

ADDRESSING OPIOID USE DISORDERS IN COMMUNITY CORRECTIONS: A SURVEY OF ILLINOIS PROBATION DEPARTMENTS



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Abstract: Nearly one-third of Illinois probationers suffer from an opioid use disorder (OUD). Despite evidence that FDA-approved medications—methadone, buprenorphine, and naltrexone—can effectively treat OUD, many probation departments do not allow their clients to use them, even when prescribed by a healthcare provider. ICJIA researchers surveyed probation departments across the state to better understand their familiarity with, and training on, the medications, as well as barriers to their clients' access and use. This article summarizes the study's findings.

Introduction

Many probationers suffer from opioid use disorders (OUD). In a 2016 national survey of drug courts, 22 percent of respondents indicated opioids as their clients' primary substance of abuse.¹ Similar rates of opioid use are seen in Illinois among criminal justice-involved individuals. Nine Adult Redeploy Illinois-funded mental health and drug court programs in 10 counties reported 33 percent of participants had an opioid use disorder (n=42).² Despite the evidence that the use of medications for OUD is effective, some probation departments do not allow their clients to use these medications even when prescribed by a healthcare provider.³

IF YOU SEE SOMEBODY WHO CONTINUES TO USE DESPITE THEIR LIVES BEING TOTALLY DESTROYED — LOSING THEIR JOBS, LOSING LOVED ONES, ENDING UP IN JAIL — NOBODY WOULD CHOOSE THAT. NOBODY ANYWHERE WOULD EVER CHOOSE THAT LIFE. SO CLEARLY IT IS BEYOND THIS INDIVIDUAL'S CONTROL ON SOME LEVEL.
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[Source for text box⁴]

Illinois Criminal Justice Information Authority (ICJIA) researchers surveyed probation departments in the state to better understand their familiarity with, training on, and barriers to probation clients accessing and using the three FDA-approved medications for OUD. This article summarizes the study's findings.

Literature Review

Substance use disorders (SUD) are chronic, relapsing, clinically diagnosed conditions. Unlike other SUD,⁵ but similar to other chronic health conditions, such as diabetes, OUD can be addressed with medication and behavioral therapy referred to as medication-assisted treatment (MAT). However, despite being the gold standard, two medications—methadone and buprenorphine—are frequently untapped, due to preconceived notions about using an opioid medication for treatment and past experiences.⁶ Criminal justice practitioners who work with clients with OUD should understand the different treatment options that exist as research indicates that treatment adherence and long-term effectiveness are predicated on individualized responses. In other words, no single treatment modality works for everyone.

What is Medication-Assisted Treatment?

MAT combines behavioral therapy with any one of three FDA-approved medications for OUD—methadone, buprenorphine (most common brand name, Suboxone[®], which has both buprenorphine and naloxone in a single film), and injectable naltrexone (brand name Vivitrol[®]).⁷ Methadone and buprenorphine have been shown to help individuals reduce overdose, illicit drug

use, crime commission, and transmission of infectious diseases.⁸ The two medications also are associated with a reduction in cravings, increased retention in treatment, increased social functioning, improved health outcomes, and reduced recidivism.⁹ Injectable naltrexone has been shown to reduce illicit drug use and extend time to relapse.¹⁰ Although oral naltrexone is available, it has not been shown to increase retention in treatment or affect other outcomes and is not recommended for treatment of OUD.¹¹ Like medication for other chronic conditions such as asthma and diabetes, methadone, buprenorphine, and naltrexone can help stabilize individuals so they can successfully maintain long-term recovery, as well as aid in breaking the cycle of offending.¹²

Methadone and Buprenorphine: Should Clients Take These Medications?

Methadone and buprenorphine are opioids, though unlike most opioids that are misused, they have very long periods of effectiveness and, when dosed appropriately, individuals feel an increased sense of stability and reduced cravings. This allows them to focus on other recovery-oriented activities.

Physical withdrawal, often accompanied by cravings, is a major challenge for individuals with OUD, even for those who are committed to recovery. Methadone and buprenorphine ease physical withdrawal symptoms. As with other medications, some clients experience a period of trial and error in finding the right drug and dosage. Other clients may be reluctant to take an opioid-based medication as part of their treatment plan because of preexisting beliefs that favor “abstinence-only” treatment.¹³ But these medications do not “replace one addiction for another.”¹⁴ Instead, they boost restoration of the brain’s chemical balance for stabilization, allowing for increased participation in treatment (e.g., medical/physical, psychological), while enhancing an individual’s overall well-being.¹⁵ Unlike heroin and other opioids that include a rapid onset and short duration of action in the brain, methadone and buprenorphine have more gradual onsets and produce stable levels of what is otherwise a naturally occurring chemical in the brain.¹⁶

Methadone is a full-agonist synthetic opioid that activates opioid receptors in the brain, helping to reduce cravings and withdrawal symptoms while blocking euphoric effects.¹⁷ Methadone is administered in a pill, liquid, or wafer form. When receiving treatment for OUD, federal regulation requires that individuals receive methadone from highly regulated and licensed Opioid Treatment Programs (OTP), certified and accredited by the federal government¹⁸ (methadone can be prescribed for pain in office settings but not for OUD). Methadone maintenance treatment (MMT) does not require detoxification from opioids to initiate treatment but does require regular visits to the treatment program, with more frequent visits in the early phases of treatment.¹⁹ Methadone regulations mandate “observed dosing” of individuals in early recovery, with a nurse watching the client take the medication. This regulation reduces the risk of diversion—or the client selling or giving his or her prescribed medication to others. Over time, clients with increased stability in their recovery may obtain “take-home doses.” The National Institute on Drug Abuse (NIDA) recommends a minimum of 12 months of MMT; however, length of treatment can last years.²⁰

