepared to respond nonjudgmentally to the myriad situations that society commonly stigmatizes and that they will likely encounter in patients with SUD such as:

- intoxication and withdrawal;
- mental health symptoms;
- history of incarceration;
- homelessness and poverty;
- substance use during pregnancy or while parenting;
- diverse racial, ethnic, religious, and cultural backgrounds; and
- diverse sexual orientations and gender identities.

Transgender individuals are significantly more likely than cisgender individuals to have substance use and mental health disorders. However, stigma and discrimination often prevent them from participating in treatment. To create a welcoming environment, treatment programs can allow transgender and gender-nonconforming patients to:

- be cohorted with their identified gender,

- use and be referred to by their chosen name and pronouns, and
- continue gender-affirming care when applicable.

When providing care, it is especially important for clinical staff to be nonjudgmental regarding substance use and mental health history, race, ethnicity, gender identity, sexual orientation, and socioeconomic status and avoid inadvertently making patients feel uncomfortable. Where possible, programs should seek to employ racially diverse staff to reflect the patient populations served. In addition, staff should be nonstigmatizing in their demeanor and avoid assumptions regarding a patient's culture, gender, and sexual orientation.[16-19]

Recommendation #2: Do not require abstinence

2. Do not require abstinence as a condition of treatment initiation or retention.

A rapidly growing body of research demonstrates that not requiring abstinence during treatment is effective at lowering treatment barriers and increasing initiation of and retention in treatment while still improving patient health and functioning.[11,12,20-26] Given that SUDs are defined by the inability to stop using substances despite harmful consequences, **policies mandating abstinence during SUD treatment are indefensible**. Such policies effectively deny care because the patient is exhibiting symptoms of the disease for which they are seeking treatment. Mandating abstinence perpetuates ongoing stigma and discrimination that would not be tolerated during treatment for any other medical condition.

Examples of Nonabstinence-Based Treatment Goals and Objectives

- Reduced quantity, potency, or frequency of substance use
- Reduced overdose risk
- Improved psychosocial functioning
- Cessation of use of some substances but not others
- Improved physical health (eg, liver or cardiac function)
- Improved mental health
- Reduced WHO risk scale scores
- Reduced risk of infectious disease transmission
- Increased participation in treatment
- Adherence to addiction or psychiatric medications

Narrowly focusing on substance abstinence overlooks the central goals of health care—prevention of disease, relief from suffering, care of the ill, and avoidance of premature death.[27] While SUD treatment has historically had a narrow focus on the achievement of abstinence, the field is evolving to embrace a central goal of "reduc[ing] individual and societal harms associated with problematic drug use."[21] Some literature suggests that singularly or primarily focusing on abstinence may limit the long-term effectiveness of SUD treatment by increasing the likelihood or severity of episodes of return to use and discouraging a patient's recovery attempts.[21]

Addiction is a chronic condition. Periods of illness exacerbation are expected during the course of a person's recovery. If abstinence is the primary goal, then patients may view return to use as a failure instead of a chance to learn and grow. Patients should feel confident that treatment programs will support them without judgment or punishment. Early in the treatment process, clinicians

should discuss how they will respond to return to use with patients, including through reassessment of the patient's treatment plan and adjustments to the services and supports provided.

Shame is a powerful driver of addictive behaviors. If patients are made to feel ashamed in response to return to use, they can be driven out of treatment and into more severe SUD.

Meet patients where they are

Each patient enters treatment with diverse needs and at a different place with regard to readiness to change. A patient's needs, motivations, and preferences are not static and may evolve throughout the course of their treatment, necessitating individualized care and the ability of the program to flexibly adapt where possible. As patients move through the continuum of care or engage with various treatment services, navigating these many considerations is difficult but an important priority.

Instead of mandating abstinence, programs should:

- meet each patient where they are; and
- tailor an individualized treatment plan based on each patient's goals and preferences, which may include harm reduction and nonabstinence health improvement goals.

Shared goals that focus on harm reduction or improved health can help create more trust, enabling the patient to be more open about struggles with continued use.

Use drug testing as a therapeutic tool

Many programs mandate drug testing, at times responding punitively to positive test results. In some instances, programs also require a positive drug test prior to treatment admission, perhaps considering recent substance use as a proxy for SUD. However, a positive drug test is neither necessary nor sufficient for establishing a diagnosis of SUD, and requiring a positive test can unintentionally encourage substance use prior to treatment initiation.

Drug testing can have important clinical purposes, such as:

- screening for withdrawal risk,
- determining use objectively when clinical findings do not match patient self-report,
- monitoring medication adherence,
- helping patients understand what substances they have been exposed to,
- monitoring substance use as a component of contingency management (CM), and
- measuring treatment progress.

As with self-reported substance use, unexpected drug test results should be addressed as part of therapy. Drug test refusal can be similarly addressed in therapy. Typically, the clinician will have a sense of the reason for an individual patient's refusal. Is the patient pregnant and afraid of the potentially serious consequences of a false positive? Is the patient very uncomfortable with the sample collection process? Does the patient's recent behavior suggest a return to substance use?

Clinicians should work with each patient to explore denial, motivation, and actual use. Positive reinforcement should be provided for negative test results. These circumstances present opportunities to demonstrate support and build trust with the patient. As trust grows, the clinician can educate the patient on the clinical reasons for drug testing and encourage those who have refused testing to participate in the future. When drug testing is handled punitively, it can drive patients out of treatment.

Drug testing can have significant negative consequences for patients who are pregnant, as well as for those who are involved with the criminal justice system or child protective services. Clinicians should carefully consider the clinical benefits and potential harms of each test for patients on an individual basis before ordering them, with the patient's informed consent. Correct interpretation of the test results is particularly important in these instances, and definitive testing should be used to confirm any findings that do not align with the patient's self-reported use.

As discussed in ASAM's *Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document*[28]:

> Drug testing should be used as a tool for supporting recovery rather than exacting punishment. Every effort should be made to persuade patients that drug testing is a therapeutic, rather than punitive, component of treatment. This process may require time and multiple conversations. If drug testing is used in such a way that it creates an ''us versus them'' mentality, it is at odds with the therapeutic alliance.

Patients have a right to refuse any treatment service, including drug testing. Treatment programs should not attempt to coerce patients into participating. Admission and discharge decisions should not be made by drug test results or refusal of drug testing alone. Drug test refusal should be well-documented, along with the clinician's interpretation of its clinical relevance for the given patient. If the patient is court mandated to complete drug testing or the program is required to share test results (eg, with a probation or parole officer, child protective services, or treatment court), this requirement should be discussed with the patient at the outset. When reporting is required, clinicians should report clinical progress along with test results.

Rethink expectations regarding use of secondary substances

Research has considered how to address concurrent use of substances other than the primary substance of concern (eg, a patient's use of marijuana while receiving treatment for opioid use disorder [OUD]) during treatment. Requiring abstinence from any—let alone all—substances as a condition of treatment is unnecessary and ultimately restricts a treatment program's ability to prevent serious harms, including overdose deaths, and improve public health.[29] It may also discourage patients from disclosing their use of other substances.

While patients should be offered treatment for all substance use concerns, abstinence should not be mandated. Similar to the management of tobacco use disorder, patients should be screened for risky patterns of use of all substances and offered evidence-based treatment accordingly.[30] However, the patient's decision to decline certain care options should not jeopardize their ongoing participation in treatment.

Unless other substance use threatens treatment outcomes, the patient's treatment goals do not need to address the use of secondary substances. Instead, programs can seek to address risky use of other substances over time through motivational interventions and in alignment with each patient's individual treatment goals.[13,31] If other substance use is undermining the patient's progress in treatment, the program should work with the patient to address it within the treatment plan. For example, if cannabis use is a trigger for alcohol use in a patient with alcohol use disorder, the treatment plan should address this interaction.

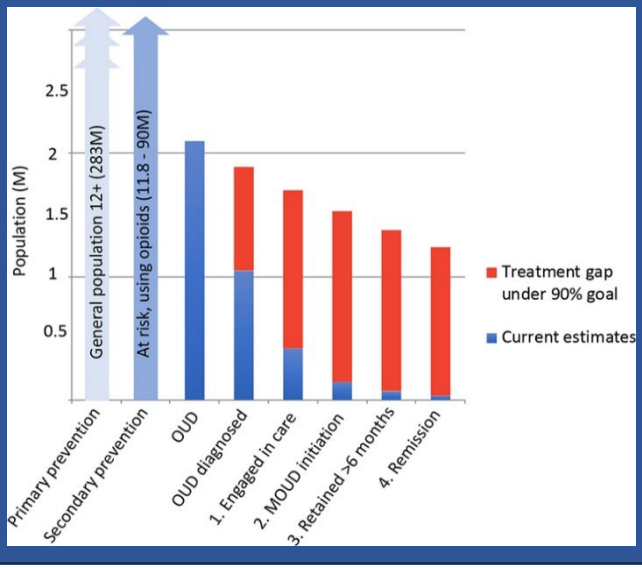
Recommendation #3: Implement clinical strategies

3. Implement clinical strategies to optimize patient engagement and retention.

The treatment gaps in engagement in care and ongoing retention are well known.[32] For example, of patients who meet criteria for OUD, roughly half receive a diagnosis. Of those who are diagnosed, less than half are engaged in care. Of those engaged in care, less than one quarter are retained for more than six months. Addiction treatment programs should be designed with a focus on improving engagement and retention in care given the known importance of these factors for long-term clinical outcomes. One key component of this is implementation of clinical strategies tailored to these goals.

