Document Title:	**Evaluation of Using Telehealth for Opioid Use Disorders in a Correctional Setting**
Author(s):	**Marina Duane, MID, Jennifer Yahner, MA, Malore Dusenbery, MS, Erica Henderson, MA**
Document Number:	**309030**
Date Received:	**May 2024**
Award Number:	**2018-75-CX-0022**

Final Research Report
NIJ FY18 Research and Evaluation in Corrections

Evaluation of Using Telehealth for Opioid Use Disorders in a Correctional Setting

Award No. 2018-75-CX-0022

Principal Investigators

Marina Duane, MID, *Principal Investigator*
Research Fellow, Chapin Hall at the University of Chicago

Jennifer Yahner, MA, *Co-Principal Investigator*
Senior Research Fellow, Urban Institute

Key Personnel

Malore Dusenbery, MS
Senior Policy Associate, Urban Institute

Erica Henderson, MA
Research Associate, Urban Institute

Acknowledgments
This study was funded by the National Institute of Justice (NIJ), Office of Justice Programs, U.S. Department of Justice, Award No. 2018-75-CX-0022. The opinions, findings, conclusions, and recommendations expressed in this document are those of the authors and do not necessarily reflect those of the Department of Justice, or of the Urban Institute or Chapin Hall, its trustees, or its funders. We also would like to thank the Franklin County Sheriff's Office (FCSO) and agency staff for their contributions to and assistance with this study, including FCSO leadership, Christopher Donelan, Ed Hayes, and Levin Schwartz as well as Courtney Silva for their partnership and contributions that made this study possible. We are also thankful to Natalie Gilbert for her substantive contributions to this technical summary, and to Urban Institute and Chapin Hall research colleagues for their review and feedback.

Abstract

At the height of the COVID-19 pandemic, in a community with high rates of opioid addiction, a jail in one county in rural Massachusetts set an example that treating addiction for people cycling in and out of incarceration can be done better (Partners for a Healthier Community Inc., 2015). In 2020, Franklin County Sheriff's Office (FCSO) capitalized on its previously built infrastructure and system partners to offer all three federally approved Medications for Opioid Use Disorders (MOUD) and provide therapeutic counseling remotely to incarcerated people as a critical component of treatment. While the majority of jails in the United States do not offer MOUD as an option to start or continue treatment during incarceration, FCSO was able to continue offering all three medications (i.e., buprenorphine, methadone, and naltrexone) during the pandemic and to meet diverse clinical needs of people coming into their jail. FCSO also continued offering individual and group counseling via telehealth throughout the pandemic and shifted to a mix of telehealth and in-person services in 2022.

In 2020, a research team from the Urban Institute and Chapin Hall at the University of Chicago in partnership with FCSO leadership worked closely to study what FCSO had accomplished to continue offering all three modalities of MOUD using telehealth. Our goal was to understand whether treatment and individual counseling as its critical component could be done remotely, what facilitated or hindered its successful application, and how clients (i.e., incarcerated people) and the professionals supporting them perceived the effects.

Our findings address a critical gap in knowledge on whether counseling can be delivered via telehealth effectively in correctional settings. We hope that our report provides useful knowledge to other jails across the country on how to shift to a treatment philosophy and create an infrastructure that is conducive to treating opioid use disorders with the dignity and prowess

required to address the complexities of unaddressed mental health needs often accompanying addiction. The results of this study are promising, as illustrated in the following highlights:

- Over a decade ago, FCSO leadership set a vision and a strategy to become a nationally recognized facility that prioritizes high-quality behavioral health treatment rather than simply "warehousing" people. Such transformation took time, but our findings suggest that at the start of the COVID-19 pandemic, most FCSO staff recognized their important role in curbing high rates of opioid addiction in Franklin County and made significant strides in expanding behavioral health treatment and therapeutic counseling as its critical component.
- By 2020, FCSO **was offering all three modalities of federally approved medications** to treat opioid use disorders as continuation and induction options. While most jails in the United States still do not offer any MOUD treatment, FCSO provides a range of options to meet the complex needs of people with opioid use disorder (OUD) diagnoses at wherever they are in the recovery stage.
- Our evaluation demonstrates ways in which FCSO was able to provide high-quality one-on-one counseling remotely at the height of the COVID-19 pandemic. For example, out of 31 surveyed clients: **90 percent reported a strong bond with their counselor**, also known as therapeutic alliance, and 84 percent rated the quality of telehealth counseling as "good" or "excellent." Furthermore, 87 percent of respondents said that counseling via telehealth helped them more effectively deal with problems in their lives, including addiction.
- Although some FCSO behavioral health staff we interviewed reported that doing trauma work in jail was challenging with people struggling with addiction and who often get released quickly was challenging, overall staff praised FCSO's decision to offer high-quality counseling and maximize client time in therapy to address important mental health needs.

Table of Contents

Appendices

Introduction

The devastating impact of the opioid epidemic on its victims and their families in the United States has been well established and documented (Centers for Disease Control and Prevention, 2023; Congressional Budget Office, 2022). Research is also ample on the high prevalence of opioid use disorders (OUDs) among people who come into contact with the criminal legal system, with 58 percent of people in state prisons and 63 percent of sentenced people in jails meeting the criteria for drug dependency or abuse (Bureau of Justice Statistics, 2017). Rural communities, especially, face a unique set of challenges in addressing the opioid epidemic, but little is known about how jails in rural settings respond to OUDs and whether they are able to effectively diagnose OUDs and meet their complex treatment needs.

Opioid Use Disorder Prevalence and Treatment Challenges in Rural Communities

The spread of the opioid epidemic has a compounding ripple effect in rural settings. When compared with urban cities, rural citizens with OUDs are more likely to be younger, single, uninsured, and impoverished, and the number of drug-related deaths in rural communities is almost twice as high as that of urban cities (National Judicial Opioid Task Force, 2019). Despite the severity of OUDs in rural communities, treatment is insufficient, exacerbating this problem. Both specialty and primary care providers are less common in rural areas, impacting patients' ability to receive a substance use disorder diagnosis and treatment (Madras et al., 2020). Of the providers that exist in rural areas, many are apprehensive about offering evidence-based Medications for Opioid Use Disorder (MOUD)[1]; whether it be due to a feeling of

[1] While both terms, Medication Assisted Treatment (MAT) and Medications for Opioid Use Disorder (MOUD), are used within the field, the Franklin County Sheriff's Office has more recently adopted "MOUD" when referring to treatment of OUD. As such, "MOUD" will be referred to as the primary term within this report.

unpreparedness or an unwillingness to bridge some of the barriers associated with rural treatment, fewer rural clinicians offer MOUD services (Lister et al., 2019). As a result of this, many rural residents must travel incredibly long distances to receive treatment. One study (Cole et al., 2019) showed that rural Medicaid enrollees with OUD travel four times longer to MOUD prescribers than the median of all Medicaid enrollees, which is associated with a lower likelihood of receiving MOUD (Madras et al., 2019).

The problems that people with OUD in rural areas face hold especially true for people in rural jails. Rural jails are less likely to have full-time behavioral health clinicians, thus compounding the challenges of diagnosing and treating OUDs (Kopak et al., 2019). A lack of full-time behavioral health clinicians also limits the ability to provide MOUD services. Once individuals are released from jails in a rural community, they face many barriers to treatment associated with living in rural communities. Often, jail facilities that provide OUD treatment fail to connect individuals with community-based programming upon release, which results in treatment disruption (Kopak et al., 2019). In rural communities, returning citizens face a lack of transportation to service providers, difficulty in building community relationships, concerns about the confidentiality of their OUDs in such a small community, and a high cost of treatment—all of which decrease the chances of receiving MOUD (Bunting et al., 2018). Treatment disruption also puts people at higher risk of relapse and, by extension, potential overdose (Ronquest et al., 2018).

OUD Treatment Philosophy and Approach in Franklin County, MA

With the third highest rates of overdose fatalities in the state and complexities with providing treatment in a rural setting, Franklin County Sheriff's Office (FCSO) in Massachusetts made a strategic decision to shift their jail facility away from simply operating as a place to contain

people, to becoming a jail that played an important role in the treatment solution to the opioid use epidemic. In 2011, the new sheriff of FCSO had a very clear vision of how he wanted to transform the agency: he set out to shift the prevalent jail culture of containment (also known as "warehousing" people) to one that embraced a philosophy of rehabilitation.

According to our research team's interviews with 21 FCSO leadership and staff, making this vision a reality did not happen overnight. But thanks to the concerted effort of bringing in state and federal grant money that allowed for expansion of treatment options, FCSO's training and retraining of current staff, in addition to hiring of new staff with the right behavioral health background and skillsets, helped the facility make important transformations. After more than 10 years of this transformation, today FCSO offers all three federally approved MOUD (i.e., buprenorphine, methadone, and naltrexone), provides high quality individual and group counseling, and facilitates a continuum of treatment care upon reentry. Such a mix of treatment options to meet a variety of individual diagnoses and needs is still lacking in many jails across the United States.

Evaluation Goal and Objectives

From 2020 to 2023, a team of researchers from the Urban Institute and from Chapin Hall at the University of Chicago partnered with FCSO to study how their jail approached MOUD treatment, particularly via telehealth during the COVID-19 pandemic. The goal of our research was to conduct a mixed-methods, implementation and outcome evaluation of FCSO's use of telehealth technology to deliver MOUD treatment, as well as counseling, which is considered a critical complement of the treatment. Being set in a rural area in Greenfield, Massachusetts, and

housing between 150 and 200 individuals a day, approximately half of whom have an OUD diagnosis, FCSO had the right conditions to meet the research team's evaluation objectives.

By 2019, FCSO had established a comprehensive behavioral health treatment approach at their facility, which included availability of all three federally approved medications (i.e., buprenorphine, methadone, and naltrexone) as well as accompanying psychotherapeutic support in the form of mandatory one-on-one counseling and group therapy, voluntary support groups, and post-release services to maintain a continuum of care in the community. FCSO also remains one of the few jails across the country to offer all three medications for those people who have been previously diagnosed in the community (known as a maintenance-on-drug option) or for those who are newly diagnosed and offered treatment for the first time upon admission (known as an induction option). Shortly after the COVID-19 pandemic began in March 2020, FCSO shifted to using telehealth to continue providing behavioral health treatment to incarcerated people, while other correctional facilities ceased all but essential medical services. FCSO has been a committed partner throughout this research to evaluate the use and effectiveness of their telehealth services, both retrospectively during the pandemic as well as prospectively as services begin to normalize.

Research Questions

This evaluation aimed to answer the following research questions:

1. How has telehealth technology been implemented by FCSO to support OUD treatment in jail and post-release, and what were the barriers and facilitators to successful telehealth implementation?
2. To what extent are FCSO correctional and behavioral health stakeholders committed to and able to sustain telehealth use in the long term?

3. How effective has telehealth technology been at providing a broader access to treatment, addressing the precursors to OUD recovery, and reducing recidivism, as measured by:
    a. Engaging individuals in OUD treatment;
    b. Achieving satisfaction among OUD treatment participants;
    c. Developing a positive OUD therapeutic alliance between counselors and clients;
    d. Facilitating a continuum of care post-release; and
    e. Reducing future re-arrests and/or admissions to FCSO jail?
4. To what extent has telehealth for OUD treatment been associated with reduced recidivism compared to in-person OUD treatment and post-release services?

Research Design and Methods

To address the gaps in knowledge on the effectiveness of using telehealth to facilitate MOUD treatment in rural settings and answer the research questions, Urban and Chapin conducted a mixed-methods evaluation, engaging in the following components:

- Reviewed policy and program materials, including FCSO documentation regarding OUD treatment and telehealth use, as well as findings from prior analyses of OUD services;
- Collected and analyzed quantitative, administrative data, including de-identified individual-level records on study participants' criminal history and OUD treatment during FCSO custody and post-release;
- Conducted and analyzed semi-structured interviews and surveys with 24 FCSO correctional and behavioral health staff and community providers regarding perceptions of OUD treatment and telehealth implementation success, barriers, and facilitators; the extent of OUD treatment engagement, equity, satisfaction, therapeutic alliance, and continuum of care; and

- Conducted and analyzed surveys of 31 participants and 4 counselors who worked with them regarding perceptions of OUD treatment engagement, equity, satisfaction, therapeutic alliance, and continuum of care.

Survey of Telehealth Counselors

In September 2021, we administrated an online survey to all four behavioral health counselors who delivered OUD treatment via telehealth from FCSO.

Survey Instrument

The survey instrument (Appendix A) included 14 questions covering the domains of respondent background, perceptions of telehealth, and scale to measure whether a bond between a counselor and a patient was formed known as therapeutic alliance. To measure therapeutic alliance, the research team slightly modified one of the most commonly used validated tools, the Helping Alliance Questionnaire, as recommended by the medical director at FCSO (Luborsky et al., 1996; Scholl et al., 2022).

Sample Characteristics

All four counselors who offered therapy from May 2020 to April 2021 completed Urban's online survey, which was administered in May 2021. Among 4 counselors, 2 identified as males and 2 identified as females. All had delivered or had been delivering services to justice-involved people for 6 months to 1 year. Three had delivered or had been delivering services to people with OUDs for 6 months to 1 year, and 1 counselor had done so for 1 to 3 years. All counselors provided both individual counseling and conducted intake clinical assessments remotely.

Analytic Methods

The secure online software program, Qualtrics, was used to collect survey data. When the survey closed, we extracted all raw data responses into the statistical software program, SPSS, and

conducted a review to clean the data, correcting for minor typographical errors and cross-checking variables for inconsistencies. We then conducted descriptive analyses, examining frequencies, percentages, means, and other statistics to produce the outputs described below.

Survey of Telehealth Participants

The secure online software program, Qualtrics, was used to collect survey data. From February to April 2022, the research team with help from on-site research liaison administered the survey to people with OUD diagnoses who were currently or recently incarcerated in FCSO and had participated in at least three sessions of individual counseling via telehealth. We identified 62 eligible participants who had received telehealth counseling between May 2020 and April 2021 and attempted to recruit them all for voluntary and confidential survey completion, in accordance with human subjects' protections approved by our Institutional Review Board and the National Institute of Justice Human Subjects Protections Office.