Research examining the effectiveness of methadone indicates that those who remain in treatment and continue to use methadone have lower rates of relapse and death due to opioid use.²¹ MMT is recommended for people with moderate to severe OUD and is most effective among those with a history of chronic opioid use.²² Research also indicates that those who are justice involved and participating in methadone treatment fare better than their counterparts receiving other types of treatment. Specifically, those on methadone have:

- A higher average number of days in community-based treatment.
- Higher rate of retention in treatment programming.
- Decreased involvement in crime and illicit drug use.
- Decreased rate of infectious disease.
- Decreased mortality upon release from prison or jail.²³

Buprenorphine is a partial agonist offering a “ceiling effect,” after which increased use of the medication provides no additional effect. This reduces the likelihood of overdose, even at extremely high doses.²⁴

Buprenorphine comes in many forms, though the most common are a film or tablet that is placed under the tongue. Other approved formulations include a film that dissolves along the inside of the cheek, six-month implant, and month-long injectable. The transdermal buprenorphine patch is approved for pain treatment only.²⁵ Sublingual and buccal film can add naloxone (an antagonist). Naloxone is a medication used to reverse an opioid overdose. The naloxone is added to these formulations to discourage people from injecting the medication. When these formulations are melted down and injected, the naloxone component becomes active, which can result in immediate withdrawal. If an individual takes the medication as prescribed, the naloxone is not active. If an individual uses other opiates while taking buprenorphine as prescribed, the high will be blunted because most of the opioid receptors in the brain will already be occupied.²⁶

Like methadone, buprenorphine reduces cravings and withdrawal symptoms. An important difference between buprenorphine and methadone is that it can be prescribed by a physician, nurse practitioner, or physician assistant in an office, hospital, health department, or correctional facility. The medical provider²⁷ must complete training administered by an approved educational provider and then obtain a special license or waiver with credentials verified and approved by the federal government.²⁸

Research indicates that buprenorphine can:

- Increase treatment retention and acceptance of community-based treatment post-release from an institutional facility.
- Decrease heroin use, increase social functioning and overall well-being, reduce cravings and withdrawal symptoms.
- Decrease mortality.
- Reduce potential contraction of HIV or hepatitis B or C.²⁹

Naltrexone: How Is It Different from the Other MAT Medications?

Naltrexone is a full antagonist, blocking the opioid receptors that adhere to heroin and other opioids. Injectable extended-release naltrexone lasts approximately 28 days.³⁰ If someone is taking naltrexone and uses an opioid, the naltrexone prevents the individual from experiencing the effects of the opioid.³¹ Less empirical evidence is available on this recently approved injectable; however, early studies show that injectable naltrexone can:

- Help maintain abstinence.
- Increase retention in treatment.
- Reduce cravings (though with some slight increases prior to subsequent injections).
- Prevent relapse.³²

Individuals can get an injection of naltrexone following a seven- to 10-day, medically managed withdrawal period (also referred to as “detox”). This requirement makes it much more difficult for some individuals to successfully initiate naltrexone-based MAT.³³

Naltrexone also comes in a pill form that can be taken daily, but this formulation has not been shown to be effective in the treatment of OUD.³⁴ Naltrexone can be a good option for individuals who prefer a non-opioid relapse prevention medication.³⁵

Results from a recent study comparing buprenorphine and naltrexone found that individuals who were successfully inducted on either medication had similar outcomes, including:

- A decrease in relapse.
- An increase in number of opioid-abstinent days.
- A decrease in self-reported cravings.

This research also explored the difficulty individuals had in successfully initiating naltrexone because of the required seven- to 10-day abstinence period.³⁶ Of the 570 participants who intended to start treatment (n=283 for naltrexone; n=287 for buprenorphine):

- 94 percent successfully started buprenorphine (n=270).
- 72 percent successfully started naltrexone (n=204) and had a larger percentage of relapse events than did those starting buprenorphine.

The association between naltrexone and reduction in mortality has not been studied, nor has the optimal length for individuals to remain on naltrexone. Current medical guidelines suggest injectable naltrexone treatment may be continued if the patient is benefiting from it and there are no contraindications to continuing the medication.³⁷

Behavioral Therapy

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends combining medication to treat OUD with counseling, behavioral therapies, and other supportive services (e.g., vocational, educational, medical, housing, mental health).³⁸ SAMHSA’s new

clinical guidelines suggest that patients should be offered and referred to counseling and behavioral therapy but that medications should not be withheld if counseling services are not available. Research indicates offering medication alone to those on waiting lists for counseling and behavioral therapies resulted in far less illicit opioid use compared to individuals waiting without medications.³⁹ Medications become a bridge while clients are on waiting lists for therapy, reducing chances for infectious disease, relapse, and overdose.⁴⁰

Research demonstrates that cognitive behavioral therapies (CBT) are highly effective in reducing substance use and abuse and reoffending.⁴¹ CBT can be used in any setting, including, but not limited to, individual, family, or group-based formats; residential and inpatient facilities; and outpatient or intensive outpatient programs. CBT focus on two key aspects:

1. Thought processes, attitudes, and values underlying problematic behavior (cognitive).
2. Observable behaviors (behavioral).⁴²

Individuals learn to understand better how thoughts and feelings influence behavior choices, and CBT also provide discussion and practice of alternative thinking and behaviors. CBT generally incorporate some combination of:

- Restructuring maladaptive thinking.
- Social skill building.
- Emotional regulation skills.
- Behavioral rehearsal (skill practice, including skill-based homework).
- Motivational enhancement techniques.
- Contingency management principles.
- Psychoeducation.
- Systematic training of alternative responses to high-risk situations (commonly known as “triggers”).⁴³

Examples of evidence-based CBT programs include, but are not limited to:

- Thinking for a Change (T4C).
- Relapse Prevention (RP).
- Voucher-Based Reinforcement Therapy (VBRT) or Prize-Based (PB) contingency management.
- Trauma-informed programs, such as Seeking Safety; Trauma Affect Regulation: Guide for Education and Therapy (TARGET); and Trauma, Addiction, Mental Health, and Recovery (TAMAR).