OUD Cascade of Care

The OUD Cascade of Care model outlines a framework for tracking health progress for an individual with OUD or at risk of OUD. The model overviews different stages of involvement with OUD—prevention, identification, treatment, and recovery—and highlights the large treatment gaps at each stage (ie, differences between the number of individuals who need care and those who receive care). This figure from Williams et al (2020) displays data estimates from 2016 reflecting individuals in the United States.[32]



Programs should implement a variety of clinical strategies throughout the course of treatment aimed at optimizing patient engagement and retention in treatment, including:

- prioritizing patients' immediate needs,
- teaching patients alternative coping strategies,

- encouraging a culture of support and shared decision-making through strong therapeutic alliances,
- using incentives and motivational enhancement strategies to encourage engagement and retention in care,
- supporting effective care for comorbid conditions, and
- advocating for patients' access to evidence-based care.

Prioritize patients' immediate needs

It is difficult to effectively participate in treatment if you are hungry and do not know when your next meal will be or if you do not know where you will sleep tonight. Similarly, it is challenging to engage in care when you are physically uncomfortable and experiencing withdrawal or know withdrawal is imminent. Programs should prioritize early assessment and triage of each patient's immediate needs, such as withdrawal management, food, and shelter.[14,15,17] It is also important to proactively consider the patient's barriers to engagement in care, such as the need for childcare or transportation.

Programs should have established policies and procedures to respond to identified needs, such as:

- screening for acute withdrawal risk,
- screening for post-acute symptoms of withdrawal,
- recommending an appropriate level of care based on the patient's biopsychosocial needs as described in *The ASAM Criteria*,
- providing or coordinating referral for withdrawal management services or addiction medication needs,
- having food on-site and available to those in need,
- providing food vouchers and/or support accessing local food kitchens,
- providing social service navigation services or resources to support access to housing assistance services,

LOW-THRESHOLD ACCESS TO ADDICTION MEDICATION

Low-threshold treatment is an important strategy for meeting people "where they are" to engage them in care and create trusting relationships with the treatment system while stabilizing their symptoms and reducing their risk for overdose and death.

The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder highlights that[4]:

> Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However, a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacotherapy, with appropriate medication management.

Some strategies that can support low-threshold access to medications include telemedicine, street medicine, and same-day appointments for medication initiation.

- providing bus passes and/or assistance accessing transportation services,
- providing or supporting access to childcare services, and
- identifying options for caring for patients' pets while they are in residential treatment.

Prioritizing immediate needs communicates that the program understands the challenges patients are facing. It tells patients that their health and wellness are important, that you see the whole person and not just the illness. This can help strengthen the therapeutic alliance and encourage retention in care.

Smaller treatment programs with modest resources may experience greater challenges with providing or facilitating these services. However, given the importance of these factors to a patient's engagement and retention in treatment, even smaller programs should consider the benefits of hiring case managers or developing peer support networks to assist incoming patients with these needs. Under-resourced programs should consider how nontraditional supports—such as volunteers and community organizations—can help them meet patients' needs.

Programs should consider developing lists of local resources (eg, food kitchens, shelters, transportation options, family assistance services) that can help support patients' immediate needs. Such a list could be provided to patients at intake or in the waiting room, and allied health staff could assist patients in determining their eligibility for resources or services.

Teach patients alternative coping strategies

People with SUD often use substances to cope with negative emotions. Most patients will need to learn and practice alternative coping strategies before they are able to discontinue substance use. Helping patients build distress tolerance and alternative coping skills is a foundational component of SUD treatment. Discussions around alternative coping skills should happen early in the treatment process

SEX- AND GENDER-RELATED CONSIDERATIONS

Many subpopulations, including sexual- and gender-minoritized and pregnant individuals experience significant barriers to engagement and retention in SUD treatment above and beyond those experienced by the broader population. It is important that SUD treatment programs aim to identify, acknowledge, and assist patients with addressing any individualized needs.

Examples of subpopulation-specific considerations may include, among others[33-36]:

- concerns related to pregnancy or postpartum, such as pain control during labor or the impact of treatment medications on a fetus or breastfeeding child;
- the impact of treatment program schedules on family scheduling needs (eg, breastfeeding schedules, custody schedules, child school or health needs);
- additional stigma faced by pregnant or parenting individuals with SUD;
- additional stigma due to identity or fear of personal disclosure (eg, of sexual orientation);
- patient comfort discussing issues related to their sexual orientation and/or gender identity in a general population setting; and
- the high prevalence of trauma among sexual- and gender-minoritized populations.

to help patients understand the role their substance use may have served in their management of stress or trauma. Clinicians should explain how treatment will help them build the skills needed to manage negative emotions in healthier ways. This is an important area for peers to share their lived wisdom and foster hope for the future.

Encourage a culture of shared decision-making

Even when treatment is mandated, the patient has autonomy over which treatment services they engage in. Every patient has a unique set of motivations for engaging in treatment. If the treatment provided is not meeting their goals, they are likely to disengage from care.

Treatment planning should involve a shared decision-making process with the patient. Clinicians should work with the patient to understand their individual needs, priorities, and motivations and construct a feasible and effective service plan accordingly. The treatment plan goals should consider what is most important to the patient. "Life worth living" goals—a concept from dialectical behavioral therapy (DBT)—help patients build a life that is meaningful and satisfying to them. Such goals should have high personal significance and help fuel their motivation to remain engaged in treatment.

Shifting from a treatment compliance mindset to a shared decision-making model—wherein patients are active agents in their own care—builds a collaborative relationship between clinicians and patients, prompting both trust in the care team and better treatment buy-in and active engagement from the patient.[12,16,37,38]

It is particularly important to foster a culture of shared decision-making and trust regarding addiction medications. Prescribers should discuss the risks and benefits of the different medication options with patients and consider each patient's preferences prior to selecting a medication. In addition, the prescriber should encourage patients to communicate openly about their cravings and side effects. Some patients may fear being seen as "drug-seeking" if they raise concerns about their dose, but understanding the patient's response is critical for determining the therapeutic dose and if they are on the right medication or formulation.

Focus on building strong therapeutic alliances

Research has consistently shown therapeutic alliance—a collaborative relationship between a patient and their clinician—to be an important factor in the success of psychotherapeutic interventions.[40-42] This mutual trust and respect allows the patient and clinician to work together to support the patient's well-being.

Research has also shown that dislike of staff is a leading cause of patients choosing to exit treatment.[14] Conversely, a strong patient–clinician relationship is a strong predictor of positive treatment outcomes.[10,14,37,43] Clinicians should thus prioritize building a strong therapeutic alliance. Key factors in developing a strong therapeutic alliance include[44]:

- demonstrating unconditional positive regard, conveying that the clinician cares for and accepts the patient without judgment;
- making a genuine effort to understand the patient's experiences and challenges; and
- being authentic, sincere, open, and honest with the patient.

Programs should regularly assess therapeutic alliance. Patient surveys can include items such as, "I believe my therapist is genuinely concerned for my welfare," "We agree on what is important for me to work on," and "My therapist and I respect each other."[42] If the patient does not have a sufficient therapeutic alliance with the clinicians on their care team, the program should offer to transition or refer the patient to an alternate clinician or care team who may be a better fit for that patient's needs. In addition, if a patient requests a different clinician, programs and staff should respond to the request without judgment or retribution.