Of 62 participants who we attempted to reach at least three times by phone or in-person, 31 completed the survey—including 15 people who were still incarcerated as of February 2022 in FCSO and 16 who were released into community. Of those who we could not engage: 20 people were unreachable or had no/incorrect contact information recorded, 7 phone numbers were not in service, 4 participants were transferred or reincarcerated in another facility. For those who were currently incarcerated, the survey was administered online with assistance from an on-site research liaison. For those who were released into the community as of February 2022, the survey was administered either online by participants or by telephone with a research liaison, depending on the participant's choice.

Survey Instrument

The survey instrument (Appendix B) included 30 questions covering the domains of respondent background, OUD diagnosis and treatment status, client satisfaction, therapeutic alliance, and drug use and arrest history. Survey questions were derived from other tools where available, which included the Helping Alliance Questionnaire (Luborsky et al. 1996). The Helping Alliance Questionnaire-II (HAq-II) was designed to measure the therapeutic alliance based on the collaboration and bond between therapist and patient. The HAq-II has both a therapist version and a patient version. These questionnaires were included in the aforementioned counselor survey and in this participant survey to measure the therapeutic alliance between counselors and clients.

Sample Characteristics

As mentioned, a total of 31 people who were incarcerated with an OUD diagnosis at some point during May 2020 to April 2021 and received at least three sessions of individual counseling via telehealth during that time (from FCSO behavioral health staff) completed the survey. These 31 participants were male (81%), female (19%); non-Hispanic (93%), Hispanic (7%); white (87%), and Black or African American (13%). The average age of respondents was 33 years old; the minimum age was 25 and the maximum age was 50. In terms of the highest level of education completed, 19 percent completed some high school, 58 percent graduated high school or obtained their GED, 16 percent completed some college, and 6 percent graduated college. This demographic profile of survey completers closely mirrored that for non-completers (of 62 eligible clients); both groups were statistically similar in age, race, gender, number of prior arrests, number of adverse childhood experiences, number of telehealth counseling sessions

received, and proportion who recidivated (based on independent samples t-tests and proportions tests).

Of the 31 respondents, 81 percent reported being diagnosed with an OUD prior to entering FCSO and 19 percent were diagnosed after entering the facility. Additionally, 52 percent received MOUD in the community prior to entering FCSO, while 48 percent started MOUD only after entering FCSO. In terms of drug use and arrest history, 55 percent of respondents reported using opioids for more than five years before they entered FCSO and 74 percent reported having been arrested more than 5 times.

While all 31 participants surveyed received individual/one-on-one counseling via computer or telehealth, 9 participants also received in-person/face-to-face counseling, and 3 participants also received counseling via workbooks and independent assignments. Additionally, 68 percent of respondents also participated in group counseling sessions.

Analytic Methods

As with the *Survey of Telehealth Counselors*, for this survey we again extracted raw data responses from Qualtrics into SPSS statistical software. From there, we reviewed the data, examining and reporting frequencies and descriptive statistics below. To produce scores for the Helping Alliance Questionnaire discussed below, we added the positively scored items and reverse scored the negatively worded items, in accordance with guidance from the HAq-II authors (Appendix C). We then integrated Haq-II scores from counselors, matching them to scores for the participants with whom they engaged, to assess the degree of alliance between counselors and clients.

Criminal History and Behavioral Health Records

To supplement the study data, we gathered via online surveys of FCSO counselors and study participants, the research team also requested from FCSO information about criminal history and behavioral health records recorded in their management information system.

DATA SOURCE

FCSO provided two quantitative datasets containing deidentified, individual-level, criminal history, and behavioral health records of people with an OUD diagnosis who were undergoing MOUD treatment in FCSO during incarceration at some point between May 2020 and April 2021. The first dataset covered the 62 individuals who received at least three telehealth counseling sessions between May 2020 and April 2021 ("telehealth dataset"), while the second dataset covered the 18 people who received at least three in-person counseling sessions during an overlapping timeframe (between October 2020 and March 2021; "in-person dataset"). The latter group of individuals was intended to serve as a comparison group to the telehealth clients.

Both Excel files included information about individuals' demographics (age, race, ethnicity, gender); number of prior arrests; number of adverse childhood experiences; mental health, addiction, and MOUD status at booking; FCSO booking date and charge(s) relevant to the incarceration of focus (between May 2020 and April 2021); sentence status, distinguishing those held pretrial from those on a sentence held under minimum, medium, or prelease security; number and dates of one-on-one counseling sessions (whether telehealth or in-person); number and dates of group therapy and support groups; first release date following booking, as of the time[2] of this study's data collection, if relevant; and any recidivism since that release.

[2] FCSO criminal history and behavioral health records were collected in April, 2022, for the N=62 telehealth dataset and May 15, 2022, for the N=18 in-person dataset.

Recidivism information was extracted by an FCSO research liaison for this study from the FCSO management information system and included data on reincarceration or returns to custody, new arraignments, and violations of probation or parole. FCSO does not typically analyze recidivism information for people released after being held pre-trial, but because a majority (74%) of those in the telehealth dataset were being held pretrial (and 28% of the in-person dataset), they agreed to provide post-release information for all people in each dataset based on review of their Franklin County House of Correction records.

SAMPLE CHARACTERISTICS

The 62 individuals who received telehealth counseling were male (79%), female (21%); non-Hispanic (90%), Hispanic (10%); white (87%), and Black (13%).[3] The average age of individuals was 35 years old; the minimum age was 22 and the maximum age was 61. Information on prior arrests was available for 46 of the 62 individuals and showed an average of 20 prior arrests per person (median 16, minimum 3, maximum 76). The total adverse childhood experiences score was available for most individuals (57 of 62) and ranged from 0 to 10, with an average score of 4.7. Finally, during their stay, the sample received an average of 8.5 individual telehealth counseling sessions per person, ranging from a minimum of three sessions (a criterion for sample selection) to a maximum of 31 sessions.

Of the 62 individuals, all were identified as having an addiction at booking, and 71 percent were already receiving some type of MOUD in the community prior to entering FCSO. Eighty-nine percent had a mental health diagnosis at booking, which included anxiety, Post-Traumatic Stress Disorder, mood disorders, Attention-Deficit/Hyperactivity Disorder, and

[3] Demographics data are based on that recorded in FCSO's management information system.

bipolar disorders, and the same percentage (89%) showed mental health symptoms at the time of their booking.

Analytic Methods

We received the criminal history and behavioral health records from FCSO as two Excel files—one reflecting the telehealth dataset (N=62) and the other the in-person dataset (N=18). After transferring these data into SPSS statistical files, we created numeric versions of string variables and computed several analytic variables to analyze recidivism. These included time since release as of the date of data collection (which was April 19, 2022, for the telehealth dataset and May 15, 2022, for the in-person dataset), and measures of any recidivism event, reincarceration or return to custody, new arraignment, and/or violation of probation or parole, if known. The latter variables were derived from a text field indicating criminal history status created by the FCSO research liaison to support this study. In SPSS, we analyzed frequencies and descriptive statistics for both datasets, and conducted independent samples comparisons of telehealth participant survey completers and non-completers (referenced above). Recidivism comparisons of telehealth and in-person counseling recipients were not possible statistically given the small number of in-person recipients with at least one year of valid recidivism data.

Interviews with FCSO Staff and Community Providers

From May 2021 through March 2022, we conducted semi-structured interviews with FCSO staff and community providers who deliver treatment and support to people with OUD during incarceration and upon release. The research team spoke with practitioners who implement, deliver, or oversee telehealth or in-person MOUD services or supports. The purpose of the semi-structured interviews was to learn the context in which MOUD treatment is offered, examine

how telehealth component compliments the behavioral health support that FCSO provides, and understand the barriers and facilitators of providing services via telehealth.

Interview Instrument

We used the interview protocol included in Appendix D to guide our semi-structured interviews.

Sample Characteristics

Of 24 practitioners that were interviewed: 3 interviewees were representatives from FCSO leadership; 4 were FCSO staff who provided behavioral health treatment and 2 were medical providers; 2 were correctional staff pivotal to participants' engagement in behavioral services; 5 were clinical interns who provided individual counseling via telehealth; 3 provided behavioral health treatment for people who reenter into community; 4 were reentry staff and 1 community provider who was embedded into FCSO to facilitate continuous treatment upon release.

Analytic Methods

The notes from semi-structured interviews were cleaned and exported into Dedoose, a secure, cloud-based software to manage and analyze qualitative data. We developed and tested a coding scheme that included themes and patterns from the collected data. Two members of the research team were assigned to code 24 transcripts from the interviews. Three members of the research team then analyzed the codes to organize them around themes and patterns in the coding scheme. Coded and analyzed qualitative data were reviewed by senior researcher and checked against original notes from several themes to ensure that interviewees' reflections were accurately represented in the analyses.

Summary of Results and Findings

Working in partnership with FCSO, we conducted a set of mixed-method evaluation activities described above to capture the nuances of providing behavioral health treatment at FCSO and in the rural community at large, and to learn perceptions of FCSO staff and clients on telehealth effectiveness. Through these activities, we identified several larger themes, described below.

1. Shifting to treatment culture takes time.

More and more jails across the country recognize the importance of providing behavioral health treatment, educational opportunities, support groups and otherwise creating conditions to better people who are housed within their facilities. At FCSO, the transition from a "containment philosophy" to that oriented towards treatment has taken over a decade. While it is still a work-in-progress, several interviewed FCSO staff and community partners noted that a treatment-oriented approach helps the facility meet incarcerated people where they are. According to some interviews and in line with existing evidence, shifting away from abstinence as the only option to offering MOUD helps people stay in treatment and potentially reduce the risk of overdosing upon release (Substance Abuse and Mental Health Services Administration, 2019).

> *"This culture did not come overnight. Awhile back abstinence type mentality prevailed. After release, many people come back to same doses, which puts their life at risk. So, over the years we have realized that we have a role [at FCSO] in preventing overdoses and helping people engage and stay in treatment." – FCSO staff*

2. Providing a variety of treatment options helps meet diverse and complex needs of people with OUDs.

Over the last decade, FCSO has built the capacity to offer all three federally approved medications, namely buprenorphine, methadone, and naltrexone but the majority of people end up on buprenorphine or methadone medications. At FCSO, all three options are offered as maintenance for those people who were on MOUD prior to incarceration. All three options are also available to initiate even if people did not receive medication prior to incarceration. This result is notable as most jails across the country still do not offer MOUD as maintenance or initiation (National Sheriffs' Association, National Commission on Correctional Health Care, 2018). Such a variety of options allows FCSO clinical staff to better tailor treatment to a variety of therapeutic needs and diagnoses. While there is a debate in the field on whether MOUD should prioritize medication and make accompanying behavioral therapy optional, the Substance Abuse and Mental Health Services Administration still emphasizes that psychosocial therapy is a critical component of MOUD treatment (Mace et al., 2020). At FCSO, a variety of available medications is accompanied by robust therapeutic treatment in the form of mandatory one-on-one counseling, group therapy and voluntary support groups. Such therapeutic services help people address their mental health needs, which often accompany addiction.

3. Hiring and supporting staff with behavioral health backgrounds are critical components of a comprehensive treatment approach.

FCSO made a strategic decision to hire and maintain staff who had the right mix of skills and professional backgrounds to provide behavioral health treatment. To date, FCSO has a clinical manager and four full-time staff who provide group and individual counseling to people with OUDs; three nurses with one of them exclusively working with MOUD patients; a robust clinical

internship that at the time of evaluation included five interns who were obtaining their clinical psychology degree from Smith College and offering one-on-one counseling remotely; and a reentry team with case workers who help facilitate connection to treatment with behavioral health providers in the community.

All counselors and staff received supervision and participated in integrated care meetings to discuss individual cases. These integrated care meetings brought together behavioral health leadership and staff, counselors, clinicians who prescribed medication and adjusted dosage, and reentry staff to discuss dosage adjustment and review the progress towards recovery for specific people. Such an investment in hiring people who are properly suited for the job and supporting them on the job is welcomed by staff. During our research team's interviews, several staff who worked with patients directly noted that it was helpful to have an experienced supervisor who helped them navigate the complexity of OUD diagnoses and therapeutic needs, and many interviewees reported that they noticed and appreciated leadership's investment in increasing staff capacity to effectively engage and support people with complex diagnoses and needs. Several interviewees also noted that integrated care team meetings were very helpful in understanding the context and nuance of each person's journey and make any necessary adjustments in their individual work with those patients whose cases were discussed.

4. When people are released into the community, providing a continuum of care can be challenging; accordingly, FCSO embedded a community behavioral health provider in their facility to facilitate this transition.

Far too often, people do not continue their behavioral health treatment after incarceration for a variety of reasons, such as challenges with transportation, limited provider options, gaps in insurance coverage, or simply a desire to dissociate from treatment, which can remind them of

their time in jail (Guillen et al., 2022; Cole et al., 2021; Bunting et al., 2018). While agreeing that engagement in treatment upon release was still a challenge in Franklin County, our interviews revealed that FCSO and their community partner found a creative solution. The major behavioral provider in the community now has an embedded staff member who works at FCSO. In partnership with the reentry team, this person can discuss treatment options with people preparing for release, make an electronic referral, and schedule their first appointment in the community. This solution reduced some burden to enroll in treatment on the people who already faced many challenges when reintegrating back into society.

5. Similar to many other jails across the country, FCSO had to face many challenges of the pandemic but were able to successfully shift most of their services online.

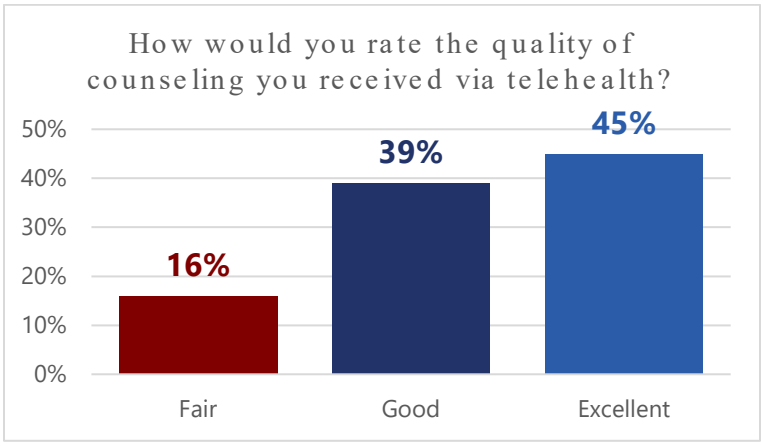
When the pandemic hit the U.S., after some trial-and-error experiences, FCSO was able to shift to remote delivery of most services to incarcerated people successfully. Below is a summary of research findings based on each type of virtual telehealth activity FCSO launched.