In general, the goals of CBT are to enhance appropriate social and emotional skills, help to develop and use interpersonal skills, target maladaptive thinking patterns, increase self-efficacy and critical thinking, and help manage or cope with risky situations.⁴⁴ Alongside behavioral therapy and counseling, peer-recovery support services can be helpful in building a social support system and sustaining progress made in behavioral therapy.⁴⁵ Peer-recovery support

services include, but are not limited to, SMART Recovery, recovery coaches, and 12-step groups (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA]).

Current Study

ICJIA researchers conducted a survey of Illinois probation departments to learn more about how they respond to probationers with OUD. Specifically, researchers sought to gauge probation departments' level of familiarity with, and training on, MAT and OUD medications. In addition, researchers explored respondents' openness to referring probation clients to MAT and the barriers for clients to access MAT. Below is detail on the methodology employed, survey findings, and implications for probation departments.

Methodology

Researchers emailed an online survey to a list of Illinois probation department directors in March 2018 from an [Illinois Probation and Court Services Association](#) directory. Researchers conducted survey reminders by phone and email from June to August 2018. The survey was closed and the data downloaded for analysis on August 30, 2018.

The research study was approved by ICJIA's Institutional Review Board. All respondents were required to review a consent form and agree to participate in the study. The survey consisted of 32 questions and was made available online using Qualtrics survey software. Some questions were taken from a similar national study of criminal justice practitioners, the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS).⁴⁶ Data were analyzed with Microsoft Excel and SPSS statistical software.

A total of 31 responses were received; however, five survey responses were excluded because more than one individual responded for their department (one survey per department was requested). The five respondents were eliminated based on 1) whether the respondent was the chief or director of probation (preferred respondent) or 2) randomly excluding those not submitted by the probation chief or director. The final sample size was 26 respondents representing 38 out of 102 Illinois counties (37 percent) but only 26 percent of probation departments. Many respondents represented counties with large probation caseloads, so the sample managed 72 percent of [2016 active adult probation caseloads in Illinois](#).⁴⁷ In addition, respondents' counties had a relatively high number of opioid overdose deaths, representing 83 percent of all [opioid overdose deaths in Illinois in 2017, according to the Illinois Department of Public Health](#).⁴⁸ *Tables 1 and 2* offer more detail on the sample.

This study was limited by a low response rate of 26 percent, which may impact the generalizability of study findings; therefore, findings do not represent the views of all probation departments in the state. Although the response rate is somewhat low, similar online surveys have yielded an average response rate of 10 to 15 percent.⁴⁹ Therefore, the response rate was not uncommon for an online survey of professionals. Despite the low response rate, still represented were counties that have relatively high numbers of opioid overdose deaths.

In addition, two counties sent survey responses based on their drug courts, rather than reporting on the scope of all probation services. Three respondents reported from circuits representing

more than one county. It is unknown whether each county within those circuits would have had the same responses to the survey and whether drug court staff respondents are representative of the larger probation department.

Table 1
Illinois Probation Department Survey Respondents in Final Sample
(N=26 respondents, 38 counties)

		State total	Sample total	Percent
Rurality	Mostly/completely urban	50	25	50.0%
	Mostly rural	40	9	22.5%
	Completely rural	12	4	33.3%
Region	Northern	18	10	55.6%
	Central	46	13	32.6%
	Southern	38	15	39.5%
Adult active probation caseloads		76,096	54,486	71.6%
Opioid overdose deaths in state		2,196	1,827	83.2%
Counties in Illinois		120	38	37.3%

Source: U.S. Census Bureau, 2010; Illinois Department of Public Health, 2018, Administrative Office of the Illinois Courts, 2018

Note: Totals may equal more than 100% due to rounding.

Table 2 indicates the job titles of the survey respondents.

Table 2
Probation Survey Respondent Titles (N=26)