Create a culture of support

Clinicians should create a culture of understanding around return to substance use. It is important to communicate early and often that return to use does not mean the patient has failed, nor does it mean the patient cannot continue in treatment.[12] The clinician should also convey that if the patient disengages from care for a time, they will be welcome to return to treatment; the program will be there to provide support when the patient is ready. This culture of support should be integrated into the therapeutic milieu. The community should understand that some patients may not be striving for abstinence. For those whose goal is

Using *The ASAM Criteria* to Support Engagement and Retention in Treatment

The ASAM Criteria is an evidence-based framework for organizing addiction treatment systems and matching patients to the appropriate level of care. These standards promote holistic, individualized, and patient-centered care in alignment with the recommendations throughout this document. *The ASAM Criteria* promotes[39]:

- **Holistic care.** All patients receive a multidimensional assessment that considers the broad biological, psychological, social, and cultural factors that contribute to their SUD and recovery.
- **Individualized treatment plans.** Treatment plans are individualized based on a patient's needs and preferences.
- **Patient-centered care.** Shared decision-making is at the heart of *The ASAM Criteria*. Patient barriers to care and patient preferences are considered when selecting a level of care and in treatment planning.
- **Integrated care** All addiction treatment programs are expected to be co-occurring capable at minimum—meaning they are prepared to identify and appropriately manage patients' co-occurring mental health concerns. In addition, medical services are integrated into the continuum of care, and patient medical concerns are considered in the treatment plan.
- **A chronic care model.** Long-term continuity of care is prioritized, and emphasis is placed on effective transitions between levels of care. Level 1.0 provides long-term remission management for patients in sustained remission.

discontinuing one or more substances, patients and clinicians should view return to use as an opportunity to learn and grow. These occurrences should not be met with disappointment or shame but, instead, with insight and awareness. What contributed to the return to use? When was the patient aware they were at risk? What strategies did the patient try? What could the patient have done differently? Does the patient need additional or different services to meet their goals? How can the milieu support them?

Use incentives to encourage engagement and retention

Contingency management (CM) is an evidence-based practice that provides incentives for recovery-focused behaviors, such as attending appointments or substance use-related outcomes (eg, negative drug test results).[13] Incentives may include cash, gift cards, transportation vouchers, food, food coupons, clothing, electronic equipment, and recreational items (eg, movie passes, sports equipment), among others. CM can be used to incentivize engagement and retention in care. Programs should explore strategies for using CM to improve engagement and retention in care, such as:

- communicating availability of incentives during initial conversations,
- providing incentives for first or early appointments, and
- providing incentives for continued engagement in care.

While funding has been a significant barrier to providing CM incentives, recent federal and state initiatives have been expanding funding for this purpose. For example, the Centers for Medicare & Medicaid Services (CMS) have issued several approvals under the Medicaid Section 1115 demonstration authority that authorize coverage of CM.[45] CM is currently permitted under several federal grant programs (eg, SAMHSA's State Opioid Response [SOR] and Tribal Opioid Response [TOR] Grants and the Health Resources and Services Administration's Rural Communities Opioid Response Program's [RCORP] Psychostimulant Support Program). See *Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention* from the US Department of Health and Human Services for additional discussion.[46]

While, some grant funding mechanisms limit the incentives that can be provided to a total of $75 per year—which evidence suggests is insufficient to achieve CM's clinical aims—other funding sources can provide an evidence-based incentive magnitude. For example, California Advancing and Innovating Medi-Cal (CalAIM) provides up to $599 per beneficiary per year.

Although available research primarily uses cash, vouchers, or material goods as incentives, programs can consider alternative incentives when funding is a concern, such as increased flexibility in the patient's treatment schedule or increased autonomy in treatment-related decision-making. For example, opioid treatment programs can use increased take-home doses as an incentive for treatment participation.[47-49]

Contingency Management Considerations and Best Practices

Incentives have been shown to be effective in promoting treatment enrollment, engagement, and retention.[50-59] When implementing incentives, programs should consider the following. Many of these considerations are discussed more fully in Rash et al (2023).[60]

The right target behavior. Consider targeting one behavior at a time rather than multiple. Effective target behaviors for treatment engagement and retention include:

- enrollment in SUD treatment,
- attending individual or group treatment sessions,
- adherence to addiction medication,
- completing personalized goals as part of a treatment plan (eg, completing a job application or scheduling a doctor's appointment), and
- completing follow-up assessments.

The right type of incentive. It is critical that the incentive be something the patient values for it to be effective. Incentives that have been studied for treatment engagement and retention include cash, gift cards, vouchers, prizes, and bus tokens.

Incentive schedule. Consider how the incentive schedule can promote your program's goals.

- **Fixed schedule.** Commonly called voucher-based CM. This schedule is a fixed, predictable amount each time the reward is given—for example, $10 for each treatment session attended. For implementation protocols, see Petry (2012) and Higgins et al (2019).[61,62]
- **Intermittent schedule.** Commonly called prize-based or fishbowl CM. This type of schedule is akin to a lottery system, where there is a probability of obtaining an incentive and different magnitudes of incentives are available. For instance, using prize draws to reinforce group attendance with prizes ranging from less than $20 to $100.[63] For a prize-based implementation protocol, see Rash et al (2023).[60]
- **Escalating schedule.** An escalating schedule increases the amount of incentive given as individuals meet the target behavior. This incentivizes meeting more consecutive goals. Fixed or variable schedules can be escalating—for example, the incentive can be at a specific rate until the patient achieves a specified milestone, at which point the incentive goes up. Reset contingencies are sometimes used with escalating schedules such that a missed target behavior will reset the reward amount to the minimum.

Deliver incentives immediately. A more immediate delivery of incentive performs better than delayed. Minimize the time between the patient completing the target behavior and delivery of the incentive as much as possible. If immediate delivery is not possible, consider immediate *notification* of earning the incentive.

Provide a sufficient incentive. Higher magnitude incentives tend to have better outcomes than lower magnitude incentives.[52] The rule of thumb is that the magnitude should be commensurate with the difficulty of the goal.[60] A sufficient magnitude can vary depending on duration, schedule, and population characteristics.[60] An insufficient magnitude will not be effective and might be counterproductive to treatment goals. A range of $385 to $533 of total expected earnings is recommended for a prize-based 12-week protocol.[60]

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Use motivational enhancement strategies to encourage engagement and retention in care

Motivational interviewing (MI) and motivational enhancement therapy (MET) are highly effective evidence-based practices for increasing patients' internal motivation for change. Increasing patients' motivation for change can increase engagement and retention in care.[64] MI principles can be integrated into program procedures at various points, from first contact with the program to intake, assessment, and clinical services.[1,21] Examples of MI include using open-ended compassionate questions to connect with patients, understand their motivations for exploring or engaging in treatment, and communicate how the program will help meet their needs.[65]

Beyond MI's clinical effectiveness, research has demonstrated that it is feasible to effectively implement in community-based settings when clinicians are provided training and supervision.[1,64] For guidance and further resources related to MI and its use in clinical treatment environments, see the Network for the Improvement of Addiction Treatment's (NIATx) resource on MI during the first contact.[65]

Support effective care for comorbid conditions

Addiction is a biopsychosocial illness. Diverse biological, psychological, social, and cultural factors influence the development of SUD, prognosis for recovery, and related treatment needs. Patients with SUDs commonly experience co-occurring mental health conditions and comorbid physical health concerns. These concerns can interfere with effective participation in SUD treatment. A patient with significant pain, depression, or anxiety, for example, may be unable to reliably attend outpatient care or effectively engage in counseling or therapy. Addressing comorbid concerns is vital for supporting engagement and retention in treatment.

While the presence of co-occurring conditions is often associated with lower treatment involvement, programs that promote a flexible and collaborative care network can facilitate better outcomes for both individual patients and the broader community.[13,15,18] In alignment with the Fourth Edition of *The ASAM Criteria*, all SUD treatment programs should be co-occurring capable at minimum.[39] Co-occurring capable refers to an approach in which addiction treatment programs welcome patients with co-occurring conditions with empathy and compassion and provide integrated services for mental health symptom management as part of routine operations. Co-occurring capable programs have the capability to address patients with co-occurring mental health concerns, including trauma, in the routine course of addiction treatment. All programs should[39]:

- screen for biomedical and psychiatric concerns;
- consider the patient's need for integrated medical and/or mental health care when making level of care recommendations;
- consider the patient's need for referrals to external medical and/or mental health providers during treatment planning; and
- either directly provide or coordinate care with external healthcare providers to support effective care for comorbid conditions that may interfere with the patient's recovery (eg, pain, depression).[15,18,66]

In medically managed programs,* care coordination may include collaborating with external medical providers on how to adjust treatment or medications for the SUD and/or comorbid conditions to support better outcomes. In clinically managed programs, care coordination may include patient navigation services, appointment reminders, medication reminders, adherence monitoring, and psychoeducation.