REMOTE ONE-ON-ONE THERAPEUTIC COUNSELING

Remote one-on-one therapeutic counseling was mandatory for people who received MOUD at FCSO during the pandemic. At the time of evaluation, counseling was provided by five interns who were working towards their clinical psychology degrees in Western Massachusetts. Our research team administered an online survey, which included the Helping Alliance Questionnaire-II, to telehealth counseling participants and their counselors to examine whether a therapeutic alliance was formed. Among 31 survey respondents, 90 percent of participants scored high, indicating a strong therapeutic alliance with their counselor. This was an important finding, particularly because jails are not often associated with a therapeutic environment; the alliance was formed even in the midst of distress brought on by the pandemic; and addiction presented a

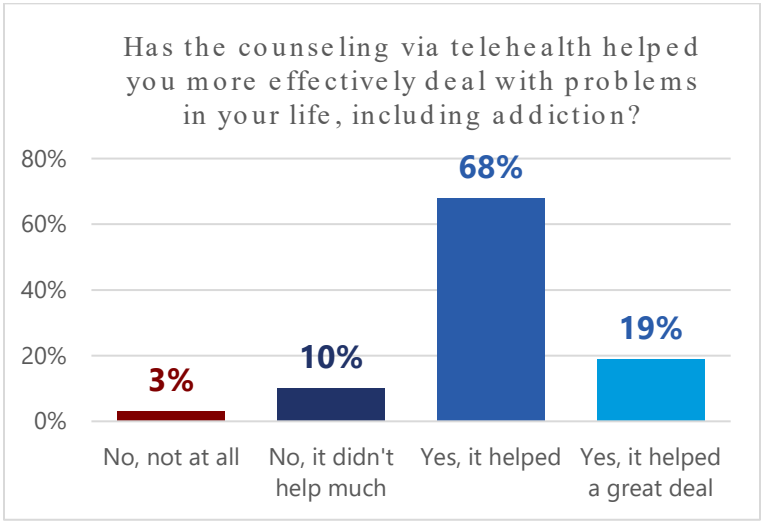
unique set of stressors and challenges to overcome in therapy. Furthermore, as figures 1 and 2 show, 84 percent of participants rated the quality of counseling via telehealth as "good" or "excellent," and 87 percent of participants said that counseling helped them more effectively deal with problems in their life, including addiction. Furthermore, 77 percent of participants reported that they liked that virtual counseling allowed for continuation of services during COVID-19.

Figure 1. FCSO Telehealth Participants' Satisfaction with Counseling



Data Source: Survey administered by the research team in February-March 2022.

Figure 2. FCSO Telehealth Participants' Satisfaction with Counseling



Data Source: Survey administered by the research team in February-March 2022.

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

The research team also administered a therapist version of the Helping Alliance Questionnaire-II to FCSO's telehealth counselors, in reference to the participants they served during the pandemic time period. The percentage of high therapeutic alliance scores given by counselors was lower than that of telehealth participants. Namely, as figure 3 shows, only 18 of the 31 scores (58%) that counselors provided were high (compared to 90% of the scores participants gave). However, according to the authors of the Helping Alliance Questionnaire-II, in a general population, therapist scores are generally lower than those of clients/patients, but research has shown that the client/patient scores are most valid (Luborsky et al., 1996)). Considering all the complexities with offering high-quality counseling in jails to people with OUDs, these findings appear promising.

Figure 3. Therapeutic Score Alliance Between Telehealth Counselors and Participants

		Participant Score	
		Low (n=3)	High (n=28)
Counselor Score	Low (n=13)	2 (6%)	**11 (35%)**
	High (n=18)	1 (3%)	**17 (55%)**

Data Source: Survey administered to counselors in May 2021 and to clients in February-March 2022.

According to these surveys and our interviews with counselors, FCSO initially experienced challenges with internet connections and privacy was not always secured for some patients at the facility. However, over time FCSO was able to address these issues and secure a private room that was dedicated to participants who attended remote counseling. Another issue that FCSO highlighted in interviews and surveys was that trauma work was generally challenging for people with OUDs in a correctional setting, especially with people who justly have brief stays at the jail.

Among notable benefits of telehealth counseling, some counselors reported that providing counseling remotely was more convenient for their schedules and helped them feel safer. Additionally, according to interviews with several FCSO staff and counselors, connecting with counselors who were not physically in the jail helped clients dissociate counselors from the correctional staff, which may have addressed several challenges with creating a therapeutic environment in a correctional setting.

Virtual Therapeutic Groups

Virtual therapeutic groups were mandated for clients who received MOUD treatment at FCSO. These groups were led by FCSO behavioral staff and an assistant facilitator. Some weekly groups employed what is known as Dialectic Behavioral Therapy that supports participants in early recovery and stages of change. Another group was an 8-session program conducted on a weekly basis utilizing the Acceptance and Commitment Therapy approach. FCSO also offered a variety of support groups on a voluntary basis ranging from Alcoholic or Narcotics Anonymous meetings, nurturing fathers, and educational groups facilitated by people from the outside, to a gamified addiction and recovery program known as ATARY that was co-led by FCSO staff and an external facilitator. This study primarily focused on the effectiveness of individual counseling, so we were not able to observe these groups or survey a larger number of participants and facilitators. However, during semi-structured interviews, FCSO staff had mixed perceptions on the effectiveness of virtual group therapy. Some interviewees mentioned challenges with creating a setup that allowed all participants to be seen on camera. Others said that meeting individual needs and managing people who presented with different symptoms and reactions to medication was a challenge. And most interviewees said that some people engaged well in group sessions, while others did not. Our analysis showed a trend that behavioral health staff tended to have

more positive perceptions of virtual group interventions, while correctional staff expressed greater doubts about their effectiveness. Most interviewees agreed that having a variety of group and individual therapeutic options helped meet incarcerated clients' needs.

TEXTEDLY

Textedly was a texting platform for sending automatic SMS text messages in bulk; it became another telehealth tool for FCSO reentry staff to connect with and share motivational and treatment-oriented messages with people after their release into the community. As of March 2022, a total of 94 clients were enrolled in Textedly and less than one percent of clients opted to unsubscribe. FCSO staff used Textedly to send out information about community resources, motivational quotes and COVID-19 testing sites. While most of the participants did not reply, some reached out to the staff member sending such texts with positive reactions. According to two interviews, at the beginning of the pandemic, some men who typically did not engage with their reentry workers did reach out for help via text. Further research is needed to understand whether SMS messaging is effective as another arm of behavioral health support and, if so, for whom. FCSO staff reported that they viewed Textedly as an additional option to reach and support some of their clients upon release.

6. People who received counseling via telehealth had similar rates of recidivism as those prior to COVID-19.

There is a growing body of research that points out the limitations of emphasizing recidivism as the main outcome when studying responses to interventions for people involved in the criminal legal system, particularly those with substance and/or behavioral health disorders (Recidivism, n.d.). Among the numerous challenges with recidivism studies, prominent limitations are a) the shift in emphasis to episodic failures rather than studying what system actors and community

providers do to help people overcome challenges and succeed; b) limited options to track events of returning to correctional settings where conviction is not the only available data point; c) documented events of recidivism do not necessarily reflect the nature of someone's behavior but instead the decisions of system actors that tend to include an overrepresentation of people who are poor and of color (Butts & Schiraldi, 2018; Duran & Brown, 2018; National Academies of Sciences, Engineering, and Medicine, 2022).

With these issues in mind, more and more researchers focus on what is known as "desistance from crime," which shifts the focus of research from single events to studying the process through which people arrive to non-offending in the future (Bucklen, 2021). In line with this recent trend in research, the research team did not include measures of self-reported recidivism in the survey of telehealth participants and does not consider the official records collected as critical to evaluating FCSO's approach to treatment. However, we do present this outcome in the context of other findings highlighted above while acknowledging its limitations.

Our analysis of recidivism focused on study participants for whom at least one year of post-release data was available, which was in line with previous analyses of FCSO recidivism data by its own researchers and by that of academics analyzing FCSO recidivism data for those with OUDs (Evans et al., 2022). Of the 62 telehealth participants, 11 individuals (18%) had not been released from FCSO at the time of this study's data collection and 12 individuals (19%) were released but for less than a year; for these 23 individuals, we did not or could not examine their recidivism. For the remaining 39 people with OUDs who received telehealth counseling during their FCSO incarceration and were released at least a year by the time of this study's recidivism data collection: 43 percent experienced some type of recidivism event within the first year of release, which included reincarceration or return to FCSO custody (23%), a new

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

arraignment (31%), and/or violation of their probation or parole (VOP; 11%). These 39 people included those who had been incarcerated in FCSO on a sentence (28%) and those detained pretrial (72%), with the only significant difference between the two groups being that pretrial detainees did not incur any VOP recidivism events. Importantly, the recidivism percentages observed are comparable to those reported by Evans, Wilson, and Friedmann (2022) in their analysis of FCSO recidivism data for 197 people with OUDs who exited FCSO jail from 2015 to 2019 (prior to the COVID-19 pandemic, when only in-person counseling was provided). Specifically, these authors reported rates of any recidivism (48%), reincarceration (21%), new arraignment (36%), and VOP (17%), compared to this study's rates of 43 percent, 23 percent, 31 percent, and 11 percent, respectively (as shown above) for people who received telehealth counseling during the pandemic. Despite the small sample sizes and limited observation window included in the present study, this similarity in recidivism rates prior and during the pandemic points to the viability of telehealth counseling for people with OUDs in correctional facilities.[4]

Limitations of the Study

This study was meant to address the gaps in research at the time on whether counseling via telehealth as a critical component on MOUD was potentially effective in correctional settings and to what extent it enhanced treatment for incarcerated people with OUDs. Since the pandemic, organizations across the country have embraced telehealth technologies more so than ever before, yet research is still lagging on how telehealth technology is used in jails and whether it can affect behavioral health outcomes as effectively as can in-person treatment.

[4] Comparison to recidivism data for the in-person dataset is not presented because of a very small sample size. Of the 18 people incarcerated in FCSO with OUDs who received at least three in-person counseling sessions, only 10 had recidivism information available for at least a year post-release at the time of data collection.

FCSO was well-suited to serve as an evaluation site as the facility offered a wide range of behavioral health services inside its correctional walls and had strong partnerships with community providers despite its rural geography. Although the information provided in this report can serve as a baseline for future research and evaluation in other correctional facilities, as with all social studies, it is subject to some limitations, including:

- Our study did not include any data collection from participants about their ability to connect to OUD treatment upon release. Future research of this issue could provide critical knowledge on clients' ability and access to post-release treatment and its relationship to overdose fatalities.
- Although this study included a variety of data collection methods to examine staff and participant perceptions of individual counseling delivered via telehealth, we did not employ as many methods to explore other telehealth treatment modalities, such as telehealth group therapy and SMS messaging. Given the global trend toward remote access behavioral health treatment, these modalities and others should be examined in greater depth in future studies.
- Of the 62 clients who received individual counseling via telehealth, only half completed our survey. Out of 31 survey completers, almost half were still (or again) incarcerated in FCSO at the time and the other half were out in the community. We experienced challenges with reaching many eligible participants who were released at the time of recruiting for the survey. Engaging formerly incarcerated people in research studies is a common challenge that often requires substantial resources and a longer study timeframe to achieve.

- Counselors completed the survey in late Spring 2021 and clients completed the survey in February-March 2022 answering questions about counseling that they received between May 2020 and April 2021. While counselors completed the survey soon after the last session with some of their clients, clients completed the survey almost or longer after their last counseling session. This gap between the client survey and the last day of service is subject to recall bias, which means that respondents may have had inaccurate or incomplete recollection of their counseling sessions.
- The collection and analyses of data from interviews and surveys were based on individuals' self-reports and may be subject to biases held by those respondents.
- As described previously, the success of telehealth delivered treatment to incarcerated people with OUDs should be measured, ideally, through a comprehensive set of outcomes that capture diverse measures of behavioral changes over time, for a relatively longer period of time with a larger number of people than available in this study.
- Recidivism data we examined was limited in scope, time, and size, with an inability to distinguish participants' behavioral changes from decisions of system actors. We have reported on one-year recidivism rates based on the administrative dataset, but in the future more research is needed on participants' recovery and desistance post-release through measures such as self-reported positive changes, overdose hospitalizations and fatalities or probation records.

Changes in Approach from Original Design and Reason for Change

Our original design included a randomized controlled trial in a different correctional setting. However, the previous site was not able to participate in the research due to the lockdown of the facility as a result of the rapid spread of COVID-19 cases. In consultation with the NIJ, we have

established a partnership with FCSO as a new site to carry out a comprehensive, mixed-methods, implementation and outcome evaluation of the use of telehealth technology for OUD treatment in FCSO correctional populations.

Expected Applicability of the Research

This study contributes essential knowledge about how telehealth can be used and evaluated in correctional settings to provide individual counseling, facilitate MOUD treatment and improve outcomes for incarcerated people with OUD. We also provide background information on the institutional culture and the nuances of how MOUD treatment is delivered at the FCSO facility to offer important context for other jails that are considering or implementing MOUD treatment virtually or in-person. We hope that our report provides useful knowledge to other jails and correctional facilities across the country on how to shift to a treatment philosophy and create an infrastructure that is conducive to treating opioid use disorders with the dignity and prowess required to address the complexities of unaddressed mental health needs often accompanying addiction. Finally, we hope that our initial study in Franklin County will serve as the basis for future research and evaluation on MOUD treatment in other correctional settings.