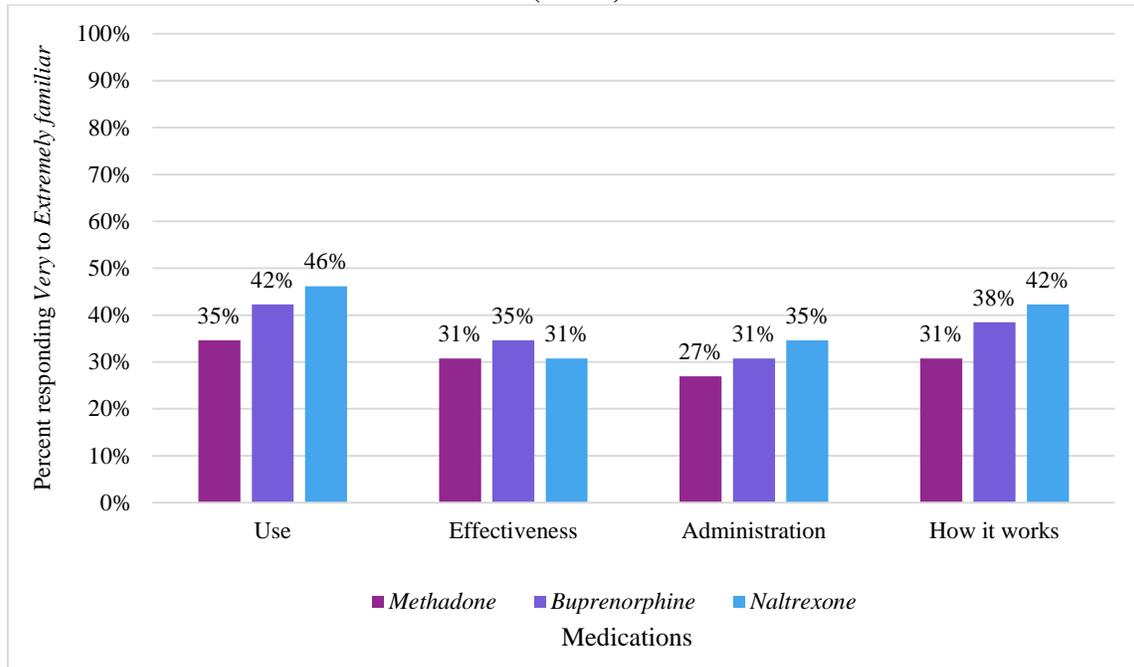
Title of survey respondent	Chief, Director, or Assistant Director	18	69.2%
	Coordinator, Supervisor, or Manager	4	15.4%
	Probation Officer	3	11.5%
	Unknown/Not Specified	1	3.8%

Main Findings

Ninety-two percent (n=24) of survey respondents reported a *moderate* to *serious* problem with opioid misuse in their counties, and 8 percent reported opioid misuse as a *slight* problem (n=2). The following are additional findings from the survey of probation departments.

Knowledge of medications. The respondents representing probation departments were asked to indicate their levels of familiarity of use, effectiveness, administration, and “how it works” for each of the three FDA-approved medications for the treatment of OUD—methadone, buprenorphine, and naltrexone. *Figure 1* depicts responses of *very* to *extremely familiar*. Respondents indicated knowing slightly less about methadone in terms of use, effectiveness, administration, and how it works, compared to buprenorphine and naltrexone.

Figure 1
Probation Responses on Familiarity with Aspects of Medications for Opioid Use Disorders (N=26)

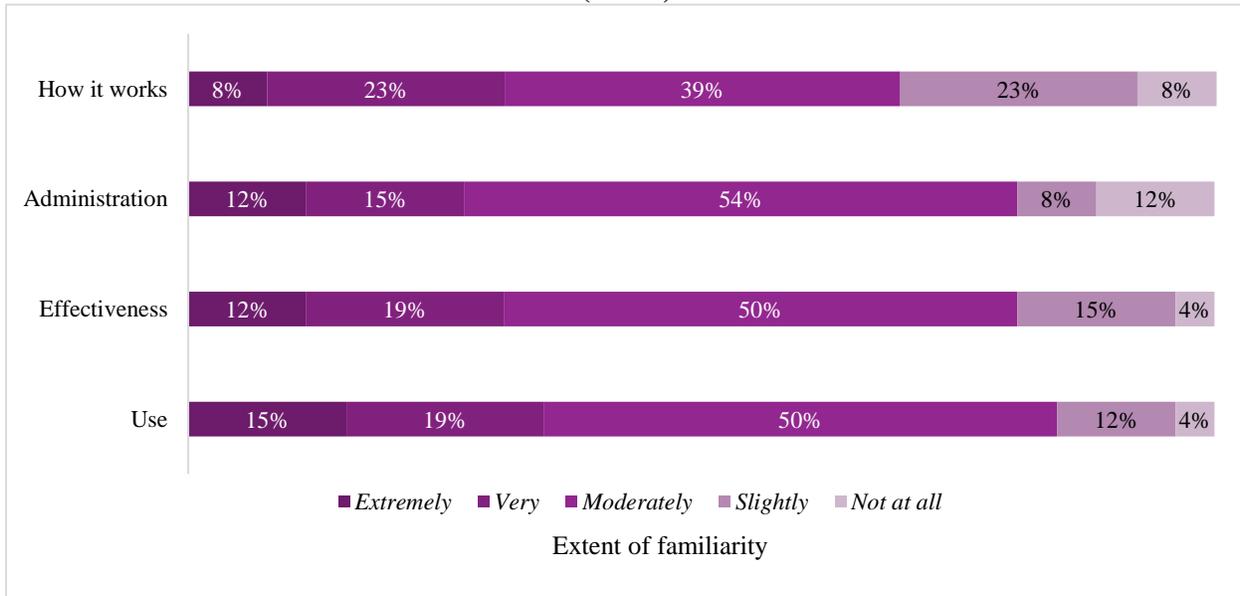


Source: ICJIA survey, 2018

Note: Figure depicts responses of *Very to Extremely familiar*. Response choices were on a 5-point Likert scale from *Not familiar at all* to *Extremely familiar*.

Probation department respondents were *moderately* familiar with methadone's use, efficacy, administration, and mechanisms of how it works for OUD (*Figure 2*).