Retention of Patients with Borderline Personality Disorder

Among individuals with a current SUD, approximately 25% also meet criteria for borderline personality disorder (BPD).[67] Patients in SUD treatment with co-occurring BPD are more likely to self-discharge and be administratively discharged from treatment.[68,69] Mediators of early treatment termination include therapeutic alliance, distress tolerance, and motivation for change.[68]

Dialectical behavioral therapy (DBT) is the standard of care for BPD and the only therapy shown to reduce withdrawal from treatment among patients with BPD.[68,70] A number of DBT strategies target the mediators of early treatment termination, including validating the patient's concerns and therapist availability, developing distress tolerance and mindfulness skills, and improving motivation for treatment. Motivational and dialectical techniques that may support patient engagement and retention include[68]:

- working to obtain an express commitment to treatment participation,
- evaluating pros and cons,
- playing devil's advocate,
- using the foot-in-the-door† and door-in-the-face‡ techniques,[71,72]
- focusing on building the patient's sense of self-efficacy for positive change,
- preparing the patient for their role in treatment (ie, role induction), and
- building shared expectations between the patient and their clinicians.

For more information on DBT, see the *DBT Skills and Training Manual* and Chapter 27: Dialectical behaviour therapy for substance use disorders in *The Oxford Handbook of Dialectical Behavior Therapy*.[73,74]

* In *The ASAM Criteria*, a program with a primary focus of treating withdrawal and/or stabilizing biomedical and psychiatric concerns while also providing the full spectrum of psychosocial services for patients who are able to participate effectively.[39]

† Per the *APA Dictionary of Psychology*, a two-step procedure for enhancing compliance in which a minor initial request is presented immediately before a more substantial target request. Agreement to the initial request makes people more likely to agree to the target request than would have been the case if the latter had been presented on its own.[71]

‡ Per the *APA Dictionary of Psychology*, a two-step procedure for enhancing compliance in which an extreme initial request is presented immediately before a more moderate target request. Rejection of the initial request makes people more likely to accept the target request than would have been the case if the latter had been presented on its own.[72]

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Advocate for patient access to evidence-based care

The mechanisms of action and effectiveness of some evidence-based practices for SUD, including addiction medications, continue to be misunderstood. As a result, some courts and social service systems may limit access to them. Similarly, some recovery support organizations may directly or indirectly discourage the use of addiction medications. Some recovery residences may exclude an individual who is taking methadone or buprenorphine, and some mutual support groups have a strong anti-medication culture. However, addiction medications are lifesaving for many patients. SUD treatment providers should work to proactively counter the stigma and misperceptions underlying these harmful practices and advocate for their patients' access to evidence-based care with any systems that seek to limit their access to or use of addiction medications.

Recommendation #4: Only administratively discharge as a last resort

4. Only administratively discharge patients from treatment as a last resort.

Administrative discharge—sometimes referred to as disciplinary discharge—refers to the termination of services when a patient fails to comply with a program's rules. SAMHSA's 2021 TEDS shows nearly 5% of patients were administratively discharged from treatment.[9] However, evidence suggests there are significant problems with underreporting, and the rate is likely much higher.[75] Administrative discharge is commonly attributed to:

- failure to follow program rules,
- failure to participate in treatment services,
- substance use or possession of substances,
- distribution of substances or other illegal behaviors,
- inability to pay, and
- threatening or violent behavior.

Historically, administrative discharges have been thought of as a way to promote compliance with program rules, protect other patients and staff, manage threats to the therapeutic milieu, and focus limited resources on those who appear to be the most likely to benefit from treatment.[12] However, the theory and practice of administrative discharge is contrary to the disease model of addiction and core ethical principles of health care and ultimately ineffective at supporting both a patient's recovery and the larger treatment system.[12,37,76,77] Discharging patients in this way is not accepted in any other area of health care. When a patient with diabetes struggles to follow nutritional recommendations, they are not discharged from care. Challenges with adherence to the treatment plan are addressed clinically, as is appropriate for any health condition.

The perceived failure of an administrative discharge can contribute to shame, despair, and depression within a patient. In addition, administrative discharge can lead to secondary losses—for example, loss of employment or child custody—all of which can drive an individual into more a severe SUD.[12] A program culture that tolerates or normalizes administrative discharges ultimately characterizes itself as unsupportive to the patients in greatest need of its services.[12] While the avoidance of negative consequences—such as

avoidance of incarceration through treatment court participation—can be motivating for some patients, there are consequences short of kicking a patient out of treatment that may be applied. The community milieu will often apply social pressure in response to behaviors that impact the community. Any consequences should be applied fairly and proportional to the infraction and should not undermine a patient's ability to access care.

While there may be instances where administrative discharges are necessary—such as in response to ongoing violent or threatening behavior—SUD treatment programs should minimize the practice. Instead of discharging patients for policy infractions, disciplinary challenges, and similar disruptions, programs should implement individualized, community-engaged, and contextualized responses. At its core, this involves the following considerations and actions:

- Programs should seek to understand the factors that contributed to the policy infraction or disciplinary challenge for the given patient.
- The patient's community should be engaged in the response. This includes both the program community as well as the patient's broader community and support systems. Who in their community has the ability to positively influence them or provide them with extra support? How can the program leverage the patient's family, friends, mutual support sponsors, and cultural and/or faith communities to address challenges and prevent them from escalating to the point of administrative discharge?
- Programs should develop contextualized responses to policy infractions and disciplinary challenges—that is, responses tailored to the factors that led to the disruptive behavior. How can the program help address these factors? For example, if the patient is selling part of their prescription in order to afford the medication or other necessities, are local programs available to help the patient afford their medication or access food or rent subsidies?

Challenges in addiction treatment often indicate more severe SUD or co-occurring psychiatric disorders and the need for clinical solutions. While some behavioral or psychiatric challenges may be beyond the capacity of a given program to address, there are numerous solutions other than discharge, including referral for concurrent care with a psychiatrist or other mental health clinician or transition to a more intensive level of care or a co-occurring enhanced (COE) program. Some patients may be unable or unwilling to transition to a more intensive level of care when recommended (eg, due to childcare responsibilities or lack of access). Clinicians should work with the patient to carefully consider all options for safely caring for them while protecting other patients and staff.

A top priority in the care of every patient should be supporting continued engagement in the continuum of care. If all efforts have been exhausted between the current care team and the patient, every effort should be made to transition the patient to an alternative treatment option that meets the patient's immediate needs. It is particularly important to consider the patient's medication needs during such transitions, including withdrawal management medications, addiction and psychiatric medications, and overdose reversal medications. Ideally, a warm handoff to the new care team should be provided. We recognize how challenging effective transition planning can be in these instances, but patients should never

be abandoned. Clinicians and treatment programs have a primary obligation to do no harm; withholding treatment or specific treatment services (eg, medication) can result in serious harm, including death.

Implement systems to prevent administrative discharge

Programs should put systems in place to prevent administrative discharge when possible. For example, programs can establish administrative discharge panels to implement standardized and thoughtful responses to disruptive behavior. When rule infractions occur, the patient and their treatment team participate in an interdisciplinary conference to jointly reflect on and re-evaluate the patient's treatment goals and openly discuss the infraction in a nonconfrontational manner.[16,78] These panels can carefully consider alternative explanations for patient behavior (eg, behavioral issues due to sleep deprivation versus intoxication). Motivational enhancement techniques can be integrated into this process, turning the situation into an opportunity for growing insight.[1,66]

These types of standardized approaches to infractions can support equitable application of administrative discharge practices. Administrative discharge panels would review disciplinary situations on a case-by-case basis and provide guidance on the development of a contextualized response. Panels should provide multidisciplinary oversight and adhere to clear and explicit policies in an effort to standardize decision-making and ensure that discharge decisions are not made inappropriately or without fair consideration.[12,79]

Clearly explain the rules and responses to infractions early in treatment

At the onset of treatment, the program's policies should be clearly communicated to patients, including the situations or behaviors that would lead to administrative discharge.[79] This conversation should include discussion of medication use, misuse, and diversion. In order to minimize perceptions of stigma and engender trust in the patient–clinician relationship, this discussion should be framed from the viewpoint of seeking to provide the patient with good clinical care and optimizing their treatment continuation, not with undertones that are punitive, accusatory, or judgmental.[12,14]

When explaining program rules to patients:

- Explain the "why" behind each rule.
- Explain how infractions can undermine clinical care or pose risks to staff or patients.
- Explain the program's legal responsibilities and boundaries.
- Be transparent about the consequences of infraction (for the patient, as well as the clinician, the program, and other patients).

Avoid administrative discharge related to return to substance use

SUDs are chronic health conditions commonly associated with periods of abstinence or reductions in use and return to use. Many factors influence risk for substance use in a patient in SUD treatment, such as availability of substances, presence of stressors and triggers, and motivation and readiness for change. The primary goals of SUD treatment are to help patients gain insight into the reasons they use substances and teach them the skills necessary to avoid use. This is rarely a linear path.