Dissemination and Close-Out Activities

This evaluation has resulted in multiple products of use to practitioners and researchers in the correctional and behavioral health fields, as follows:

- Final research report to NIJ on all the activities conducted for the study;
- Policy brief presenting key study findings in practitioner-accessible language to be published on Urban's web-site;
- Scholarly journal article presenting study findings in researcher-accessible language;

- Two presentations on interim findings at the Annual American Society of Criminology Conferences in 2021 and 2022;
- Presentation of findings at the NIJ's 2023 Research Conference and recording of a podcast series highlighting the results and discussion of our study;
- Practitioner-oriented webinar where research team and FCSO partners will discuss the findings from this study.

References

Bucklen, K. B. (2021, October 25). *Desistance-focused criminal justice practice*. National Institute of Justice. https://nij.ojp.gov/topics/articles/desistance-focused-criminal-justice-practice

Bunting, A. M., Oser, C. B., Staton, M., Eddens, K. S., & Knudsen, H. (2018). Clinician identified barriers to treatment for individuals in Appalachia with opioid use disorder following release from prison: A Social Ecological Approach. *Addiction Science & Clinical Practice*, *13*(1). https://doi.org/10.1186/s13722-018-0124-2

Bureau of Justice Statistics. (2017, June). *Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009*. Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf.

Butts, J. A., & Schiraldi, V. (2018, March 15). *The recidivism trap*. The Marshall Project. https://www.themarshallproject.org/2018/03/14/the-recidivism-trap

Centers for Disease Control and Prevention. (2023, May 8). *Understanding Drug Overdoses and Death*. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/epidemic/index.html

Cole, E. S., DiDomenico, E., Cochran, G., Gordon, A. J., Gellad, W. F., Pringle, J., Warwick, J., Chang, C.-C. H., Kim, J. Y., Kmiec, J., Kelley, D., & Donohue, J. M. (2019). The role of primary care in improving access to medication-assisted treatment for rural Medicaid enrollees with opioid use disorder. *Journal of General Internal Medicine*, *34*(6), 936–943. https://doi.org/10.1007/s11606-019-04943-6

Cole, T. O., Robinson, D., Kelley-Freeman, A., Gandhi, D., Greenblatt, A. D., Weintraub, E., & Belcher, A. M. (2021). Patient satisfaction with medications for opioid use disorder treatment via telemedicine: Brief literature review and development of a new assessment. *Frontiers in Public Health*, *8*. https://doi.org/10.3389/fpubh.2020.557275

Congressional Budget Office. (2022, September). The Opioid Crisis and Recent Federal Policy Responses. https://www.cbo.gov/system/files/2022-09/58221-opioid-crisis.pdf

Duran, J., & Brown, S. C. (2018, August 8). *Fewer people are going back to prison-but that doesn't paint the...* Vera Institute of Justice. https://www.vera.org/news/fewer-people-are-going-back-to-prison-but-that-doesnt-paint-the-entire-picture

Evans EA, Wilson D, Friedmann PD. (2022, Feb 1). Recidivism and mortality after in-jail buprenorphine treatment for opioid use disorder. Drug Alcohol Depend. doi: 10.1016/j.drugalcdep.2021.109254. Epub 2022 Jan 18. PMID: 35063323; PMCID: PMC8852331.

Guillen, A. G., Reddy, M., Saadat, S., & Chakravarthy, B. (2021). Utilization of telehealth solutions for patients with opioid use disorder using buprenorphine: A scoping review. *Telemedicine and e-Health*, *28*(6), 761–767. https://doi.org/10.1089/tmj.2021.0308

Kopak, A. M., Guston, K., Maness, L., & Hoffmann, N. G. (2019). A prospective study of behavioral health indicators and repeat jail admissions among rural inmates. *Health & Justice*, *7*(5). https://doi.org/10.1186/s40352-019-0087-8

Lister, J. J., Weaver, A., Ellis, J. D., Himle, J. A., & Ledgerwood, D. M. (2019). A systematic review of rural-specific barriers to medication treatment for opioid use disorder in the United States. *The American Journal of Drug and Alcohol Abuse*, *46*(3), 273–288. https://doi.org/10.1080/00952990.2019.1694536

Luborsky, L., Barber, J. P., Siqueland, L., Johnson, S., Najavits, L. M., Frank, A., & Daley, D. (1996). The revised helping alliance questionnaire (HAq-II): psychometric properties. The Journal of psychotherapy practice and research, 5(3), 260.

Mace, S., Siegler, A. Wu, K., Latimore, A., & Flynn, H. (2020). Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit. The National Council for Behavioral Health and Vital Strategies.

Madras, B. K., Ahmad, N. J., Wen, J., & Sharfstein, J. (2020). Improving access to evidence-based medical treatment for opioid use disorder: Strategies to address key barriers within the treatment system. *NAM Perspectives*, 1–37. https://doi.org/10.31478/202004b

National Academies of Sciences, Engineering, and Medicine. (2022). The Limits of Recidivism: Measuring Success After Prison. Washington, DC: The National Academies Press. https://doi.org/10.17226/26459.

National Judicial Opioid Task Force. (2019). Promising Strategies in Providing Opioid Use Disorder Treatment to Rural, Frontier, and other Underserved Communities.

National Sheriffs' Association; National Commission on Correctional Health Care. (2018, October). Jail-Based Medication-Assisted Treatment Promising Practices, Guidelines, and Resources for the Field. https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf

Partners for a Healthier Community, Inc. (2015). Opioid Overdose in Western Massachusetts. *Baystate Health*, *1*.

Recidivism. National Institute of Justice. (n.d.). https://nij.ojp.gov/topics/corrections/recidivism

Ronquest, N., Willson, T., Montejano, L., Nadipelli, V., & Wollschlaeger, B. (2018). Relationship between buprenorphine adherence and relapse, health care utilization and costs in privately and publicly insured patients with opioid use disorder. Substance Abuse and Rehabilitation, 9, 59–78. https://doi.org/10.2147/sar.s150253

Scholl CC, Soares MC, do Nascimento E, Trettim JP, de Matos MB, Stigger RS, Pires AJ, Tabeleão VP, da Silva RA, Souza LDM, Quevedo LA, de Figueiredo VLM. (2022, March 29). Evidence of validity of the revised Helping Alliance Questionnaire based on the internal structure in a Brazilian clinical sample. Clin Psychol Psychother. doi: 10.1002/cpp.2654. Epub 2021 Aug 7. PMID: 34318979.

Substance Abuse and Mental Health Services Administration. (2019). Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.

Appendix A.

Telehealth Franklin County Practitioner Survey

Start of Block: Consent

Q1

Thank you for your help. This study is being done by the Urban Institute. We are a nonprofit research organization headquartered in Washington, DC. We do research to help people and communities.

This study is funded by the National Institute of Justice, U.S. Department of Justice, to help them learn more about how to help people re-enter the community after incarceration.

Here in Massachusetts, Urban is studying “telehealth” in jail, prison, and the community. Telehealth means you deliver health services by video, by phone, or through text instead of in person. For example, the telehealth person talks to you through a computer instead of sitting next to you.

Urban is working with the Franklin County Sheriff’s Office (FCSO). We want to know if telehealth can be used for medication assisted treatment (MAT) and other support services for justice-involved people with opioid use disorders.

We invite you to take a short survey, about 15 minutes long. It will ask about MAT and supportive services you delivered in jail, prison, or the community to help with opioid use. You will enter answers into your computer, phone, or tablet. No FCSO staff or service providers will see your answers.

If you take this survey, we promise:

Confidentiality. Everything we collect in this study will be private. Only the research team will see information linked to you. We will never use your name in a report. Nothing we collect can affect your FCSO services or involvement. Confidentiality is protected by the law. Urban researchers must sign a pledge to not tell anyone outside the team about you.

Voluntary Participation. This survey is voluntary. This means you do not have to take part if you do not want to. You may skip any questions you do not want to answer or refuse to give us information. You may leave the survey any time. Your decision will not affect any FCSO services you deliver.

We value your opinions and experiences. Your participation helps us learn how to help people with opioid use disorders. We will also do our very best to protect your privacy. Also, when this study is complete, de-identified data will be archived with a publicly available research database. This will not contain your name at all.

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

For any questions about the study, contact [researcher] at the Urban Institute. You can call her collect at (202) XXX-XXXX. Or you can write her at Urban Institute, 500 L'Enfant Plaza, SW, Washington, DC 20024.

Q2 **Do you agree to take part in this study of telehealth?**

- ○ Yes, I agree to participate in the survey/study. (1)
- ○ No, I do not agree to participate in the survey/study. (2)

Skip To: End of Survey If Do you agree to take part in this study of telehealth? No, I do not agree to participate in the survey/study.

End of Block: Consent

Start of Block: Background

Q3 Please input your research ID number:

_____

Q4 What is your gender?

- ○ Male (1)
- ○ Female (2)
- ○ Self-describe: (3) _____

Q5 How long have you delivered/been delivering services to justice-involved people?

- ○ Less than 6 months (1)
- ○ 6 months to 1 year (2)
- ○ 1 to 3 years (3)
- ○ More than 3 years (4)

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Page Break

Q6 How long have you delivered/been delivering services to people with opioid use disorders?

- ○ Less than 6 months (1)
- ○ 6 months to 1 year (2)
- ○ 1 to 3 years (3)
- ○ More than 3 years (4)

Q7 What type of counseling or support services do/did you provide? *Please select all that apply.*

- ☐ Individual counseling (1)
- ☐ Group counseling (2)
- ☐ Psychosocial supportive case management (3)
- ☐ Intake clinical assessments (4)
- ☐ Other (please specify): (5) _____

End of Block: Background

Start of Block: Perceptions of Telehealth

Q8 To what extent do you believe telehealth is useful for opioid use disorder treatment? Telehealth means you deliver health services by video, by phone, or through text instead of in person.

- ○ Not at all useful (1)
- ○ Slightly useful (2)
- ○ Moderately useful (3)
- ○ Considerably useful (4)
- ○ Completely useful (5)
- ○ I don’t know (98)

Page Break

Q9 For the FCSO treatment specifically, was having a telehealth program beneficial in any of the following ways? *Please select all that apply.*

- ☐ Improved quality of care (1)
- ☐ Provided access to more specialists for the target population (2)
- ☐ Providing counseling became more convenient (3)
- ☐ Providing counseling to justice-involved people became safer (4)
- ☐ Increased access to services (5)
- ☐ Made counseling more accessible during clients' crises (6)
- ☐ Allowed for continuation of services during COVID-19 (7)
- ☐ ⊗ None of the above (99)
- ☐ Other (please specify): (8) _____

Page Break

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Q10 Which of the following barriers or difficulties did you encounter with using telehealth at FCSO, if any? *Please select all that apply.*

- [ ] Poor connection (1)
- [ ] No Wi-Fi (2)
- [ ] Scheduling (3)
- [ ] Inconveniences of my physical space (4)
- [ ] Inconvenience of physical space for the client (5)
- [ ] Physical space of the client was not private (6)
- [ ] Privacy concerns over technology (7)
- [ ] Security concerns over technology (8)
- [ ] Lack of technical support to help me trouble shoot issues (9)
- [ ] Resistance from those who are incarcerated (10)
- [ ] Resistance from administrators (11)
- [ ] Resistance from security staff (12)
- [ ] Resistance from health care providers (13)
- [ ] None of the above (99)
- [ ] Other (please specify): (14) _____

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Page Break

Q11 What **challenges** around telehealth use were expressed by your patients receiving services? *Please select all that apply.*

- ☐ Contact felt impersonal (1)
- ☐ Technology issues were frustrating (2)
- ☐ The service quality was not the same as it would be if in-person (3)
- ☐ Privacy or security concerns (4)
- ☒ None of the above (99)
- ☐ Other (please specify): (5) _____

Q12 What **benefits** around telehealth use were expressed by your patients receiving services? *Please select all that apply.*

- ☐ Increased access to services (1)
- ☐ Increased access to specialists (2)
- ☐ Improved quality of services (3)
- ☐ Privacy and security (4)
- ☐ Ease of use (5)
- ☐ Convenience (6)
- ☐ Flexibility (7)
- ☐ Allowed for continuation of services during COVID-19 (8)
- ☒ None of the above (99)
- ☐ Other (please specify): (9) _____

Page Break

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Q13 Please answer the following with the level to which you agree with each statement.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	I Don't Know (98)
You were satisfied with patient quality of care using telehealth (Q13_1)	○	○	○	○	○	○
You believe telehealth technology was well suited to your patient population and their needs (Q13_2)	○	○	○	○	○	○
Technical support was available and easy to use (Q13_3)	○	○	○	○	○	○
Technical problems did not often interfere with telehealth (Q13_4)	○	○	○	○	○	○
You were adequately trained to use the telehealth technology (Q13_5)	○	○	○	○	○	○
Telehealth was an effective use of time (Q13_6)	○	○	○	○	○	○
Telehealth rooms/locations were convenient for use (Q13_7)	○	○	○	○	○	○
Telehealth was not disruptive	○	○	○	○	○	○

and could fit in with the current routine (Q13_8)						
Thorough services using telehealth was possible (Q13_9)	○	○	○	○	○	○
There was a loss of contact associated with telehealth (Q13_10)	○	○	○	○	○	○

Page Break

Q14 What changes could be made to sustain or improve the use of telehealth within the Franklin County Sheriff's Office men's and women's facilities? *[Open-ended]*

_____

_____

_____

_____

_____

End of Block: Perceptions of Telehealth

Start of Block: Caseload

Q15 Before completing this survey, your former FCSO supervisor will have shared the following information with you: Your Faciliatory Researcher ID, which you will need to enter in the beginning of the survey. Please do not enter your name in the survey. How many people you delivered therapy to from November 2020 through the end of April 2021 The names of your patients and their corresponding Participant Researcher IDs. You will need these IDs when you respond to the survey about your therapeutic alliance with each client. Please do not enter participant names, use their Participant IDs only.

Q16 How many patients did you have in your caseload from November 2020 through the end of April 2021?:

_____

End of Block: Caseload

Start of Block: The Helping Alliance Questionnaire

Q17 **Please complete this questionnaire about therapeutic alliance and insert the Participant Researcher ID number for each person you worked with from November 2020 through the end of April 2021.** ***This question will repeat itself based on your number of reported patients.***

Q18 Please enter the Patient Researcher ID number. The research ID and a corresponding patient's name should have been given to your by your former FCSO supervisor. Do not type the patient's name here, it was shared for your records only.