Figure 2
Probation Responses on Familiarity with Aspects of Methadone for Opioid Use Disorders (N=26)

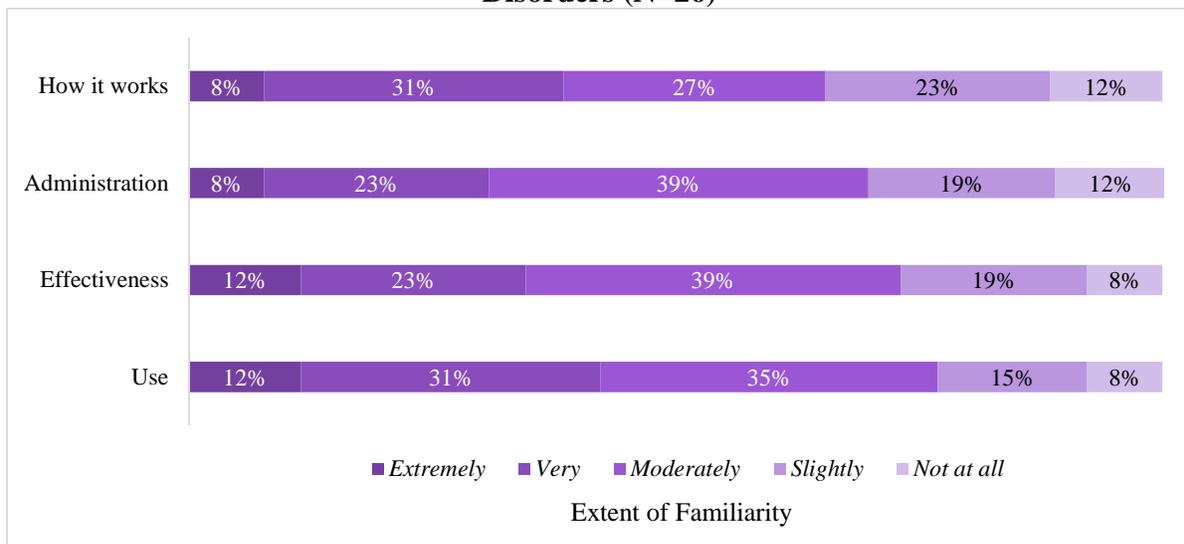


Source: ICJIA survey, 2018

Note: Responses choices were on a 5-point Likert scale from *Not at all* to *Extremely familiar*.

Most respondents reported being *moderately* familiar with aspects of buprenorphine. Nearly one-third of respondents were *slightly* or *not at all familiar* with how buprenorphine is administered (32 percent) and how it works (32 percent) and 43 percent reported being *very* or *extremely familiar* with how to use buprenorphine (*Figure 3*).

Figure 3
Probation Responses on Familiarity with Aspects of Buprenorphine for Opioid Use Disorders (N=26)



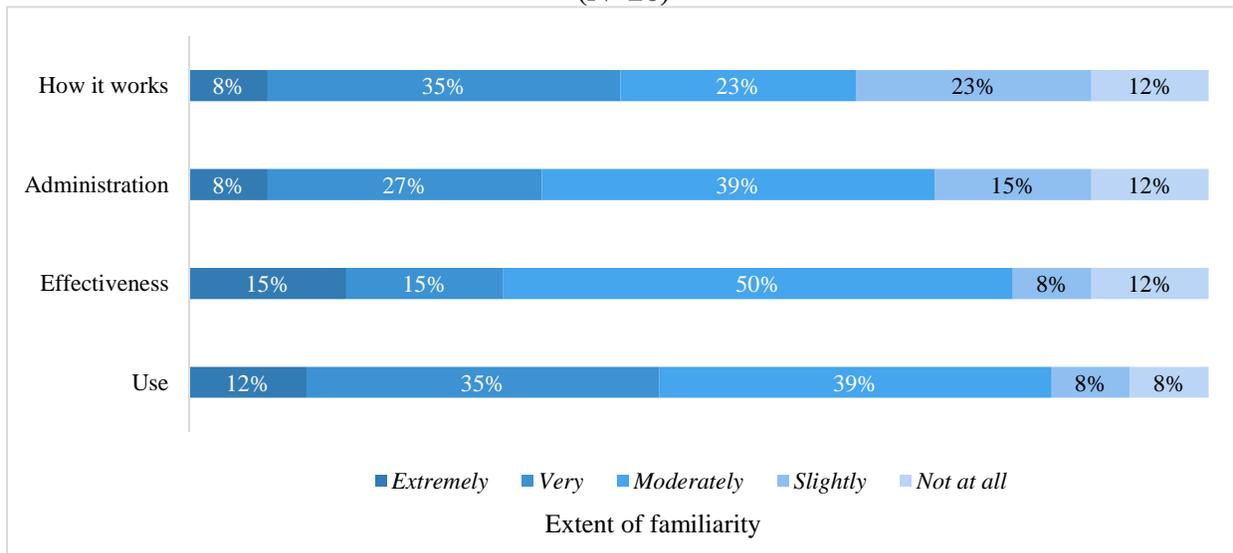
Source: ICJIA survey, 2018

Note: Response choices on a 5-point Likert scale from *Not at all* to *Extremely familiar*.

Most probation department respondents reported being at least *moderately* familiar with naltrexone use, effectiveness, and administration. Almost one-half of respondents were *extremely* or *very familiar* with how naltrexone is used/its purpose (47 percent) and how it works (43 percent); however, fewer than one-third considered themselves *extremely* or *very familiar* with the efficacy of naltrexone (30 percent).

Just more than one-third of respondents (35 percent) indicated they were *very* or *extremely familiar* with how naltrexone is administered (*Figure 4*).