Continued use of substances despite related harms is a symptom of the disease and should not be met with administrative discharge. It should instead prompt re-evaluation of the treatment plan. If the patient is not meeting their established goals related to substance use,

a clinical response should be developed in partnership with the patient that considers the following questions:

- What factors contributed to the patient's substance use?
- At what point did the patient become aware of their risk for use?
- What strategies, if any, did the patient use to try to avoid use?
- What skills, services, or supports could have helped the patient avoid use?
- Does the patient's recent pattern of use suggest greater risk than originally thought? Does it indicate the need for a more intensive level of care?

Programs should treat return to use or continued use as an opportunity for the patient to gain insight into their substance use patterns, related risks, and the types of skills they can employ to avoid use and meet their treatment goals. It is also an opportunity for the program community to learn from one another. The community milieu can provide a nonjudgmental, compassionate response that seeks to understand which services and supports a person may need to help them meet their goals.

The Impact of Nonabstinence on Other Patients

One patient's use of substances can affect other patients and the community milieu. Some patients may find it challenging to see other patients intoxicated; it may trigger cravings or negative emotions. Some patients may be frustrated by the program's inability to protect them from these challenges. However, seeing others intoxicated is something that patients will experience outside of the treatment setting. It is important for patients to learn how to manage the resulting cravings and emotions.

This does not mean the treatment program should encourage substance use. Rather, substance use should be addressed clinically, without judgment, and with recognition that recurrence is a common part of most patients' recovery journeys. Substance use should be addressed directly within the milieu through dialogue on the impact of the substance use on the patient and those around them. This presents an opportunity for individual growth and for the community to learn from one another.

If a patient's ongoing use of substances is having a negative impact on another patient or the milieu, clinicians should consider providing more one-on-one services and less group time while the issue is being addressed. Programs should exhaust all clinical options before considering an administrative discharge.

It is important to differentiate between a patient being intoxicated on-site at the treatment program and a patient bringing substances into the facility where they may pose a direct threat to other patients' health or recovery. Treatment programs have an obligation to keep substances out of the facility; this can be particularly challenging in a residential facility. Programs should seek to understand the reasons for the infraction and identify solutions other than administrative discharge. If the program is unable to identify a solution that adequately protects the safety of other patients, transition to an alternate level of care or administrative discharge may be necessary.

Avoid administrative discharge related to poor treatment adherence

Programs should avoid using specific thresholds of late or missed appointments as the sole reason for discharge. Such situations do not directly endanger the patient or other patients, nor do they significantly disrupt provision of services. Instead, it may indicate poor treatment match, weak therapeutic alliance, or the need for increased program flexibility.[79]

As discussed previously, the clinician should seek to understand the factors leading to an individual's poor treatment adherence. Does the patient have conflicting responsibilities—such as childcare or caretaker responsibilities; work or school requirements; or court, probation, or parole requirements—that make treatment attendance challenging? Are mental or physical health concerns impacting the patient's ability to engage in treatment? Is lack of transportation preventing the patient from reliably participating? Is the patient ambivalent about treatment? Adherence challenges should be met with an individualized clinical response that addresses these factors.

Outpatient programs face numerous challenges due to missed appointments. Many programs have long waitlists and are understandably concerned about the patients for whom they do not have bandwidth to serve. Fee-for-service providers cannot bill for their time when appointments are missed, and many payers will not pay for the services provided in intensive outpatient programs (IOPs) if the patient does not participate in a minimum number of service hours in a given week. IOPs should consider offering outpatient services where they can transition patients to if they are unable to reliably attend the required minimum intensive programming. States can help support this flexibility. For example, New Jersey offers a single license that covers outpatient programs, IOPs, and high-intensity outpatient programs (HIOPs). This licensing framework can allow programs to flexibly meet the needs of patients who are unable to attend the full IOP or HIOP services.

Similarly, if concerns exist regarding medication adherence, clinicians should communicate with patients in a nonaccusatory manner about potential concerns for misuse or diversion. If a patient is diverting their medication, why are they doing so? Is it because they cannot afford their medication unless they sell some of it? Are they sharing with friends or family who need but do not have access to the medication? Are they selling their medication to have enough money for basic necessities like food or rent? Are they having an inadequate clinical response to the medication?

The clinician should work with the patient to develop a medication adherence strategy based on individualized factors. Strategies may include doing pill counts, performing more frequent drug testing for medication metabolites, using CM incentives for medication adherence, addressing side effects that make the patient reluctant to take the medication, and/or switching to an injectable extended-release medication formulation when appropriate. The clinician should also consider whether the patient requires additional supports or services to address factors contributing to their poor adherence.

Prescribers have a responsibility to monitor for and prevent diversion of controlled medications.[80] If patients are diverting their medication, clinicians may have no choice but to discontinue the prescription. Clinicians should clearly communicate this to patients early and often. Discontinuation of medication should be a last resort and framed as nonpunitively as

possible in order to preserve patient–clinician trust and collaboration.[12,37] When discontinuation is necessary, clinicians should:

- consider alternative medications—such as switching from oral buprenorphine to injectable extended-release formulations, extended-release naltrexone, or methadone;
- consider the risks related to discontinuation—such as the increased risk for withdrawal, overdose, and overdose death—and take steps to mitigate these risks; and
- continue psychosocial treatment services.

Avoid administrative discharge related to disruption of the milieu

SUD treatment is often provided in a group format, which produces group dynamics; consequently, a key responsibility of treatment programs is creating and managing a healthy therapeutic milieu. The milieu teaches patients how to handle relationships both inside and outside the treatment community and give peer feedback in a positive way. Clinicians and allied health staff should educate patients on the role and importance of the milieu and their role in it.

The milieu plays an important role in preventing and managing disciplinary issues. It is important for programs to preemptively communicate milieu respect and expectations, community safety, and conflict de-escalation strategies with the group. Other conversations that can help prepare the milieu to address disciplinary issues include understanding:

- potential triggers for other group members,
- how other group members may learn differently,
- how to effectively manage interpersonal relationships,
- the benefits of group therapy in providing social support for recovery,[6]
- how feeling loved and supported by the milieu can prevent conflict escalation,[79] and
- the importance of not abusing positions of authority.

Clinicians should debrief within the community following any significant disruptions—and when safe to do so. When appropriate, consider ways to leverage the group/milieu dynamic to respond to a patient's disciplinary issues. It is important that staff are well-trained in milieu management and supervision since a poorly managed milieu can increase risks for conflict.

Prevent administrative discharge related to threatening or violent behavior

Threatening and violent behaviors are some of the most serious concerns that a program needs to manage. For patients, initiating SUD treatment can be a very stressful experience that can be exacerbated by intoxication or withdrawal symptoms. Programs should be aware of these risks and preemptively prepare for such situations by ensuring that program staff are trained in conflict de-escalation.[3,13,76]

Programs can also seek to prevent such situations by communicating with patients in advance. For example, a case manager or clinician can reach out to patients prior to intake

to understand their concerns and immediate treatment needs, as well as to help the individual know what to expect as they begin treatment.[12] The program can then take steps to mitigate any identified concerns that may pose a risk for agitation or violence.

When threatening or violent situations do occur, the first priority should be keeping both patients and staff safe. In severe situations involving physical harm or violence that require police presence, staff should convey to police that the patient is in crisis and should be approached from a perspective of getting them needed care instead of from a disciplinary perspective.

Once the immediate risk has been mitigated, clinical staff should approach such situations with the goal of understanding the cause(s) of the patient's behavior and developing an individualized response to reduce the risk of the situation recurring. Where possible, ask questions to understand the trigger(s) or cause(s) of the patient's agitation. Consider whether program protocols may have impacted the situation and acknowledge and apologize for any program or staff contributions.

If it is safe to do so, the program should look for ways the community milieu can support the patient to help them and others learn and grow from the experience. These situations can represent important opportunities to demonstrate the role of community in providing nonjudgmental, compassionate support. Programs should also consider how to engage the patient's social and cultural support systems, including peer outreach and support networks, in supporting an effective response.[12,16]

Consider alternatives to administrative discharge

Whenever possible, programs should consider alternatives to administrative discharge. The clinician should determine if the patient poses an ongoing threat to staff, other patients, and the milieu when determining the appropriate response. Can the program safely mitigate any ongoing risks? Does the disciplinary incident indicate that the patient needs a more intensive level of care or referral for psychiatric or medical services? For example, if a patient is experiencing psychosis or other mental health symptoms that require assessment and management beyond the scope of what the SUD treatment program can provide, the program should consider transitioning the patient to a more intensive level of care, a COE program, or a mental health treatment program that is able to manage their immediate SUD and mental health treatment needs.