_____

Q19 These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your patient, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

	Strongly Disagree (1)	Disagree (2)	Slightly Disagree (3)	Slightly Agree (4)	Agree (5)	Strongly Agree (6)
The patient felt he/she could depend upon me. (1)	○	○	○	○	○	○
He/she felt I understood him/her. (2)	○	○	○	○	○	○
The patient felt I wanted him/her to achieve the goals. (3)	○	○	○	○	○	○
At times the patient distrusted my judgment. (4)	○	○	○	○	○	○
The patient felt he/she was working together with me in a joint effort. (5)	○	○	○	○	○	○
I believe we had similar ideas about the nature of his/her problems. (6)	○	○	○	○	○	○
The patient generally respected my views	○	○	○	○	○	○

about him/her. (7)						
The patient believed the procedures used in his/her therapy were <u>not</u> well suited to his/her needs. (8)	○	○	○	○	○	○
The patient liked me as a person. (9)	○	○	○	○	○	○
In most sessions, we found a way to work on his/her problems together. (10)	○	○	○	○	○	○
The patient believed I related to him/her in ways that <u>slowed up</u> the progress of the therapy. (11)	○	○	○	○	○	○
The patient believed a good relationship was formed between us. (12)	○	○	○	○	○	○
The patient believed I was experienced in helping	○	○	○	○	○	○

people. (13)						
I wanted very much for the patient to work out his/her problems. (14)	○	○	○	○	○	○
The patient and I had meaningful exchanges. (15)	○	○	○	○	○	○
The patient and I sometimes had unprofitable exchanges. (16)	○	○	○	○	○	○
From time to time, we both talked about the same important events in his/her past. (17)	○	○	○	○	○	○
The patient believed I liked him/her as a person. (18)	○	○	○	○	○	○
At times the patient saw me as distant. (19)	○	○	○	○	○	○

End of Block: The Helping Alliance Questionnaire

Start of Block: Conclusion

Q20 Is there anything else you would like to share about your experience with using telehealth technology for opioid use disorder treatment? *[Open-ended]*

_____

_____

_____

_____

_____

End of Block: Conclusion

Appendix B.

Telehealth Franklin County Participant Survey

Start of Block: Consent

Q1
Thank you for your help. This study is being done by the Urban Institute. We are a nonprofit research organization headquartered in Washington, DC. We do research to help people and communities.

This study is funded by the National Institute of Justice, U.S. Department of Justice, to help them and the field learn more about how to help people re-enter the community after incarceration.

Here in Massachusetts, Urban is studying “telehealth” in jail, prison, and the community. Telehealth means you get health services by video instead of in person. For example, the telehealth person talks to you through a computer instead of sitting next to you.

Urban is working with the Franklin County Sheriff’s Office (FCSO). We want to know if telehealth can be used for medication assisted treatment (MAT) and supporting services. MAT helps people with opioid disorders.

We invite you to take a short survey, about 20 minutes long. It will ask about MAT services and supports you got in jail, prison, or the community to help with opioid use. You will enter answers into your computer, phone, or tablet. No FCSO staff or service providers will see your answers.

If you take this survey, we promise:

Confidentiality. Everything we collect in this study will be private. Only the research team will see information linked to you. We will never use your name in a report. Nothing we collect can affect your FCSO services or involvement. Confidentiality is protected by the law. Urban researchers must sign a pledge to not tell anyone outside the team about you. There is one exception. We must share if you tell us about plans to commit a future crime or to hurt anyone. But we will not ask about these issues.

Voluntary Participation. This study is voluntary. This means you do not have to take part if you do not want to. You may skip any questions you do not want to answer or refuse to give us information. You may leave the study any time. Your decision will not affect any FCSO services you receive.

To thank you for your participation, we will give you a $XX gift card after completing the survey today. If you are still incarcerated, FCSO will hold this gift card in your property until you are

released and will give it to you the day of your release. If you are in the community, our FCSO research partner will send you the gift card by mail, email, or text message.

We value your opinions and experiences. Your participation helps us learn how to help people with opioid use disorders. We will also do our very best to protect your privacy. Also, when this study is complete, de-identified data will be archived with a publicly available research database. This will not contain your name at all.

For any questions about the study, contact [researcher] at the Urban Institute. You can call her collect at (202) XXX-XXX. Or you can write her at Urban Institute, 500 L'Enfant Plaza, SW, Washington, DC 20024.

Q2 Do you agree to take part in this study of telehealth?

- ○ Yes, I agree to participate in the survey/study. (1)
- ○ No, I do not agree to participate in the survey/study. (2)

Skip To: End of Survey If Do you agree to take part in this study of telehealth? No, I do not agree to participate in the survey/study.

End of Block: Consent

Start of Block: Respondent Background

Q3 Please input your research ID number (you should have received it from Courtney):

_____

Q4 How old are you?

- ○ Years old: (1) _____
- ○ Prefer not to answer (97)

Q5 What is your gender?

- ○ Female (1)
- ○ Male (2)
- ○ Self-describe: (3) _____
- ○ Prefer not to answer (97)

Page Break

Q6 Do you consider yourself to be... *Please check all that apply.*

- [ ] American Indian or Alaska Native (1)
- [ ] Asian (2)
- [ ] Black or African American (3)
- [ ] Native Hawaiian or Pacific Islander (4)
- [ ] White (5)
- [ ] Some other race (6)
- [ ] I don't know (98)
- [ ] Prefer not to answer (97)

Q7 Do you consider yourself to be Hispanic or Latino?

- ○ Yes (1)
- ○ No (2)
- ○ Prefer not to answer (97)

Page Break

Q8 What is the highest level of education you completed?

- 6th grade or less (1)
- 7th – 9th grade (2)
- 10th – 11th grade (3)
- High school graduate (4)
- G.E.D. (5)
- Some college (6)
- College graduate (7)
- Post-graduate study (8)
- Prefer not to answer (97)

End of Block: Respondent Background

Start of Block: Opioid Use Disorders and Treatment Status

Q9 **In this survey, we would like to know about your experience receiving counseling by telehealth – either by video, phone, or text – with your FCSO therapist. Your counseling by telehealth could have taken place anytime between November 2020 and April 2021.**

Q10 Have you ever been diagnosed with an Opioid Use Disorder?

- Yes, I was diagnosed before I entered Franklin County Sheriff's Office (jail) (1)
- Yes, I was diagnosed after I entered Franklin County Sheriff's Office (jail) (2)
- No, never (3)
- I don't know (98)
- Prefer not to answer (97)

Q11 During your time in the Franklin County Sheriff's Office jail, did you participate in a treatment program for opioid use disorder?

- Yes (1)
- No (2)
- I am not sure (98)
- Prefer not to answer (97)

Page Break

Q12 During your time in the Franklin County Sheriff's Office jail, did you receive Medication Assisted Treatment for an opioid use disorder (for example, medication known as buprenorphine (Suboxone, Subutex), methadone, naltrexone (Vivitrol))?

- Yes, I continued receiving MAT like I had in the community before entering FCSO (1)
- Yes, I started MAT only after entering FCSO (2)
- No, I did not receive MAT in FCSO (3)
- Prefer not to answer (97)

Q13 What type of Medication Assisted Treatment did you receive while in the Franklin County Sheriff's Office jail?

- Buprenorphine (also known as Suboxone or Subutex) (1)
- Methadone (2)
- Naltrexone (also known as Vivitrol) (3)
- Prefer not to answer (97)

Page Break

Q14 Did you receive **individual or one-on-one** counseling while in the Franklin County Sheriff's Office jail?

- ○ Yes (1)
- ○ No (2)

Q15 Was individual/one-on-one counseling required while in the Franklin County Sheriff's Office jail?

- ○ Yes, it was mandatory (1)
- ○ No, it was optional (2)
- ○ Prefer not to answer (97)

Page Break

Q16 How did you receive individual/one-on-one counseling while in the Franklin County Sheriff's Office jail? *Please select all that apply.*

- ☐ In-person (face-to-face) with counselor: About how many sessions? (1) _____
- ☐ Via computer or telehealth: About how many sessions? (2) _____
- ☐ Via workbooks (3)

Q17 During your most recent or current stay in the Franklin County Sheriff's Office jail did you participate in any **group** counseling sessions?

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (98)

End of Block: Opioid Use Disorders and Treatment Status

Start of Block: Client Satisfaction

Q18 **The next questions ask about your experience with FCSO telehealth counseling sessions.**

Q19 Which type of telehealth technology have you used for counseling services? *Please select all that apply.*

- [ ] Phone (1)
- [ ] Computer (2)
- [ ] Tablet (3)
- [ ] TV Screen in a public room at the jail (4)
- [ ] Other (please specify): (5) _____

Q20 How would you rate the quality of the counseling you received via telehealth?

- ○ Poor (1)
- ○ Fair (2)
- ○ Good (3)
- ○ Excellent (4)
- ○ Prefer not to answer (97)

Q21 Has the counseling you received via telehealth helped you more effectively deal with problems in your life, including addiction?

- ○ No, not at all (1)
- ○ No, it didn't help much (2)
- ○ Yes, it helped (3)
- ○ Yes, it helped a great deal (4)
- ○ Prefer not to answer (97)

Page Break

Q22 **Please select how much you agree with the statements below about your experience with counseling via telehealth.**

Q23 I could clearly see the counselor during the session

- Strongly agree (1)
- Agree (2)
- Disagree (3)
- Strongly disagree (4)
- Prefer not to answer (97)

Q24 I could clearly hear the counselor during the session

- Strongly agree (1)
- Agree (2)
- Disagree (3)
- Strongly disagree (4)
- Prefer not to answer (97)

Q25 The camera or other equipment embarrassed me or made me feel uncomfortable

- ○ Strongly agree (1)
- ○ Agree (2)
- ○ Disagree (3)
- ○ Strongly disagree (4)
- ○ Prefer not to answer (97)

Page Break

Q26 The room I was in during the session was comfortable

- Strongly agree (1)
- Agree (2)
- Disagree (3)
- Strongly disagree (4)
- Prefer not to answer (97)

Q27 I was NOT concerned about my privacy during counseling via computer

- Strongly agree (1)
- Agree (2)
- Disagree (3)
- Strongly disagree (4)
- Prefer not to answer (97)

Q28 I would not be able to get counseling in jail without technology

- ○ Strongly agree (1)
- ○ Agree (2)
- ○ Disagree (3)
- ○ Strongly disagree (4)
- ○ Prefer not to answer (97)

Page Break

Q29 What are some things you **did not** like about telehealth counseling? *Please select all that apply.*

- ☐ Contact feels impersonal (1)
- ☐ Technology issues are frustrating (2)
- ☐ The service quality is not the same as it would be if in-person (3)
- ☐ Privacy or security concerns (4)
- ☐ ⊗ None of the above (99)
- ☐ Other (please specify): (6) _____
- ☐ ⊗ Prefer not to answer (97)

Page Break

Q30 What are some things you liked about telehealth counseling? *Please select all that apply.*

- ☐ Increased access to services (1)
- ☐ Increased access to specialists (2)
- ☐ Improved quality of services (3)
- ☐ Privacy and security (4)
- ☐ Ease of use (5)
- ☐ Convenience (6)
- ☐ Flexibility (7)
- ☐ Allowed for continuation of services during COVID-19 (8)
- ☐ ⊗ None of the above (99)
- ☐ Other (please specify): (10) _____
- ☐ ⊗ Prefer not to answer (97)

Page Break

Q31 Please provide any additional comments or suggestions about your experience with counseling via telehealth.

_____

_____

_____

_____

_____

End of Block: Client Satisfaction

Start of Block: Helping Alliance Questionnaire

Q32 In this section, we would like to know about your experience with the therapist who connected with you by telehealth – either by video, phone, or text – while you were in jail anytime between November 2020 and April 2021. We are not asking about your current therapist, if you have a different one now.

Page Break

Q33 INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

	Strongly Disagree (1)	Disagree (2)	Slightly Disagree (3)	Slightly Agree (4)	Agree (5)	Strongly Agree (6)
I felt I could depend upon the therapist. (1)	○	○	○	○	○	○
I felt the therapist understood me. (2)	○	○	○	○	○	○
I felt the therapist wanted me to achieve my goals. (3)	○	○	○	○	○	○
At times I distrusted the therapist's judgment. (4)	○	○	○	○	○	○
I felt I was working together with the therapist in a joint effort. (5)	○	○	○	○	○	○
I believed we had similar ideas about the nature of my problems. (6)	○	○	○	○	○	○
I generally respected the	○	○	○	○	○	○

therapist's views about me. (7)

Page Break

Q34 INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

	Strongly Disagree (1)	Disagree (2)	Slightly Disagree (3)	Slightly Agree (4)	Agree (5)	Strongly Agree (6)
The procedures used in my therapy were not well suited to my needs. (8)	○	○	○	○	○	○
I liked the therapist as a person. (9)	○	○	○	○	○	○
In most sessions, the therapist and I found a way to work on my problems together. (10)	○	○	○	○	○	○
The therapist related to me in ways that slowed up the progress of the therapy. (11)	○	○	○	○	○	○
A good relationship was formed with my therapist. (12)	○	○	○	○	○	○
The therapist appeared to	○	○	○	○	○	○

be experienced in helping people. (13)						
I wanted very much to work out my problems. (14)						

Page Break

Q35 INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

	Strongly Disagree (1)	Disagree (2)	Slightly Disagree (3)	Slightly Agree (4)	Agree (5)	Strongly Agree (6)
The therapist and I had meaningful exchanges. (15)	○	○	○	○	○	○
The therapist and I sometimes had unprofitable exchanges. (16)	○	○	○	○	○	○
From time to time, we both talked about the same important events in my past. (17)	○	○	○	○	○	○
I believed the therapist liked me as a person. (18)	○	○	○	○	○	○
At times the therapist seemed distant. (19)	○	○	○	○	○	○

End of Block: Helping Alliance Questionnaire

Start of Block: Drug Use and Arrest History

Q36 We have just a few questions about your incarceration and opioid use history. Again, these are voluntary and your answers will be confidential, but will help us understand different people's experiences. Please answer these questions as they relate to your stay at the Franklin County Sheriff's Office jail anytime between November 2020 and April 2021.