Figure 4
Probation Responses on Familiarity with Aspects of Naltrexone for Opioid Use Disorders
(N=26)

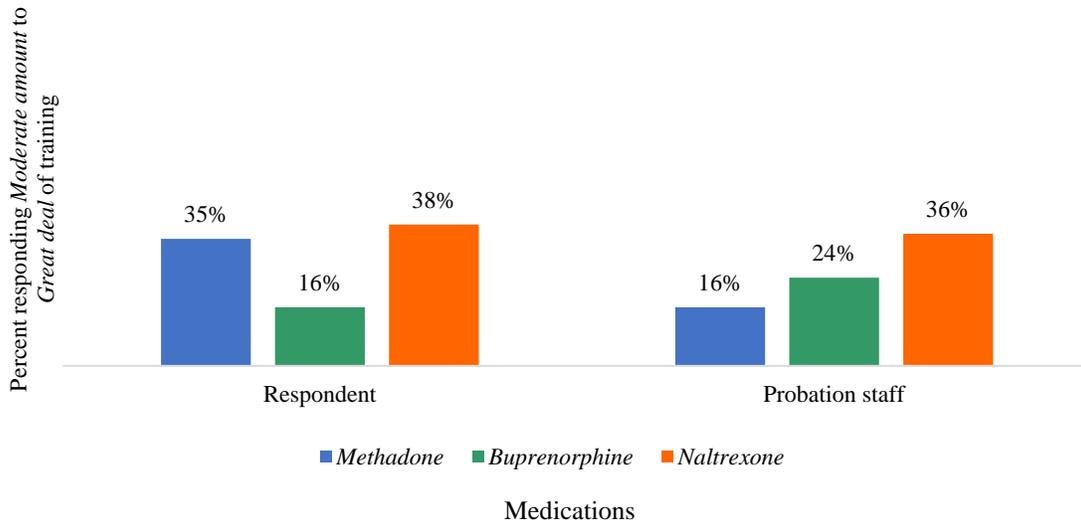


Source: ICJIA survey, 2018

Note: Response choices on a 5-point of Likert scale from *Not at all* to *Extremely familiar*.

Training on medications. Respondents who were mostly probation department directors were asked to report on training on OUD medications for themselves as well as their staff. Overall, the amount of training was low, with more training on naltrexone than buprenorphine or methadone (*Figure 5*). Sixty-five percent of respondents were *extremely* or *moderately* interested in further MAT training (n=17).

Figure 5
Probation Responses on Amount of Training on Medications for Opioid Use Disorders
(N=26)



Source: ICJIA survey, 2018

Note: Figure depicts responses of *A moderate amount*, *A lot*, and *A great deal*. Response choices were on a 5-point Likert scale from *None at all* to *A great deal*.

Most respondents, speaking on behalf of themselves and their staff, received training from outside consultants (38 percent and 45 percent, respectively) (*Table 3*). One respondent indicated staff received training from pharmaceutical sales representatives. It is possible that respondents considered sales representatives as outside consultants or that training as part of conferences/events was provided by sales representatives.

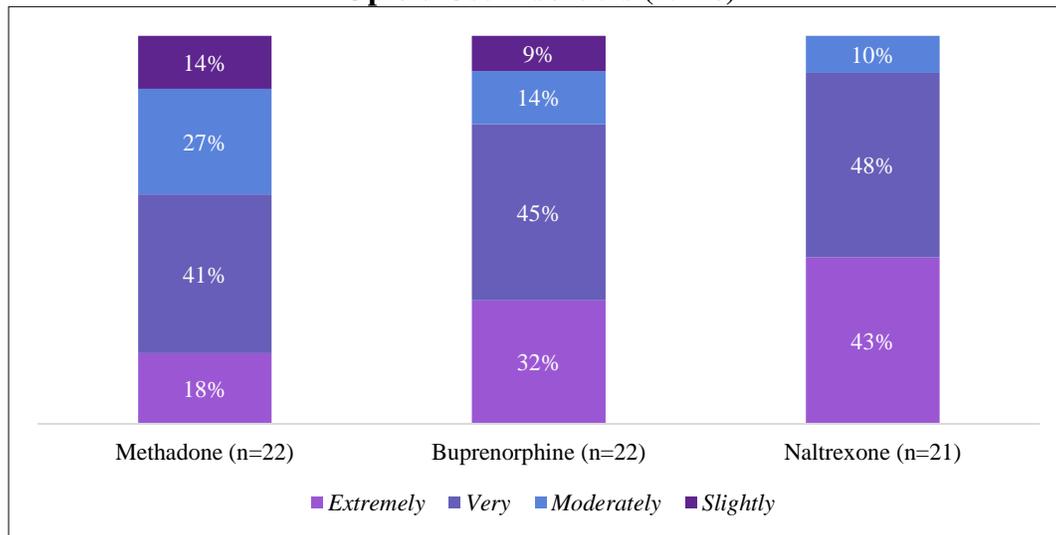
Table 3
Probation Department Training on Medications Where Offered/Sought (N=26)

	Respondents (n=21)	Staff (n=20)
Provided by outside consultants	38%	45%
Provided by agency	19%	20%
Sought on own	14%	15%
Other (e.g., conferences, training events, sales representatives, or as part of previous or current job)	29%	20%

Source: ICJIA survey, 2018

Client referrals for medication-assisted treatment. Respondents were asked to report on referrals for MAT from their own perspective, as well as on behalf of their staff. According to respondents, a high percentage of their staff were *extremely* or *very* open to referring clients to naltrexone treatment (91 percent). Many also were *extremely* or *very* open to referring clients to buprenorphine treatment (77 percent) and methadone treatment (59 percent) (*Figure 6*).