Programs should also consider issuing a hold on patient placement in the program instead of a discharge to address ongoing risks while a threat is being assessed further or an external provider is providing services. In certain cases, administrative discharge of a patient from treatment may be necessary, such as when the patient's continued participation would pose a threat to the safety of other patients or staff.[79] Programs should have clear policies outlining the circumstances under which administrative discharge of a patient is necessary or appropriate. In all instances, the patient should be referred and offered a warm handoff to an appropriate alternate treatment provider or level of care, which may be within either the SUD or mental health treatment systems as appropriate based on the individual's needs.[12,78]

In situations where a patient is put on placement hold or administratively discharged, the program should carefully consider their immediate needs. For example, consider the patient's need for continued access to any addiction and psychiatric medications, overdose reversal medication (eg, naloxone), and linkages to resources for immediate needs such as food, shelter, and transport; simply providing a list of programs or shelters is insufficient.[16]

In alignment with Recommendation #1, programs should strive for a nonjudgmental and compassionate approach in these situations. Patients should be assured they will be welcomed back into treatment once the potential threats and underlying drivers of the disciplinary challenge have been resolved. Programs should clearly define what factors would need to be in place for patients to be readmitted. A prior administrative discharge alone should not be justification for programs to refuse a future request for admission. Programs should proactively and collaboratively discuss prior behaviors that led to discharge with the patient and work with them to develop a plan to mitigate the risk for a subsequent administrative discharge.

Recommendation #5: Re-engage those who disengage

5. Seek to re-engage individuals who disengage from care.

Another important strategy for improving engagement and retention is proactively working to re-engage individuals who disengage from care, including those who do not show up for initial scheduled appointments.

Despite a program's best efforts to promote retention in care, some patients will choose to leave a treatment program or decide not to engage after showing initial interest. Such situations should prompt programs to extend efforts to re-engage patients, including the following strategies:

- When a patient chooses to exit treatment, if possible, ask them why they are choosing to leave and consider how program procedures can be flexibly adjusted to ameliorate any identified issues. Programs should specifically ask the patient about their therapeutic alliance with their primary clinician and other key members of their treatment team. If therapeutic alliance is a significant factor in the patient's decision to self-discharge, the program should offer a referral to another clinician or program.
- Adopt a nonpunitive approach to self-discharge, wherein the patient is referred to programs and services they are willing to engage with and linkages to resources for immediate needs. Communicate clearly and earnestly to the patient that they are welcome to return to treatment in the future.[12]
- Follow up promptly with patients who miss appointments or treatment visits and encourage them to re-engage, offering low-barrier options for re-engagement (eg, direct street outreach, telehealth) if possible.[10]
- Consider use of lower-effort yet high-frequency communication methods such as texting, which has been shown to be an effective method to coordinate continuing care with patients.[81]

Ultimately, a patient may disengage from care for many reasons outside of a program's control or realm of influence, such as a patient's lack of readiness to change, financial or insurance issues, personal issues that prevent a patient's engagement in treatment, or poor patient–program fit.[14] However, it is important to convey to patients that they are welcome to return to care when they are ready, and the program can help them work through barriers to care.

Recommendation #6: Build connections with those not seeking treatment

6. Build connections to people with SUD who are not currently seeking treatment.

As discussed previously, 85% of individuals with SUD do not receive treatment in a given year.[7] Among those, 94.7% do not perceive a need for treatment, while 4.5% perceive a need for treatment but do not seek it.[7] Often, such individuals may, in fact, be at highest risk for overdose or other substance-related harms.[1] Programs can adopt several strategies to facilitate treatment engagement among individuals who may not be actively seeking treatment.

For patients, program convenience and accessibility is a large factor in treatment initiation and retention; therefore, direct street outreach in high-need areas may prompt individuals to consider treatment by eliminating barriers such as needing to travel to a treatment site or pay for public transport.[1,16,17,66] Further, it demonstrates a lack of wait time to access services, which has been identified as one of the largest barriers to successful treatment initiation.[16,17] Finally, it demonstrates a program's compassion, flexibility, and willingness to value patient needs and "meet them where they are at."[3,10,16]

Treatment programs should engage with community programs focused on harm reduction to establish connections with individuals who are not actively seeking treatment. Alliance with harm reduction organizations is an established method to engage with individuals who continue to use substances in order to facilitate care.[3,11,16,82] Research demonstrates that harm reduction services foster trusted connections with the healthcare system and facilitate engagement in treatment.[83-85]

Engagement with other established community networks or programs—such as cultural groups or organizations focused on family and community wellness—may also facilitate treatment initiation by leveraging individuals' trust in their pre-established social and community networks.[66,86] For example, Street Haven—a multi-service women's agency in Toronto, Canada—initially focused on shelter and housing services and evolved to incorporate substance use treatment.[6,87]

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Street Haven[6]

Street Haven (SH) is a multi-service agency that offers a variety of integrated services for women experiencing or at risk of homelessness in Toronto, Canada. Provided services include emergency shelter, supportive housing, residential addiction treatment, outreach treatment, and educational and pre-employment training. SH was originally developed in 1965 by nurse Peggy Ann Walpole as a drop-in support center for women discharged from emergency hospital care as a result of the debilitating effects of homelessness. Originally offering emergency shelter and related supports, SH responded to the health needs of its clientele and, in 1976, established a residential addiction treatment program. SH recognized that access to addiction treatment can be particularly challenging for women experiencing homelessness due to hardships that increase the likelihood for substance use. The suite of available services has since further expanded, and the 90-day immersive program serves up to 50 women annually.

Recommendation #7: Cultivate staff buy-in

7. Cultivate staff buy-in.

The effectiveness of the strategies outlined in Recommendations #1–6 all depend on staff buy-in. Staff have the power to cultivate a welcoming, nonjudgmental culture. However, ample evidence has illustrated that people who use substances experience stigma from healthcare professionals, including staff in SUD treatment settings.[13,14,16,19] Such attitudes are often implicitly or overtly perceptible to patients, who cite judgment from or dislike of staff as a leading cause of choosing to exit treatment.[14]

An important accompaniment to adjusting clinical strategies and program policies and procedures to improve engagement and retention of all patients—including nonabstinent patients—is aligning these efforts with broader organizational change.[43] Staff buy-in is a critical factor in any process improvement effort. Programs should cultivate staff understanding and buy-in for service changes and ensure that both administrative and clinical staff are well-trained and able to provide respectful, compassionate, nonjudgmental, culturally humble, and trauma-sensitive care. Programs should consider applying an evidence-based framework for process improvement such as the NIATx model.[88]

It is critical that staff understand the rationale behind these organizational changes and support implementation. Key change areas where staff buy-in is crucial include[13,43,79]:

- the evidence-based reasons why the program is not requiring patients to be abstinent from substances;
- the effectiveness of long-term treatment with addiction medications; and
- the culture of minimizing administrative discharges and, instead, developing acceptable alternatives to discharge, including the reasoning behind these policies

and their basis in evidence-based standards of care to support patient engagement and retention in treatment.

To this end, programs should provide both administrative and clinical staff with training and education on the rationale and evidence base for proposed changes and prepare them to effectively support implementation of these changes. Staff training should include:

- bias and stigma reduction, including encouragement of nonjudgmental communication, respect, acceptance, and compassion (see *Words Matter: Preferred Language for Talking About Addiction* from the National Institutes of Health)[13,14,43,89];
- strategies for nonjudgmental, individualized, and contextualized responses to difficult patient situations such as return to use, medication diversion, and patient–staff conflicts[1,13];
- strategies on how to use the community milieu to both prevent and respond to behavioral infractions;
- the use of de-escalation strategies to prevent violence and other behavioral infractions;
- the role of community and social and cultural support systems in complementing and optimizing patient care; and
- the program's role in addressing the broad biopsychosocial factors that influence addiction and recovery and helping patients build recovery capital.

Staff who understand and support these initiatives and are well-prepared to implement them are key to the overall success in improving patient engagement and retention.

Recommendation #8: Prioritize staff retention

8. Prioritize retention of front-line staff.

Treatment program staff occupy stressful, demanding roles that are frequently underappreciated both societally and systemically. The satisfaction and retention of staff plays an important role in patient retention in treatment[18,86]; for this reason, among others, it is critical to support staff education, training, and workplace needs in order to contribute to overall program effectiveness.

Many factors influence staff retention, including burnout, supervisory support, educational opportunities, paperwork burden, organizational leadership, salary, benefits, and opportunities for advancement. This complex and multivariate challenge has been well-described elsewhere[90]; a full analysis of SUD workforce challenges is beyond the scope of this document. However, we recommend that programs prioritize the satisfaction and retention of front-line staff by[91]:

- directly engaging with staff—including through employee pulse surveys—to understand program-specific factors that influence their workplace wellness and retention[3,18,86];

- considering whether staff's basic needs are being met and how the program can support them in meeting these needs, including through provision of fair wages, paid leave, and benefits;
- balancing staff training requirements with practicality—that is, ensuring staff possess the necessary education and awareness and feel prepared for and supported in their roles but not demanding unnecessarily onerous continuing education requirements[3,18]; and
- proactively addressing staff burnout.