Q37 Thinking about before your stay at the Franklin County Sheriff's Office jail between November 2020 and April 2021, how long did you use opioids?

- Never (1)
- 1-5 months (2)
- 6 months - 1 year (3)
- 1-2 years (4)
- 3-5 years (5)
- 6-10 years (6)
- More than 10 years (7)
- Prefer not to answer (97)

Q38 Throughout your lifetime, how many times have you been arrested?

- ○ 1 time (1)
- ○ 2-5 times (2)
- ○ 6-10 times (3)
- ○ More than 10 times (4)
- ○ Prefer not to answer (97)

End of Block: Drug Use and Arrest History

Start of Block: Closing

Q39
Thank you so much for your help on this survey! **Do you have any last comments to share that might help other people like yourself?**

_____

_____

_____

_____

_____

Q40 **We would like to give you a $40 gift card for completing this survey. If you are still incarcerated, this gift card will be held in your property until you are released and will be given to you the day of your release.**

Q41 Are you currently still incarcerated at the Franklin County Sheriff's Office jail?

- ○ Yes (1)
- ○ No (2)

End of Block: Closing

Appendix C. Helping Alliance Questionnaire

Scoring Guide

This article (Luborsky et al., 1996) on the HAq-II was based on a sample of 246 adult patients diagnosed with DSM-III-R cocaine dependence, and the results refer to the patient and therapist versions of the HAq-II in a pilot study. The following is a quick analysis of scoring the HAq-II based on the current paper.

As far as scoring goes, you add up the positively scored items and reverse score the negatively worded items, thus arriving at a total score. That is the score of the HAq-II. For example, for item 1, if the score is 5 you add 5 to the total score since that item is positive, but in the case of item 4, for example, a score of 5 would add only 2, 1 is 6, 2 is 5, etc., to the total score since that is a negative and thus reverse-scored item.(Items 4, 8, 11, 16, and 19 should be reverse scored)

What does the final total score of the HAq-II mean? We can begin to answer this looking at Table 1. The table shows mean scores based on session and whether the therapist or patient filled out the HAq-II. Let's just look at session 2, since that has been regarded as a good session that one can look at alliance. The mean score based on patient reports is 5.15 +/- 0.58, with a minimum of 2.11 and a max of 6.00. To get the mean Total score, just multiply by 19, the amount of items on the scale. The therapist scores are generally lower, but studies have shown that the patient scores are most valid, so let's stick to those. Dr. Luborsky and I suggest that a good cutoff point for good versus poor alliance may be the mean score minus 1 standard deviation, so in this case that would be 5.15-0.58 = 4.57. Translating this into a total score, 4.57 x 19 = 86.83. Tentatively, based on this study alone and on 2nd session patient reported alliance scores, 86.83 seems to be a good cutoff point, let's call it 86. So scores that fall below 86 are poor alliance. Of course, we will look at many more samples and studies before we come up with an official number.

The Revised Helping Alliance Questionnaire (HAq-II)

Psychometric Properties

LESTER LUBORSKY, PH.D.
JACQUES P. BARBER, PH.D.
LYNNE SIQUELAND, PH.D.
SUZANNE JOHNSON, B.A.
LISA M. NAJAVITS, PH.D.
ARLENE FRANK, PH.D.
DENNIS DALEY, M.S.W.

The concept of the therapeutic alliance and its operationalization have received much attention in recent years. One of the early self-report measures of the therapeutic alliance was the Helping Alliance questionnaire (HAq-I). This scale was recently revised to exclude the items that explicitly reflect improvement. Using the revised 19-item HAq-II on a sample of 246 patients diagnosed with DSM-III-R cocaine dependence, the authors found that the new scale had excellent internal consistency and test-retest reliability. Further, the HAq-II demonstrated good convergent validity with the California Psychotherapy Alliance Scale (CALPAS) total score. Alliance levels as measured by the CALPAS or the Helping Alliance questionnaire during early sessions were not associated with pretreatment psychiatric severity or level of depression.

(The Journal of Psychotherapy Practice and Research 1996; 5:260–271)

Description and measurement of the therapeutic alliance based on the collaboration and bond between therapist and patient has been a major focus of theoretical and empirical studies in the last two decades. Many measures have been developed to assess the construct of the therapeutic alliance. Helped by Bordin's[1] theoretical division of the alliance into "goals, tasks, and bonds," Luborsky[2] introduced the quantitative concept of the Helping Alliance with three different types of measures composed of similar items: the Helping Alliance Global Rating method,[3] the Helping Alliance Counting Sign method,[4] and the self-report Helping Alliance questionnaire[5] (L. Luborsky et al., "The Penn Helping Alliance Questionnaire (HAq-I): Its Composi-

Received July 20, 1994; revised September 12, 1995; accepted September 20, 1995. From the Center for Psychotherapy Research, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania; Harvard Medical School, Boston, Massachusetts; and Western Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania. Address correspondence to Dr. Luborsky, 514 Spruce Street, Philadelphia, PA 19106.

tion and Research Supports," submitted for publication, 1995).

The Helping Alliance methods, as well as other measures of the therapeutic alliance, have been successful predictors of outcome. Summarizing 24 studies, Horvath and Symonds[6] showed that the average effect size of the correlation between alliance and outcome was estimated as $r = 0.26$. This was a conservative estimate because the authors considered all nonsignificant findings where the value of the correlation was not presented by the original authors as $r = 0.0$.

In recent years, we have become aware that the HAq-I was limited by the presence of items that were explicitly assessing early symptomatic improvement[7,8] and by the fact that all the items were worded positively. To address these limitations, we deleted the 6 items reflecting early improvement and added 14 new items that appeared to tap more fully the various aspects of the alliance as described by Bordin[1] and Luborsky.[2] Five of the new items related to the collaborative effort of patient and therapist; for example, "The therapist and I have meaningful exchanges." Five additional items addressed the patient's perception of the therapist; for example, "At times I distrust the therapist's judgment." One of the other added items dealt directly with the patient's motivation: "I want very much to work out my problems"; and one other was related to the patient's perception of the therapist's feelings about the patient: "I believe that the therapist likes me as a person." In contrast to the previous version, the revised HAq (hereafter referred to as the HAq-II) included five items that were worded negatively; for example, "The procedures used in my therapy are *not* well suited to my needs."

In the present article we describe the psychometric properties of the HAq-II. We also examine its relations with another widely used measure of the alliance, the California Psychotherapy Alliance Scale[7,9] (CALPAS) and with selected sociodemographic variables.

METHODS

Subjects

Participants in this study were 246 outpatients drawn from a total sample of 313 outpatients with a DSM-III-R diagnosis of cocaine dependence who were randomized to one of four treatment conditions described below as part of their participation in the training/pilot phase of the National Institute on Drug Abuse (NIDA) Cocaine Collaborative Study (CCS). The study is coordinated from a center at the University of Pennsylvania and is being conducted there and at Brookside Hospital, McLean/Massachusetts General Hospital, and Western Psychiatric Institute and Clinic.

Exclusion criteria included history of bipolar disorder, psychotic symptoms or disorder, organic brain syndrome, current opioid dependence, current active suicidal or homicidal potential, medical contraindication, or homelessness.

At intake, the patients' average age ($\pm$ SD) was 33 ± 6.6 years (range 19–59); 69% of the patients were male and 31% were female. Fifty-six percent were Caucasian, 41% African American, and 3% Hispanic or American Indian. Sixty-one percent of the patients were employed. Seventy-six percent of the patients lived alone, and 24% were married or lived with a partner. Seventy-five percent of the sample were primarily crack users, 21% were primarily snorters, and 4% primarily injected cocaine. On average at the time of intake, patients were using cocaine 8.9 days per month and were spending more than $1,000 a month on drugs. Fifty-two percent of patients had other substance dependence diagnoses (mostly alcohol dependence), and 55% had a personality disorder diagnosis, of which group 20% had antisocial personality disorder. In addition, 15% of patients had a diagnosis of current depressive disorder (9% current major depression), and 17% had some other Axis I diagnosis.

Treatment

The pilot study was designed to train therapists and counselors and to finalize the protocol for a clinical trial to examine the efficacy of four psychosocial treatments for outpatients diagnosed with cocaine dependence. The treatments were supportive-expressive dynamic therapy[10] (SE), a psychodynamic treatment based on Luborsky's model;[11] cognitive therapy[12] (CT) based on Beck's model; individual drug counseling (IDC) based on the 12-step addiction model (D. Mercer and G. Woody, unpublished, 1992); and group drug counseling (GDC), a psychoeducational and problem-solving group treatment also grounded in the 12-step addiction model (D. Mercer et al., unpublished, 1994). In the pilot phase, patients were randomized to one of the treatment conditions after a brief stabilization phase in which patients had to establish that they could achieve a period of initial abstinence measured by 3 consecutive drug-free urine screens within 30 days. All patients in the individual conditions also received the GDC treatment. Those patients randomized to the GDC-alone condition received only the group treatment. Group sessions were held twice a week for 2 months and once a week for the next 4 months. The active phase of the individual treatment was also 6 months long and consisted of twice-weekly sessions for the first 3 months of treatment and once-weekly sessions for months 4–6. Three to six booster sessions were offered to patients who had stayed in active treatment for the full 6 months.

Therapists and drug counselors had been selected by their training units on the basis of a combination of background education and training, letters of reference, and two audiotaped samples of their therapy/counseling work. Educational requirements for SE and CT therapists were the same (a Ph.D., M.S.W., or M.D.), but the experience criteria differed. SE required 3 to 4 years of postgraduate clinical experience; CT required 6 months of postgraduate experience for M.S.W.s, 1 year for Ph.D.s, or, for M.D.s, 1 year of supervised individual CT experience during residency. The SE and CT therapists recruited to this study had performed an average of 9.9 and 10.6 years of postgraduate clinical work, respectively.

Drug counselors could not exceed certain levels of qualifications. The highest terminal degree allowable was a bachelor's degree in a mental health–related field, a counseling certificate, or a master's degree in addiction counseling (Certified Alcoholism Counselor). All counselors were required to have 2 to 3 years of drug counseling experience, and, if in recovery themselves, to have at least 5 years in recovery.

Measures

Beck Depression Inventory[13] (BDI). This is a 21-item self-report measure of depression. It is a much-used, reliable measure of depressive symptoms.[14]

Helping Alliance questionnaire (HAq-II). The original HAq-I[5] is a widely used 11-item questionnaire that measures the strength of the patient-therapist therapeutic alliance. To make up the 19 items of the HAq-II, 6 items were removed from the HAq-I and 14 new items were added. Each item is rated on a 6-point Likert scale (1 = I strongly feel it is not true, 6 = I strongly feel it is true). Both a patient and a therapist version were developed. Negatively worded items are reverse scored. The patient version is reproduced as Appendix A.

Addiction Severity Index[15] (ASI). The ASI is a structured interview that assesses the patient's lifetime and current (last 30 days) functioning in seven target areas related to substance use: medical status, employment status, alcohol use, drug use, legal status, psychiatric status, and family/social relationships. The measure offers composite scores for each target area as well as severity ratings. It has been shown to be reliable and valid.[16,17] Test-retest reliability of 0.83 or higher is reported on all scales.[18] We report here only the drug use and psychiatric composite scores because

these are prognostic factors that might affect, or have been shown to affect, the establishment of alliance.[19]

Brief Symptom Inventory[20] (BSI). This is a brief, 53-item version of the self-report Symptom Checklist-90–Revised, a measure of psychiatric symptoms. Each item is rated on a 5-point Likert scale that ranges from "not at all distressed" to "extremely distressed." The measure yields three global indicators and nine symptom dimensions. The global severity index (GSI), the mean of the 53 items, is used in the current study. Reliability and validity data on the measure are reviewed in Derogatis.[21]

California Psychotherapy Alliance[7,9] (CALPAS). This is a 24-item questionnaire with a 7-point Likert scale (1 = not at all, 7 = very much so). The CALPAS is composed of four scales: Patient Working Capacity, Patient Commitment, Therapist Understanding and Involvement, and Working Strategy Consensus. Like the HAq, the CALPAS has both a patient and a therapist version. Reliability and validity are reviewed in Gaston.[7]

Cocaine Inventory. This is a measure modified for this study from an unpublished measure originally designed by Bristol-Myers Squibb.[22] There are no summary scores for this measure, but it consists of the following questions: how many times she or he has used cocaine in the last week, how much money was spent on cocaine in the last week, the method of administration, and number of times other drugs were used in the last week. In this study, only the first item was used to reflect that week's cocaine use.

Hamilton Rating Scale for Depression.[23] The Structured Interview Guide for the Hamilton Rating Scale for Depression[24] (SIGH-D) was used. Although the 27-item version of the interview was administered to patients, the scores reported are for the 17 items in the most commonly used version of the Hamilton. The SIGH-D is a structured clinical interview that assesses a variety of depressive symptoms, including depressed mood, guilt, neurovegetative symptoms, hopelessness, helplessness, and suicidality. The Ham-D and the SIGH-D are standard measures in the field.

Global Assessment of Functioning[25] (GAF, DSM-III-R, Axis V). This is a single global rating scale that takes into account psychological, social, and occupational functioning. The GAF is much the same as the older 100-point Health-Sickness Rating Scale,[26] but it ranges from 0 to 90. These scores reflect low to high levels of functioning.

Procedures

Patients filled out the HAq-II and the CALPAS at the end of sessions 2, 5, and 24 and the last session of the active phase of treatment. The therapists filled out the HAq-II and the CALPAS on the same occasions. The patients also completed the Cocaine Inventory prior to each session and had twice-weekly urine screens for drug use. The BDI, Hamilton, GAF, BSI, and other measures were administered at intake into the study.

A total of 246 patients completed one of the alliance measures at least once. As a result, the *n*'s differ for the different analyses. Excluded from the sample are 6 patients who had to change therapists during treatment because their therapists left the study.