Figure 6
Probation Responses on Extent that Staff are Open to Referring Clients for Medication for Opioid Use Disorders (N=26)



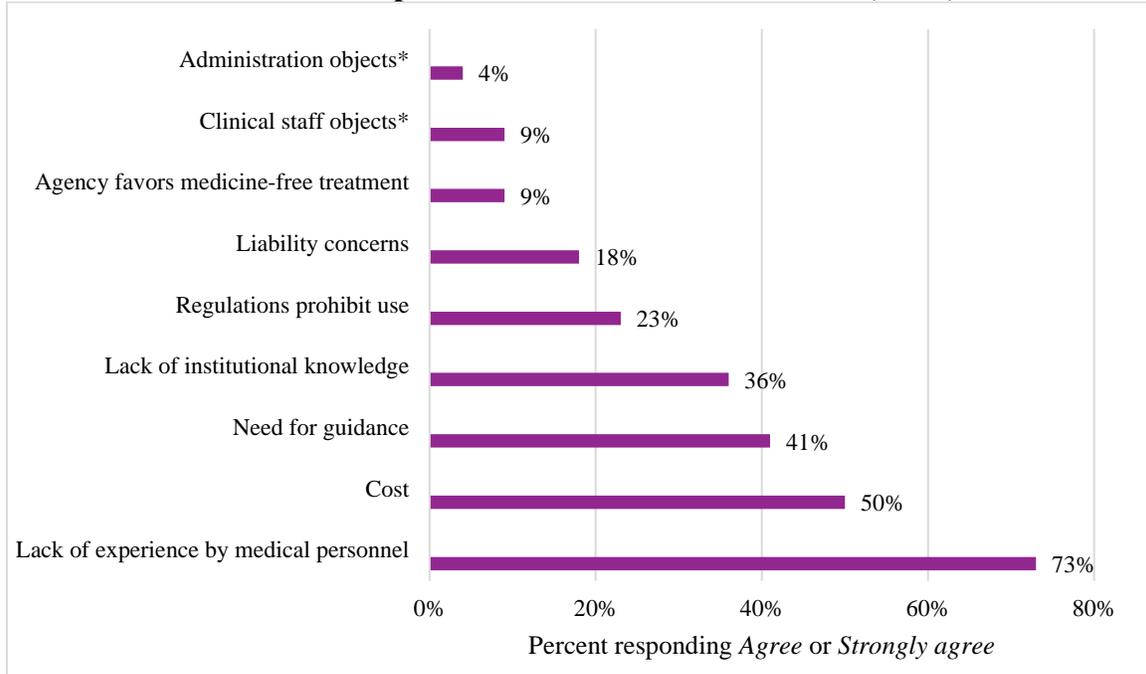
Source: ICJIA survey, 2018

Note: Response choices were on a 5-point Likert scale from *Not at all* to *Extremely*. No respondents reported *Not at all*. Totals may not equal 100% due to rounding.

A large majority of respondents would *allow* clients on their probation caseloads to be on buprenorphine (96 percent), naltrexone (96 percent), and methadone (92 percent). This is in sharp contrast to the results of a 2013 national study in which 40 percent of drug court respondents with clients on probation would allow clients to continue methadone or buprenorphine.⁵⁰

Barriers to medication-assisted treatment. Sixty-one percent of respondents indicated MAT barriers existed to a *moderate* to *very great* extent. *Figure 7* depicts the types of probation client barriers to MAT, as reported by survey respondents. The most common barriers cited were lack of medical personnel experience (73 percent) and cost (50 percent). Further, 23 percent reported that regulations within their organization or jurisdiction prohibited using medications for SUD treatment.

Figure 7
Probation Responses on Client Barriers to MAT (N=22)



* denotes n=23 responses

Source: ICJIA survey, 2018

Note: Figure depicts responses of *Agree* to *Strongly agree*. Response choices were on a 5-point Likert-scale from *Strongly disagree* to *Strongly agree*.

One respondent commented, “MDs tend to pick a medication and stick to it. Ours is not a big proponent of Vivitrol [naltrexone] but uses Suboxone.” This suggests that medication choice may be dependent on individual doctor preferences. Another noted, “Our small, rural community has no providers who offer MAT,” indicating that access to evidence-based SUD treatment may vary depending on location or region. Lack of access impacts the jurisdiction’s ability to address justice-involved clients’ needs appropriately and adequately.

Conclusion and Implications for Probation

Although MAT is not for everyone and treatment must be an individualized decision between a patient and his or her doctor, access to the three forms of FDA-approved medications to treat OUD in conjunction with therapy can help slow the trajectory of the current opioid crisis and save lives.⁵¹ MAT has been proven effective for helping justice-involved individuals with OUD. Studies have shown all three MAT medications have reduced illicit drug use and recidivism reductions with methadone and buprenorphine. These outcomes are enhanced through collaboration with social service, behavioral health, and public health providers. Increasing access to this evidence-based strategy can help individuals successfully complete supervision and become productive members of society, while enhancing quality of life and potentially saving lives.

Address Barriers to MAT for the Treatment of Probation Clients with Opioid Use Disorders

Barriers noted by surveyed probation departments in Illinois included lack of institutional knowledge, need for guidance, cost, and lack of experience by medical personnel. Some barriers can be addressed by probation departments through education and training. Other barriers can be overcome through collaboration with clients, healthcare providers, substance use and mental health treatment providers, probation and court services agencies, and other social service agencies. *Table 4* provides common barriers and concerns about MAT programs and suggestions for how these can be addressed.