Treatment program staff commonly have lived experience with SUD. Programs should be aware that their staff may struggle with mental health concerns and be susceptible to vicarious trauma. Efforts to build and retain well-trained staff should acknowledge that many members of the workforce have experienced trauma and may continue to be exposed to trauma as part of the work that they do. As discussed in *The ASAM Criteria*[39]:

> Taking care of the workforce is an imperative of every behavioral health organization. It is important that staff have access to mental health support and are well-trained in setting and maintaining boundaries with patients; in addition, each program should be thoughtful about the systems and structures that it puts in place to protect the mental health of its workforce. A workplace that takes care of its employees' wellness promotes a culture of safety where the workforce can care for themselves within the demands of the job while also caring for patients with significant trauma and co-occurring conditions.

Many efforts are ongoing to develop models for improving staff satisfaction and retention. Programs may wish to incorporate learnings from model programs nationwide, such as the Washington State Health Care Authority's Recovery Navigator Program (RNP) and San Francisco's Larkin Street Youth Services.[2,3]

Washington State Health Care Authority Recovery Navigator Program (RNP)

RNP believes the following key workplace features contribute to the program's ongoing success[3]:

- **Fostering a diverse workforce:** RNP standards state that staff must include individuals with lived experience with SUD and should represent the community served with respect to visible and invisible diversities, including race, gender expression and sexual orientation, and disabilities. Staff also undergo extensive diversity and cultural appropriateness training alongside other professional training requirements.
- **Prioritizing manageable workloads:** RNP outlines staffing quotas for all departments (eg, intake, assessment, case management) and standardized caseload expectations, providing caseload adjustment and support when required from a technical assistance provider.
- **Providing staff supports:** RNP includes an Operations Work Group for staff to discuss operational, administrative, and client-specific issues and develop protocols to address them. Additionally, each RNP has a care team supervisor who provides supervision and training to staff, as well as general support, crisis support, and conflict resolution services.

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Larkin Street Youth Services

Larkin Street Youth Services believes the following key workplace features contribute to the program's ongoing success[2]:

- **Engaging staff in program evaluation:** Larkin's front-line staff, management team, and board are all involved in quality improvement and evaluation activities, including identifying potential growth initiatives, reviewing and selecting the most promising initiatives, identifying funding sources, and developing and enacting funding strategies.
- **Investing in the development of the management team:** In addition to being heavily involved in Larkin's growth planning, management is encouraged to make leadership decisions based on both personal beliefs and in-house qualitative and quantitative data.
- **Obtaining the necessary resources and expertise to deliver results:** Larkin's management team brought on additional administrative support, finance and development staff, and an associate executive director to handle an increased workload, while the board enlisted an external fundraising expert.

Recommendation #9: Align program policies and procedures

9. Align program policies and procedures with the commitment to improve engagement and retention of all patients, including nonabstinent patients.

Given the importance of engagement and retention in SUD treatment for long-term outcomes, programs should carefully consider how all aspects of their program design—including policies and procedures—support or hinder efforts to improve these variables. Programs should adjust their formal policies and procedures to align with the recommendations in this document. Further, we recommend that a program's policies and procedures consider:

- offering flexible appointment bookings,
- minimizing the administrative burden during program intake,
- offering nontraditional communication options, and
- avoiding administratively limiting patient access to evidence-based addiction medications.

Offer flexible appointment bookings

Appointment flexibility is a significant factor in supporting access to outpatient care. Programs should consider how to offer flexible, patient-centered appointment bookings that prioritize meeting each patient's individual needs. This may include offering a wider variety of appointment availability, as permitted by program staffing limitations and other factors. Offering options for early morning and late day appointments, same-day appointments for treatment entry, walk-in appointments for medication dispensing or administration, and

telemedicine appointments for certain services and allowing last-minute changes to appointment schedules can substantially lower common treatment barriers, including but not limited to accommodating patients' work schedules, their receipt of other social services, and caretaking responsibilities.[10,14,16,17,86,92]

Minimize the administrative burden during program intake

Patients have highlighted the complex, lengthy, and invasive nature of administrative intake to treatment as a substantial barrier.[3,16,17] Programs should thoroughly review current intake procedures to ensure all requested intake information is indeed imminently necessary and has an intentional purpose, exploring opportunities for reducing redundancies in the information and forms that patients are required to provide.

Programs may also consider a tiered intake system wherein only the most essential patient information is collected at the point of intake—such as key demographic and payment information and the minimum clinical information necessary to determine an appropriate level of care recommendation—while additional details are collected at a later time (see the Washington State Health Care Authority's RNP for one example).[3] The Fourth Edition of *The ASAM Criteria*, released in October 2023, promotes two distinct assessments[39]:

- a Level of Care Assessment, which collects just enough information prior to admission to select an appropriate level of care based on the patient's clinical needs; and
- a Treatment Planning Assessment, which is a full biopsychosocial assessment conducted after admission and used to guide development of an individualized treatment plan.

Adjusting intake procedures may require coordination with payers and policymakers, who are often driving forces for the collection of this information. In cases where a formal diagnosis is required to initiate treatment, programs should, where possible, work with payers to consider options that allow for reimbursement of initial services based on a presumptive diagnosis.

Offer nontraditional communication options

Many patients, particularly younger patients, may be more comfortable communicating with programs asynchronously. Offering nontraditional communication methods, such as texting, has been shown to allow for higher-frequency contact and be an effective method for coordinating continuing care.[81]

Do not administratively limit patient access to evidence-based addiction medications

Programs should adopt a patient-centered and evidence-informed approach to decisions surrounding the type and dose of withdrawal management and addiction medications offered to patients.[1,10,13,66,78] Medication selection and dosing should be driven by a patient's clinical presentation, response to medication, and preferences in a shared decision-making process. This process should include a balanced discussion of the risk and benefits of the various treatment options (eg, methadone versus buprenorphine versus naltrexone for the treatment of OUD) and consider the patient's preference regarding medication formulation (eg, buprenorphine sublingual films versus tablets versus long-acting injectables) whenever possible.[10,13]

Consider how required medical tests or evaluations impact engagement and retention

Programs should consider how polices that require medical tests or evaluation prior to initiation of or changes to treatment can impact patient engagement and retention. For example, one common barrier to accessing methadone treatment is blanket policies that require an electrocardiogram (ECG) prior to methadone initiation or dose changes. Patients often do not have timely access to a primary care provider or cardiologist. Programs should carefully consider if such broad policies are necessary. In this case, would it be more appropriate to allow providers to use their clinical judgment? Clinicians could weigh the risks and benefits for individual patients, considering the benefits of methadone versus the potential risks of QTc prolongation and the risks associated with untreated or undertreated OUD. Programs with these types of policies should consider how they can facilitate access to the required care, such as by offering the service on-site or formally partnering with a nearby external provider who can enable timely access.

Recommendation #10: Measure progress

10. Measure progress and strive for continuous improvement of engagement and retention.

Many factors will influence a program's success in improving patient engagement and retention. Evaluating outcomes and iteratively adjusting implementation strategies are critical for long-term success. In order to comprehensively understand and improve upon patient engagement and retention, programs should consider the following:

- How to broadly define *progress* and *success* and consider various aspects of these constructs, including those not related to a patient's complete abstinence from substances.[6,21] Examples may include:
    - administrative discharge rate,
    - self-discharge rate,
    - the proportion of initial engagements that lead to an intake appointment,
    - the wait time between a referral and the intake appointment or for other treatment services,
    - the degree of success in meeting each patient's immediate needs during intake (eg, food security, access to shelter, access to transport),
    - the proportion of patients who remain in treatment until a planned transition to a less intensive level of care,
    - patient attendance at group and/or individual appointments,
    - the total duration of patient engagement,
    - patient-reported measures of therapeutic alliance,
    - patient satisfaction,
    - staff satisfaction, and
    - staff retention.

- How to assess whether certain program changes (eg, new staff training or adjusted program policy) are associated with decreased wait times, greater patient satisfaction, or other identified metrics of success.
- How to meaningfully evaluate quality improvement efforts.[86] Programs should consider pre-existing measurement models, such as the RE-AIM framework employed by the California Bridge Program.[1] Other examples may include:
    - a patient survey within the first month of treatment investigating early impressions (eg, Did you feel your needs were met? Was the intake environment safe and welcoming? Do you believe your counselor or therapist is genuinely concerned for your welfare?);
    - ongoing patient surveys focused on factors that influence retention in treatment;
    - staff surveys focused on which clinical strategies, policies, and procedures are working well and which are not and how these can be improved; and
    - staff surveys focused on factors related to staff retention.