RESULTS

Basic descriptive statistics for the alliance measures at the different points in time are presented in Table 1. One hundred and ninety-seven patients filled out both the CALPAS-P and the HAq-II at session 2.

Reliability

Internal consistency (Cronbach's alpha) of the 19-item HAq-II and of the CALPAS (total scale) was measured separately for sessions 2, 5, and 24 and was found to reflect homogeneous scales (Table 2). For example, correlations between corrected item and total scale for the items of the HAq-II patient version at session 2 ranged from 0.30 to 0.79.

Only 3 out of 19 correlations were below 0.40, and the median correlation between corrected item and total was 0.64. Because patients sometimes did not complete a particular item on a scale or subscale, the number of patients on which the Cronbach's alphas were computed is somewhat lower than the number of patients presented in Table 1 for all measures.

Test-retest reliability coefficients for all measures, but especially for the HAq-II patient version, were quite high over a three-session span from session 2 to session 5 (Table 3). A mean ($\pm$SD) of 16.3 ± 10.3 days elapsed between these sessions. We also examined the correlations between the alliance measures filled out at session 5 and again at session 24. The correlations that are shown in Table 4 provide an index of the stability of the measure over the relatively long period of time between those two sessions (a mean of 112.3 ± 41.1 days). The degree of similarity between alliance ratings at session 5 and at session 24 were quite high. Nevertheless, it needs to be emphasized that only between 75 and 88 patients and between 78 and 88 therapists had scores on the different instruments on these two occasions because of patient attrition and lack of compliance with research requests (where patients and therapists either were not given the forms or did not fill them out).

Factor Structure

We examined the factorial structure of the HAq-II patient version filled out at session 2 by using a principal components analysis with a varimax rotation. Using the scree test and a criterion of eigenvalues greater than 1, three factors were extracted. Because the third factor consisted of only two items (#11 and #14) and explained only 6% of the variance, this factor was not retained. Factor 1 ("positive therapeutic alliance") was made up of items 1, 2, 3, 5, 6, 7, 9, 10, 12, 13, 15, 17, and 18 and explained 43.3% of the variance. Factor 2 ("negative therapeutic alliance") was made up of items 4, 8, 16, and 19 and explained 10.6% of the variance. At session 2 the correlation between factors 1 and 2 was found to be $r = 0.48$ ($n = 200$, $P < 0.001$). At session 5, the correlation was $r = 0.60$ ($n = 182$, $P < 0.001$); at session 24, r was 0.64 ($n = 87$, $P < 0.001$). Because of the high correlations between these two factors at the different points in time, the high internal

TABLE 1. Descriptive statistics of the alliance measures at sessions 2, 5, and 24

Variable	Session	Mean ± SD	Minimum	Maximum	*n*
HAq-P	2	5.15 ± 0.58	2.11	6.00	201
HAq-P	5	5.26 ± 0.55	3.26	6.00	182
HAq-P	24	5.30 ± 0.62	1.53	6.00	87
HAq-T	2	4.63 ± 0.61	2.42	5.95	200
HAq-T	5	4.72 ± 0.53	3.00	5.95	178
HAq-T	24	4.92 ± 0.57	3.00	6.00	90
CALPAS-P	2	5.84 ± 0.65	3.78	6.96	246
CALPAS-P	5	5.90 ± 0.69	3.58	7.00	213
CALPAS-P	24	6.00 ± 0.69	3.65	7.00	92
CALPAS-T	2	4.57 ± 0.89	1.67	6.96	246
CALPAS-T	5	4.74 ± 0.83	2.75	6.17	206
CALPAS-T	24	4.94 ± 0.97	2.38	6.67	93

Note: HAq-P = Helping Alliance questionnaire-II, Patient version; HAq-T = HAq-II, Therapist version; CALPAS-P = California Psychotherapy Alliance Scales, Total Scale, Patient version; CALPAS-T = CALPAS, Total Scale, Therapist version.

consistency of the entire scale, and the small number of items in factors 2 and 3, only the results using the entire scale are presented throughout the rest of this article.

Validity Studies

Convergent Validity With Another Measure of the Alliance: Table 5 shows the correlations between the HAq-II and the CALPAS total scores for both the patient and therapist versions at sessions 2, 5, and 24. Large significant correlations were found between the two measures of alliance when filled out by the same person. The correlations between the patient version of the CALPAS subscales and the HAq-II ranged from 0.38 to 0.71, indicating a fair amount of common variance (ranging from 35% to 49%, depending on the subscale and the session measured). The relation between the therapists' version of the CALPAS and HAq-II tended to be slightly higher than the patients' correlations, ranging from 0.61 to 0.79.

Discriminant Validity: Alliance versus sociodemographic variables: Correlations between the alliance measures early in treatment and age, race, gender, marital status, and employment were also computed. As expected, no relation between those variables and either measure of alliance at session 2 or session 5 was found.

Discriminant Validity: Alliance versus pretreatment measures of severity of psychiatric dysfunction and drug use: To examine the discriminant validity of the alliance and psychiatric severity, we computed correlations among those variables. As shown in Table 6, neither measure of alliance was associated with intake measures of psychological functioning (GAF), psychiatric severity (ASI psychiatric severity and BSI), drug use (ASI drug use), or depression level (Hamilton Depression and BDI). Because of the number of correlations done, we corrected the alpha level by dividing it by 12. There was no indication that higher alliance was related to intake measures of symptom severity. Furthermore, inspection of the data in Table 6 does not reveal any differences in the patterns of correlations of the HAq-II or of the CALPAS.

Discriminant Validity: Alliance versus concurrent measures of severity of psychiatric dysfunction and drug use: To complete this further analysis, we looked at the symptom measures that were available at the time the alliance questionnaires were filled out. The only session measure given to the patient at the same time as the alliance measure was the Cocaine Inventory. We examined the correlations between one item on this instrument ("How many times have you used cocaine in the last week?") and the respective alliance measures at both ses-

TABLE 2. Internal consistency of HAq-II and CALPAS for patient and therapist versions and their correlations

Scale	Session 2	Session 5	Session 24
HAq-II–Patient	0.90 ($n = 174$)	0.90 ($n = 171$)	0.93 ($n = 83$)
HAq-II–Therapist	0.93 ($n = 193$)	0.90 ($n = 169$)	0.91 ($n = 88$)
CALPAS–Patient	0.80 ($n = 217$)	0.84 ($n = 199$)	0.82 ($n = 83$)
CALPAS–Therapist	0.94 ($n = 217$)	0.94 ($n = 188$)	0.95 ($n = 87$)

Note: HAq-II-P = Helping Alliance questionnaire-II, Patient version; HAq-II-T = HAq-II, Therapist version; CALPAS-P = California Psychotherapy Alliance Scales, Total Scale, Patient version; CALPAS-T = CALPAS, Total Scale, Therapist version.

sion 2 and 5. Because the number of times cocaine was used was not distributed normally (many patients had not used in the last week), we calculated Spearman rank correlations. As shown in the bottom row of Table 6, we found that the higher the alliance (as measured by the HAq-II and the CALPAS), the lower the amount of drug use during the same week. The correlations were significant for session 5, although not for session 2.

DISCUSSION

In this report we present psychometric data on the HAq-II, an improved version of the HAq-I in composition and length. Both patient and therapist versions of the new scale showed good internal consistency and test-retest reliability even though the latter coefficients might have been reduced by opportunities for changes in the patient-therapist relationship occurring in the normal course of treatment. Long-term stability of the alliance in those patients who stayed in treatment until at least session 24 also was found to be adequate considering the amount of time between the two sessions.

In terms of convergent validity, the HAq-II demonstrated high convergence with another, widely used self-report measure of alliance, the CALPAS total score (correlations of 0.59 to 0.69 for the patient version and 0.75 to 0.79 for the therapist version; Table 5). This was the first demonstration of this agreement;

TABLE 3. Test-retest reliability of the HAq-II and the CALPAS over 3 sessions (from session 2 to 5) for patient and therapist versions

Scale	Patient Version	Therapist Version
HAq-II	0.78 ($n=168$)	0.56 ($n=166$)
CALPAS Total	0.59 ($n=197$)	0.53 ($n=194$)
Patient Working Capacity	0.46	0.44
Patient Commitment	0.55	0.53
Working Strategy Consensus	0.50	0.49
Therapist Understanding and Involvement	0.34	0.59

Note: HAq-II = Helping Alliance questionnaire-II; CALPAS = California Psychotherapy Alliance Scales, Total Scale. All $P<0.001$.

TABLE 4. Correlations of the HAq-II and the CALPAS between sessions 5 and 24: stability

Scale	Patient Version	Therapist Version
HAq-II	0.34^{**} ($n=74$)	0.55^{***} ($n=78$)
CALPAS Total	0.49^{***} ($n=85$)	0.52^{***} ($n=88$)
Working Capacity	0.39^{***}	0.41^{***}
Patient Commitment	0.52^{***}	0.54^{***}
Working Strategies	0.36^{**}	0.48^{***}
Therapist Understanding	0.28^{*}	0.46^{***}

Note: HAq-II = Helping Alliance questionnaire-II; CALPAS = California Psychotherapy Alliance Scales, Total Scale.
$^{*}P<0.01$; $^{**}P<0.005$; $^{***}P<0.001$.

an earlier study had reported low convergence between the Helping Alliance Rating Scale and the CALPAS.[27] That study, however, used rater-based methods, rather than self-report, to assess alliance. It thus seems that, at least in cocaine-dependent patients. the two self-report measures converge, although further studies are needed to generalize across clinical samples. The level of convergence is also evident when comparing the two measures qualitatively. Five of the items from each scale are virtually the same, and several others are very close in meaning.

One of the most important changes introduced in this new version of the HAq is the attempt to eliminate items that directly reflect symptomatic improvement.[28] Neither of the alliance measures in the early sessions of therapy was associated with intake measures, indicating that the alliance is not a function of pretreatment symptomatology. This finding supports the discriminant validity of both measures of alliance and is consistent with the report of Gaston et al.,[29] who similarly found a lack of relation between the Hamilton Depression Scale and the CALPAS in a group of elderly depressed patients.

Nevertheless, lower drug use in the previous week was found to be associated with relatively better alliance at session 5, although not at session 2. Because this finding was consistent across both the CALPAS and the HAq, and because the CALPAS has not been criticized as reflecting early improvement, it is our impression that the present results reflect the relation between alliance and outcome. This finding is consistent with Fenichel's[30] observation that greater cocaine use is associated with poor alliance because drug abusers' involvement with the addictive substance minimizes meaningful involvement with people.

It may be presumptuous on our part to expect that alliance measures will be completely independent from early symptomatic improvement, since patients are likely to feel better about the therapist (increased alliance) when they experience the therapist as helpful and symptoms are relieved. Moreover, being helped is likely to generate the expectation that additional help may be forthcoming. Therefore, the best one can hope for in terms of developing measures of alliance is to minimize items that manifestly reflect early improvement. In the present study we have shown that the pattern of associations between the HAq-II and early symptomatic improvement is no different from the pattern of relations between the CALPAS-P and early symptomatic improvement. Further, because alliance is sometimes related to early symptomatic improvement, this covariation has to be partialed out as Gaston and colleagues did when predicting outcome.[29]

The initial results on the validity of the

TABLE 5. Correlations between HAq-II and CALPAS subscales and total filled out by patients and therapists at sessions 2, 5, and 24

	HAq-II					
	Session 2		Session 5		Session 24	
Scale	Patient ($n = 197$)	Therapist ($n = 200$)	Patient ($n = 182$)	Therapist ($n = 174$)	Patient ($n = 92$)	Therapist ($n = 87$)
CALPAS scale						
Working Capacity	0.43	0.63	0.45	0.64	0.39	0.62
Patient Commitment	0.38	0.74	0.54	0.77	0.59	0.72
Working Strategies	0.57	0.75	0.69	0.68	0.71	0.70
Therapist Understanding	0.53	0.64	0.58	0.61	0.63	0.69
CALPAS Total	0.59	0.79	0.68	0.79	0.69	0.75

Note: HAq-II = Helping Alliance questionnaire-II; CALPAS = California Psychotherapy Alliance Scales, Total Scale. All $P < 0.001$.

HAq-II are promising, and we recommend this version of the alliance measure as an improvement over the HAq-I. Nevertheless, there are several limitations. Although the overall patterns of results obtained in the present sample of cocaine-dependent patients do not seem to deviate from results in more "neurotic" samples,[28] further experience with the HAq-II in nonaddicted patients would increase confidence in the generalizability of the present findings. Moreover, the HAq-I and HAq-II have not yet been administered concurrently. Therefore, it cannot be concluded with confidence that the present version is, in general, more valid than the older one or, more specifically, that it reduces the inclination toward measuring early improvement. Nevertheless, data from this study suggest that the HAq-II provides some improvement in the measurement of the alliance over the HAq-I, since the pattern of covariation between the HAq-II and other variables does not differ from the pattern of covariation between the CALPAS-P and other variables.

This research was supported in part by National Institute on Drug Abuse Research Scientist Award 2K05 DA00168-24 and by NIDA Grant 5U18 DA07085 (to Lester Luborsky); 5R01 DA08237 (to Jacques P. Barber); and NIMH Clinical Research Center Grant P50 MH45178 and Coordinating Center Grant U18-DA07090 (to Paul Crits-Christoph).

The NIDA Cocaine Collaborative Study is a NIDA-funded cooperative agreement involving four clinical sites, a coordinating center, and NIDA staff.