Table 4
What Probation Officers Should Know About Medication-Assisted Treatment (MAT)

Barriers	Concerns	The Facts	Suggestions
Medication diversion (sharing, selling, or using to get high)⁵²	<ul style="list-style-type: none"> • Redirecting medication(s) for illegitimate/illegal purposes • Overdose from diverted medication 	<ul style="list-style-type: none"> • Different formulations have less risk for diversion and/or overdose; medication is typically diverted to others not prescribed to help individually manage withdrawal symptoms as opposed to getting high.⁵³ • Methadone and buprenorphine are highly regulated. Buprenorphine overdose is very rare because of the ceiling effect. In cases in which it is involved in an overdose, other drugs that also slow breathing are typically involved (for example, alcohol, benzodiazepines). • Methadone regulations require that early in treatment people are observed while taking the medication at least 6 days per week, which reduces the risk that someone could take more than prescribed. • During the 28 days that the naltrexone injection is active, risk for opioid overdose is almost zero. When the injection wears off, the risk for opioid overdose increases, though few research studies analyzed this because of short follow-up time frames. 	<ul style="list-style-type: none"> • Better coordination and understanding between prescribers/OTPs and probation. • For individuals who may be using this diverted education, refer for treatment assessment for MAT (currently self-treating opioid use disorder, pain, and/or depression). • Educate clients on the benefits and risks of medications and illicit use of medications in combination with other substances or medications.
Healthcare coverage and/or cost⁵⁴	<ul style="list-style-type: none"> • Medications not covered or minimally covered by insurance • Lack of insurance 	<ul style="list-style-type: none"> • In Illinois, eligible individuals with OUD do not require prior authorization mandates (requiring review by the health insurance company of the medication as medically necessary for coverage) or lifetime limits (set dollar amount a health insurance company will spend for an individual’s covered benefits). • There are clinics and programs for people without insurance in Illinois. • Illinois’ helpline for opioids and other substances is 1-833-2FINDHELP. • There is greater methadone access through Medicaid State Methadone, which is also now a Medicaid-covered benefit. 	<ul style="list-style-type: none"> • Reach out to healthcare experts for concerns regarding cost/coverage (e.g., county health departments, Illinois Department of Human Services/ Division of Substance Use Prevention and Recovery (SUPR), Illinois Department of Insurance, Medicaid plans); ask about insurance coverage.⁵⁵ • Reach out to non-profits to help navigating potential funds and resources for treatment needs. • New Illinois Public Act 97-0437, commonly referred to as the “Mental Health Parity Law.” Coverage for mental and behavioral health conditions should be no more restrictive than financial requirements for hospital and medical benefits covered by the policy. Includes coverage for: <ul style="list-style-type: none"> ○ Behavioral health medicine through telemedicine (e.g., telepsychology). ○ Early Mental Health Treatment Pilot Program. ○ Addiction medications on lower tiers, no prior authorization for addiction medications.

Rejection by 12-step community⁵⁶	<ul style="list-style-type: none"> • Recovery support groups prefer abstinence only • Belief it is replacing one drug with another • Peer stigmatization of MAT 	<ul style="list-style-type: none"> • OUD is a chronic condition that can be effectively treated with medication and behavioral support. • Experts refer to MAT as the gold standard for OUD treatment. • Rejection of MAT is not founded on scientific evidence or 12-step philosophy—and violates a long-held 12-step policy (AA members should not “play doctor”; seek advice and counsel from a qualified physician). • Peer support is important for recovery, but they should not act as medical advisors. • Treatment should be individualized to what will work best for the person. 	<ul style="list-style-type: none"> • Refer to other recovery support services such as SMART recovery groups or recovery coaches or encourage clients to find out if there are groups offered at the program where they are getting methadone or buprenorphine. • Partner with community-based organizations for information on peer recovery support groups, treatment information, and other recovery support services that will best fit the needs of the individual.
Treatment capacity⁵⁷	<ul style="list-style-type: none"> • Community-based programs, providers lack sufficient capacity to treat everyone with opioid use disorder • No state has sufficient capacity to treat everyone with opioid use disorder • Inadequate treatment system with forced withdrawal for those who are justice involved 	<ul style="list-style-type: none"> • There is a widespread lack of community- and incarceration-based treatment, especially evidence based. • MAT is an underutilized evidence-based practice, with the majority of treatment providers not offering any MAT or only short-term options. • Forced withdrawal on sanctioning (e.g., incarceration, non-MAT treatment providers) can increase likelihood of relapse, recidivism, overdose, and psychological and physical symptoms. 	<ul style="list-style-type: none"> • Develop relationships with local treatment providers, physicians to help connect probationers to pharmacological treatment; peer recovery support services. • Reach out to not-for-profit and other community-based resources that may help in navigating treatment and placement for probationer. • Work with providers that offer evidence-based treatment, including long-term MAT (not forced taper or time limits).
Negative perceptions of MAT⁵⁸	<ul style="list-style-type: none"> • Probation officer belief that medications are used to replace one addiction with another or see OUD as a moral failing • Probation officer stigma, misperceptions, negative attitudes, and general lack of awareness about medications 	<ul style="list-style-type: none"> • MAT medications, particularly buprenorphine and methadone, are highly studied, validated pharmacological therapies. • All major national and international health organizations (such as World Health Organization (WHO), National Institute on Drug Abuse (NIDA), Centers for Disease Control (CDC), and SAMHSA) support and acknowledge the value of MAT as the gold standard treatment for OUD. • MAT helps individual become functioning, participatory member of society, with higher retention in treatment programs. • OUD is a chronic condition, not a moral failing. 	<ul style="list-style-type: none"> • Increase/enhance training on opioids, OUD, and opioid treatment options to counter misperceptions, myths, and misunderstandings within probation—outreach to healthcare providers, experts, and professionals. • Eliminate sanctioning and/or disqualification of clients from treatment programming because of use of prescribed medication(s) for OUD; increase understanding that treatment is an individualized process. • Refer clients to all appropriate resources, despite personal beliefs.

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