RE-AIM Framework[1]

RE-AIM is a framework for assessing and improving the integration of evidence-based interventions within public health settings. RE-AIM considers five dimensions—reach, effectiveness, adoption, implementation, and maintenance—from which measurable outcomes and appropriate data sources can be identified for a given program. For instance, an outcome of interest in the effectiveness dimension might be the number of patients who attended an intake session, while the corresponding data source might be program intake records.

Programs should consider applying an evidence-based framework for process improvement such as the RE-AIM framework or the NIATx model.[1,88]

Where feasible, programs should consider engaging staff and patient voices in the development of survey measures and evaluation planning. Staff can provide front-line insights into program workflow, environmental considerations, and staff health and wellbeing. Patients or others with lived experience can provide invaluable insight into meaningful patient health outcomes and program improvements. Incorporating staff and patient voices into quality improvement efforts also reflects a program's structural and cultural commitment to community engagement and valuing lived experience.

Five Key Principles of the NIATx Model[87]:

1. Understand and involve the customer.
2. Fix key problems; help the CEO sleep.
3. Pick a powerful Change Leader.
4. Get ideas from outside the organization or field.
5. Use rapid-cycle Plan-Do-Study-Act testing to establish effective changes.

To optimize relevance and uptake, individual treatment programs should determine their quality improvement goals and identify measurement tools to evaluate them. Ideally, programs should consult with various stakeholders such as clinicians, other program staff, and patients to arrive at these determinations. Quantitative,

validated survey measures that programs might consider implementing, depending on their evaluation goals, may include measures that explore[93,94]:

- patient health and functioning, such as the Brief Psychiatric Rating Scale (BPRS), the Health of the Nation Outcome Scale (HoNOS), the Outcome Questionnaire-45 (OQ-45), the Outcome Rating Scale (ORS), and the Treatment Effectiveness Assessment (TEA)[95-99];
- staff effectiveness, morale, and satisfaction, such as the Evidence-Based Practice Attitudes Scale (EBPAS) and the Maslach Burnout Inventory (MBI)[100,101];
- program effectiveness and therapeutic relationship, such as the Implementation Leadership Scale (ILS), the Treatment Perceptions Questionnaire (TPQ), the Session Rating Scale (SRS), and the Substance Use Treatment Barriers Questionnaire (SUTBQ)[102-105]; and
- clinician bias, such as the Medical Condition Regard Scale (MCRS).[106]

Health Disparities in Treatment Engagement and Retention

Significant racial and ethnic disparities exist in patient engagement and retention in substance use treatment. Ample research has demonstrated that various patient populations experience lower treatment initiation rates compared to White patients, including people who are Black or American Indian and those living in economically disadvantaged communities.[107] In 2018, only 18% of people who identified as needing treatment actually received it. In Black communities, only 10% of people diagnosed with an SUD received addiction treatment, and only 8% in Latinx communities.[108] Compared to White patients:

- Black and Latinx youth experience lower retention in substance use treatment,[109]
- Black patients are more likely to experience lost contact or administrative discharge by treatment programs,[110] and
- Black and Latinx patients experience lower treatment completion rates.[111]

A multitude of factors likely influence these trends; one suggested reason is that patients attending programs consisting primarily of others from a different social, economic, or cultural background may have difficulty connecting to and identifying with the other patients. This psychological isolation may decrease treatment engagement and, ultimately, retention.[111]

The ethnic and racial representation of program staff may also play a role in treatment disparities. Research suggests that racial concordance between clinicians and patients impacts the therapeutic alliance, perceptions of patient-centered care, and retention in treatment.[112-115]

Significant racial and ethnic disparities also exist in patient experience and quality of treatment received. While only 18.3% of people with a diagnosis of OUD in the past year received treatment with addiction medications, this falls to 16.4% among Hispanic/Latinx

patients and 11.2% among Black patients.[7] Black patients in treatment have been shown to be 70% less likely to receive a prescription for buprenorphine than White patients when controlling for payment method, sex, and age.[116] Further, a study of privately insured people who received emergency room treatment for an overdose revealed that Black patients were half as likely to obtain post-overdose treatment compared to White patients.[117]

ASAM has recognized and discussed these significant and problematic health disparities in addiction medicine through a series of public policy statements. These statements provide addiction medicine professionals with recommendations to improve the quality and equality of care delivered to racially and ethnically diverse popuations.[118] With specific regard to minimizing disparities in the engagement and retention of patients in SUD treatment, ASAM recommends that treatment programs do the following:

- **Align program policies and procedures with the recommendations outlined in this document** in an effort to make care more accessible, continuous, and flexible and lower treatment barriers for all patients.
- **Identify and address health disparities within your own program.** Comprehensively examine potential disparities in patient engagement and retention by evaluating program data sources. Consider whether differences based on race, ethnicity, sexual orientation, or gender are present in length of treatment, administrative discharges, self-discharges, patient satisfaction, use of medications, and treatment outcomes. Consider how to address the resulting findings.
- **Prepare staff to serve a diverse patient community.** This may involve efforts to hire and retain program staff who reflect the community being served. Programs should also provide staff with training to support the delivery of culturally humble care, including intentional efforts to incorporate cultural considerations of populations they are less familiar caring for. For resources related to culturally and linguistically appropriate services (CLAS) see the Addiction Technology Transfer Center Network's (ATTC) CLAS Resources.[119]
- **Consider marginalization and differential treatment based on factors other than race and ethnicity**, such as religious or spiritual beliefs, sexual orientation, gender diversity, different primary or preferred language, or prior incarceration. Consider how these and other factors can contribute to misdiagnoses, misunderstandings, and patient challenges with program belonging or relatability.
- **Share knowledge with and learn from community partners.** Connect with other treatment programs serving both similar and different communities. Reflect on how different programs identify and address disparities and engage and retain a variety of different populations. Federal, state, or community organizations that serve minoritized populations may be able to provide resources or serve as partners to advocate for funding for treatment programs to incorporate initiatives to address disparities—by enhancing staff training and expanding services to include telehealth or other methods, for example.
- **Proactively connect patients who are not receiving optimal care for reasons related to marginalization with alternate programs** that may better suit their needs and circumstances or other resources that may be able to assist them.

Public comments accepted through Monday, June 3 2024 via the online survey form at https://bit.ly/EngagementASAM

A Note for Policymakers

While this document is not intended to be policy focused, policymakers play a key role in supporting SUD treatment programs' efforts to improve patient engagement and retention. We recommend that policymakers consider how they can support SUD treatment programs to adopt the recommendations outlined in this document, including the following:

- **Consider the impact of state licensing requirements.** In certain states, program licenses are specific to a level of care. One consequence of this structure is that if a patient enrolled in treatment requires a different level of care, they must be transferred to a new program. Patients are often lost to care during these transitions. One possibility to address this challenge is exploring licensing programs that provide multiple levels of care, minimizing the need for patients to discharge and disengage from one treatment program and engage with another treatment program elsewhere and supporting better continuity of therapeutic relationships. As patients move to different levels of care within a treatment organization, they may be able to continue receiving services from the same clinical staff with whom they have forged therapeutic alliances and maintain connections to the same peer support staff.
- **Consider adjustments to mandated reporting standards and procedures**. Presently, many treatment programs experience large burdens related to mandated reporting—such as when patients are in possession of contraband drugs and instances of return to substance use—that are not consistent with the principles outlined throughout this document. Aligning reporting mandates and protocols can be an important component of creating a cultural shift toward acceptance of nonabstinent treatment goals.
- **Consider how to facilitate appropriate reimbursement for clinicians, case managers, and/or other program staff for their efforts related to re-engagement and retention of patients**. Currently, payers routinely consider a patient's last day of service as their last day of enrollment in a treatment program, and program staff are therefore unable to charge or receive any resources for the time and effort they commit to re-engage disengaged patients. Regardless of their success, these efforts are critical to optimizing patient retention in treatment and, ultimately, patient health outcomes; consequently, it is vital that programs have the resources needed for re-engagement efforts. Outreach efforts to engage prospective patients should be similarly supported.
- **Consider aligning insurance benefits more appropriately with the realities experienced by many individuals with SUD**. Often, a patient's benefits are cut off due to life disturbances such as incarceration, resulting in complex and lengthy re-enrollment procedures following release. This process can result in treatment disruptions or gaps in care during a time when a patient may be particularly vulnerable and in need of treatment services. To minimize healthcare disruptions, payers can explore opportunities that allow for more continuous patient coverage.
- **Consider how payment policies may unintentionally incentivize administrative discharge**. Typically, IOPs provide a minimum of 9 hours of services per week. In some states, if a patient in an IOP program participates in 6 hours of services in a given week, the program is unable to bill for the services provided. This can have a

significant impact on the program's ability to continue treating the patient and may lead to administrative discharge.

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