TABLE 6. Correlations between alliance at session 2 and session 5, as viewed by the patient, and intake measures of psychiatric severity and concurrent drug use

	CALPAS		HAq-II	
Measure	**Session 2**	**Session 5**	**Session 2**	**Session 5**
Intake measures				
ASI PSYCH	0.04	0.04	0.05	0.12
n	235	203	192	173
ASI drug use	−0.01	0.07	−0.08	0.02
n	240	207	199	180
BDI	−0.09	0.04	−0.07	0.01
n	220	189	181	162
SIGH-D	−0.01	0.03	−0.10	0.03
n	231	202	191	175
GAF	−0.01	0.02	0.03	−0.02
n	235	205	195	177
BSI (GSI)	−0.05	−0.03	−0.03	0.03
n	225	194	183	165
Cocaine use	−0.05	−0.01	−0.09	0.02
n	244	212	200	181
Concurrent measure of drug use				
Times cocaine used[a]	−0.01	−0.21**	−0.09	−0.18*
n	214	189	179	163

Note: HAq-II = Helping Alliance questionnaire-II. CALPAS = California Psychotherapy Alliance Scales, Total Scale. ASI = Addiction Severity Index; PSYCH = Psychiatric severity composite; Drug use = drug use composite; BDI = Beck Depression Inventory; SIGH-D = Structured Interview Guide for the Hamilton Rating Scale for Depression; GAF = Global Assessment of Functioning; BSI = Brief Symptom Inventory; GSI = global severity index; Cocaine use = cocaine use at intake for the last 30 days; Times cocaine used = during last week.
[a]Spearman rank correlation.
*$P < 0.05$; **$P < 0.001$.

The coordinating center at the University of Pennsylvania, Philadelphia, PA, includes Paul Crits-Christoph, Ph.D., Principal Investigator (PI); Lynne Siqueland, Ph.D., Project Coordinator; Karla Moras, Ph.D., Assessment Unit Director; Jesse Chittams, Ph.D., Director of Data Management/Analysis; Larry Muenz, Ph.D., Statistician; Aaron T. Beck, M.D., and Bruce Liese, Ph.D., Heads of Cognitive Therapy Training Unit; Lester Luborsky, Ph.D., and David Mark, Ph.D., Heads of Supportive-Expressive Training Unit; George Woody, M.D., and Delinda Mercer, M.A., Heads of the Drug Counseling/Addiction Recovery Program; and Delinda Mercer, Denis Daley, and Gloria Carpenter, Heads of Group Drug Counseling Unit.

The collaborating staff at NIDA include Jack Blaine, M.D., and Lisa Onken, Ph.D. The four participating clinical sites are University of Pennsylvania, Lester Luborsky, Ph.D. (PI), Jacques P. Barber, Ph.D. (Co-PI); Brookside Hospital, Nashua, NH, Arlene Frank, Ph.D. (PI), Steve Butler (Co-PI); McLean/Massachusetts General Hospital, Boston, MA, Roger Weiss, M.D. (PI), David Gastfriend, M.D. (Co-PI); University of Pittsburgh/Western Psychiatric Institute and Clinic, Pittsburgh, PA, Michael Thase, M.D. (PI), Dennis Daley, M.S.W. (Co-PI). The contributions of John Boren, Ph.D., the project officer for this cooperative agreement, are also gratefully acknowledged.

REFERENCES

1. Bordin E: The generalizability of the psycho-analytic concept of the working alliance. Psychotherapy: Theory, Research and Practice 1979; 16:252–260
2. Luborsky L: Helping alliances in psychotherapy: the groundwork for a study of their relationship to its outcome, in Successful Psychotherapy, edited by Claghorn JL. New York, Brunner/Mazel, 1976, pp 92–116
3. Morgan R, Luborsky L, Crits-Christoph P, et al: Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. Arch Gen Psychiatry 1982; 39:397–402
4. Luborsky L, Crits-Christoph P, Alexander L, et al: Two helping alliance methods for predicting outcomes of psychotherapy: a counting signs versus a global rating method. J Nerv Ment Dis 1983; 171:480–492
5. Luborsky L, McLellan AT, Woody GE, et al: Therapist success and its determinants. Arch Gen Psychiatry 1985; 42:602–611
6. Horvath AO, Symonds BD: Relation between working alliance and outcome in psychotherapy: a meta-analysis. Journal of Counseling Psychology 1991; 38:139–149
7. Gaston L: Reliability and criterion-related validity of the California Psychotherapy Alliance Scales–Patient version. Psychological Assessment 1991; 3:68–74
8. Barber JP, Crits-Christoph P: Development of a therapist adherence/competence ratings scale for Supportive-Expressive Dynamic Psychotherapy: a preliminary report. Psychotherapy Research 1996; 6:79–90
9. Gaston L, Marmar CR: California Psychotherapy Alliance Scale, in The Working Alliance: Theory, Research and Practice, edited by Horvath A, Greenberg L, New York, Wiley, 1994, pp 85–108
10. Mark D, Faude J: Supportive expressive therapy for cocaine abuse, in Dynamic Therapies for Psychiatric Disorders (Axis 1), edited by Barber JP, Crits-Christoph P. New York, Basic Books, 1995, pp 294–331
11. Luborsky L: Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive Treatment. New York, Basic Books, 1984
12. Beck AT, Wright FD, Newman CF, et al: Cognitive Therapy of Substance Abuse. New York, Guilford, 1993
13. Beck T, Ward CH, Mendelson M, et al: An inventory to measure depression. Arch Gen Psychiatry 1961; 4:561–571
14. Beck AT, Steer RA, Garbin MG: Psychometric properties of the Beck Depression Inventory: twenty-five years of evaluation. Clinical Psychology Review 1988; 8:77–100
15. Fureman I, Parikh G, Bragg A, et al: Addiction Severity Index, 5th edition. Philadelphia, University of Pennsylvania Veterans Administration Center for Studies of Addiction, 1990
16. McLellan AT, Luborsky L, Cacciola J, et al: New data from the Addiction Severity Index: reliability and validity in three centers. J Nerv Ment Dis 1985; 173:412–423
17. Kosten TR, Rounsaville BJ, Kleber HD: Comparison of clinical ratings to self-reports of withdrawal during clonidine detoxification of opiate addicts. Am J Drug Alcohol Abuse 1985; 11:1–10
18. McLellan AT, Kushner H, Metzger D, et al: The fifth edition of the Addiction Severity Index. J Subst Abuse Treat 1992; 9:199–213
19. Luborsky L, Barber JP, Siqueland L, et al: Establishing a therapeutic alliance with substance abusers. National Institute on Drug Abuse Research Monograph Series (in press)

20. Luborsky L: Therapeutic alliances as predictors of psychotherapy outcomes: factors explaining the predictive success, in The Working Alliance: Therapy, Research and Practice, edited by Horvath A, Greenberg L. New York, Wiley, 1994, pp 38–50
21. Derogatis LR: BSI: Administration, Scoring, and Procedures Manual-II, 2nd edition. Towson, MD, Clinical Psychometric Research, 1992
22. Gawin FH, Kleber HD, Byck R, et al: Desipramine facilitation of initial cocaine abstinence. Arch Gen Psychiatry 1989; 46:117–121
23. Hamilton MA: A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62
24. Williams JBW: A structured interview guide for the Hamilton Depression Rating Scale. Arch Gen Psychiatry 1988; 45:742–747
25. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised. Washington, DC, American Psychiatric Association, 1987
26. Luborsky L, Diguer L, Luborsky E, et al: Psychological health as a predictor of outcomes of psychotherapy. J Consult Clin Psychol 1993; 61:542–548
27. Tichenor V, Hill CE: A comparison of six measures of working alliance. Psychotherapy 1989; 26:195–199
28. Gaston L, Marmar CR, Gallagher D, et al: Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy processes. Psychotherapy Research 1991; 1:104–113
29. Gaston L, Marmar CR, Thompson LW, et al: Relation of patient pretreatment characteristics to the therapeutic alliance in diverse psychotherapies. J Consult Clin Psychol 1988; 56:483–489
30. Fenichel O: The Psychoanalytic Theory of Neuroses. New York, WW Norton, 1945

Appendix A. Helping Alliance Questionnaire, Patient Version

Instructions: These are ways that a person may feel or behave in relation to another person—their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. *Please mark every one.*

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. I feel I can depend upon the therapist.	1	2	3	4	5	6
2. I feel the therapist understands me.	1	2	3	4	5	6
3. I feel the therapist wants me to achieve my goals.	1	2	3	4	5	6
4. At times I distrust the therapist's judgment.	1	2	3	4	5	6
5. I feel I am working together with the therapist in a joint effort.	1	2	3	4	5	6
6. I believe we have similar ideas about the nature of my problems.	1	2	3	4	5	6
7. I generally respect the therapist's views about me.	1	2	3	4	5	6
8. The procedures used in my therapy are *not* well suited to my needs.	1	2	3	4	5	6
9. I like the therapist as a person.	1	2	3	4	5	6
10. In most sessions, the therapist and I find a way to work on my problems together.	1	2	3	4	5	6
11. The therapist relates to me in ways that slow up the progress of the therapy.	1	2	3	4	5	6
12. A good relationship has formed with my therapist.	1	2	3	4	5	6
13. The therapist appears to be experienced in helping people.	1	2	3	4	5	6
14. I want very much to work out my problems.	1	2	3	4	5	6
15. The therapist and I have meaningful exchanges.	1	2	3	4	5	6
16. The therapist and I sometimes have *un*profitable exchanges.	1	2	3	4	5	6
17. From time to time, we both talk about the same important events in my past.	1	2	3	4	5	6
18. I believe the therapist likes me as a person.	1	2	3	4	5	6
19. At times the therapist seems distant.	1	2	3	4	5	6

Appendix D.

Guide for Interviews with Practitioners
Evaluation of Telehealth in Franklin County Sheriff's Office

A. BACKGROUND

1. Please briefly describe your current position and responsibilities.
    a. What is your title?
    b. How long have you been in this position?

B. FOR FCSO CORRECTIONAL AND BEHAVIORAL HEALTH STAFF

OUD Treatment

2. Are you familiar with the services and assistance available for people with OUDs at your facility?
    a. *(if relevant)* What kind of Medication Assisted Treatment (MAT) was available?
    b. *(if relevant)* What kind of counseling was available?
    c. *(if relevant)* What supports did OUD clients receive other than counseling?
3. What was the nature of your involvement with people with OUDs? What were your roles and responsibilities specific to providing services for people with Opioid Use Disorders (OUDs)?
4. How many people with OUDs do you work with?
5. What is/was the nature of your involvement with people who receive MAT?
    a. How many people do/did you work with who receive MAT?
    b. What works/worked well at your facility for people who are receiving MAT? What did not work well?

Telehealth Use

6. Are you familiar with how FSCO uses telehealth? (*Provide definition and examples if necessary*.)
7. What is the process and protocol for using telehealth for people with OUD at your facility? What is your role in providing telehealth for people with OUD?
8. (*For behavioral health and medical providers*) What do you think about using telehealth to provide counseling as part of people's MAT? (*Specific to FCSO and generally)*
    a. Are you supportive of using telehealth for such purposes?
    b. What are some benefits to providing counseling virtually?
    c. What are some challenges to providing counseling virtually? Do you think counseling through telehealth can be used long-term? Why? Why not?
    d. Are there other applications of telehealth that you think have been more effective or should be explored?
    e. Do you have recommendations for how telehealth can be used effectively?
9. (*For CCWs, reentry, managers, IT, and leadership*) What do you think about using telehealth to provide OUD-related services?

a. What are some challenges you have experienced?
b. What do you think has worked well?
c. Has telehealth worked better for some services or applications than others? If so, which?
d. Do you have recommendations for how telehealth can be used effectively?

10. What do you think about using telehealth to connect justice-involved people at FSCO with community service providers in preparation for or upon their release?

a. What might be some challenges to using telehealth to connect with justice-involved patients in the community?
b. *(If relevant*) What do you think about using telehealth to provide counseling as part of MAT once people are released?

11. Do you think telehealth can be used long-term? Why? Why not? What challenges might exist?

12. Can telehealth be used eventually in all FCSO facilities post-pandemic? Why? Why not? What challenges might exist?

C. FOR COMMUNITY-BASED PRACTITIONERS

OUD Treatment

13. To what extent do you work with people with OUDs who are released from FCSO?

a. What is the nature of your work with this population?
b. Are people released from FCSO different from other people who have OUDs? In what way?

14. What kind of treatment is available for people with OUDs at your agency?

15. Is treatment for formerly incarcerated adults different than treatment for other people with OUDs?

16. How do you receive information about people's need of treatment at your agency? prior involvement with criminal justice system?

a. Do you receive a direct referral from FCSO staff?
b. What does the referral process entail?
c. Do you have walk-ins from patients? How often? How do you find out that they were released from FCSO?

Telehealth Use

17. Are you familiar with telehealth?

18. Does your agency currently use telehealth technology?

a. To what extent?
b. For what type of treatment?
c. Are there limitations to using telehealth for certain disorders?

D. FOR FCSO LEADERSHIP/ADMINISTRATION

OUD Treatment

1. Why is it important to offer treatment and supports for OUD in your facilities?

2. Tell us about your role in introducing MAT and counseling

a. Why did you think it was important to have MAT in FCSO

b. Is it important to have counseling as part of MAT? Why?
c. There is a variety of supports (e.g., group and individual) – why is it important to have those?

3. Do you make an effort to establish partnerships with outside providers?
   a. Who are the providers?
   b. Why do you work with them?
   c. What works/worked well at your facility for people who are receiving MAT and counseling? What did not work well?

Telehealth Use

4. Can you tell us why you were interested in having telehealth options available in your facility?

   a. Did you embark on this journey before COVID or after?

   b. What was your role in ensuring that some services such as counseling were available through telehealth? Are you supportive of using telehealth for such purposes?
   c. What are some benefits to providing counseling virtually?
   d. What are some challenges to providing counseling virtually? Do you think counseling through telehealth can be used long-term? Why? Why not?
   e. Are there other applications of telehealth that you think have been more effective or should be explored?
   f. Do you have recommendations for how telehealth can be used effectively?
   g. What was your role in ensuring that FCSO administration and staff who provide services felt supported in offering services via telehealth?

5. What do you think about using telehealth to connect justice-involved people at FSCO with community service providers in preparation for or upon their release?

   a. What might be some challenges to using telehealth to connect with justice-involved patients in the community?
   b. *(If relevant*) What do you think about using telehealth to provide counseling as part of MAT once people are released?

6. Do you think telehealth can be used long-term? Why? Why not? What challenges might exist?

7. Can telehealth be used eventually in all correctional facilities post-pandemic? Why? Why not? What challenges might exist?

E. CONCLUSION

8. Is there **anything else** we didn't ask that **you'd like to share with us about your work or experiences?**

THANK YOU VERY MUCH FOR TIME TODAY. WE LEARNED A GREAT DEAL!