There May Not Be a Tomorrow: Immediacy, Motivational Interviewing, and Opioid Intervention Courts

Michael D. Clark[1]
Director, Center for Strength-Based Strategies
Teresa Chandler
Assistant Director, Center for Strength-Based Strategies

THE AGELESS PHRASE "necessity is the mother of invention" was evidenced several decades ago when jail beds became full of crack-cocaine offenders, leaving the jurisdiction of Miami-Dade County, Florida, with no options to secure violent offenders. Necessity then met with innovation in 1989 with the creation of the first drug court (Kirchner, 2014). Something similar seems to be occurring with the recent birth of opioid intervention courts. The nation's first Opioid Intervention Court (OIC) was established in Buffalo in 2017 after three traditional drug-treatment court defendants fatally overdosed on opioids before their second court appearance—with these three deaths occurring *within a single week* (US Federal News, 2019).

The well-established treatment court model was deemed not enough and not fast enough for those in danger of overdose—prompting a new response. Buffalo, New York, started a first-ever treatment court with the primary goals of saving lives via a brief post-arrest medical intervention option. This option occurs within hours of arrest, where non-violent offenders with opioid use disorder are offered Medication for Opioid Use Disorder (MOUD), counseling, and residential assistance.

New OICs are starting up as they attempt to incorporate the Buffalo Court's critical immediacy model. They are likened to "emergency rooms" for life-saving triage and stabilization of new arrestees believed to be at high risk for opioid overdose (J. Smith, personal communication, December 18, 2019). Evidence that this new OIC model has mainstreamed is found in a 2019 publication "*Opioid Intervention Courts: 10 Essential Elements*" (Center for Court Innovation, 2019). Further support is demonstrated by the U.S. Bureau of Justice's (BJA) funding of a process report of the Buffalo OIC. To help new OIC courts, the report offers a deep-dive into how these 10 essential elements were implemented (Carey, van Wormer, & Johnson, 2022). With this review of implementation characteristics, the OIC model now is emerging with a structure of established research-based best practices to enable model replication.

In this article we speak to the need for evidence-based treatment to raise the odds for success within these new short-term triage courts. This is not an easy task, as this "immediacy" approach must respond to crisis timelines, helping staff to establish rapid engagement, and strategically influence crucial (potentially life-saving) decisions upon first contact (Carey et al., 2022).

What are the evidence-based approaches that can sync with the needs of this "rapid court engagement" model—and do so with effectiveness? Interventions must fit the quickened time range of minutes, hours, and days rather than weeks, months, or years. Considering most EBPs, this might seem an impossible order to fill. However, consider Moyers' (2015) description of Motivational Interviewing as the only EBP that values the relational aspects of treatment (engagement, collaboration) at the same level it values the technical aspects (evidence-based practice). The "what" you do (technical) and the "how" you do it (relational) are both equally prized and become a dual skill focus by an MI practitioner. In addition, this approach has a "gold standard" fidelity measure[2] that assesses both technical adherence as well as relational delivery to determine a person's MI competency/proficiency level (Moyers, Rowell, Manuel, Ernst, & Houck, 2016).

While it is not a perfect fit for every need, Motivational Interviewing has the ability to meet the demands of an OIC, warranting strong consideration. With MI as a court's fundamental service approach, a jail assessment can create "potent opportunities" (Forman & Moyers, 2019). These skills can extend to any participant during this stabilizing programming and run from initial contact to later warm handoffs for continuing care.

Nine benefits of Motivational Interviewing

[1] Corresponding author contact: Michael D. Clark. Email: mike.clark.mi@gmail.com Center for Strength-Based Strategies, 2843 East Grand River Ave., #312, East Lansing, MI 48823 (USA). Website: www.buildmotivation.com

[2] This measure is the well-researched Motivational Interviewing Treatment Integrity metric (MITI).

are presented for consideration. A tenth benefit will act as a summary to close this review:

1. Motivational Interviewing fits. It is an EBP for OUDs that is well-suited for brief interventions—even single sessions or within compressed time frames.

MI fits for OICs. Developed over 40 years ago in the SUD treatment field, MI is recommended by the National Drug Court Institute as an evidence-based treatment for substance use disorders (NDCI, 2019). This is coupled with the American Society for Addiction Medicine recommending MI as an accepted treatment option for opioid use disorders (ASAM, 2020). Within this new ASAM publication, "National Practice Guideline for the Treatment of Opioid Use Disorder," Motivational Interviewing is recommended for use with multiple special populations, including pregnant women, adolescents, individuals with co-occurring psychiatric disorders, and individuals in the criminal justice system after arrest. MI is also recommended to assist engagement of the newly arrested for the use of methadone, buprenorphine, and naltrexone, the three leading medications prescribed for opioid use disorders (ASAM, 2020). MI can help emerging OICs shoulder the many complexities and struggles of working with this population.

With OICs, the objective is to keep someone alive to start initial stabilization, while steadying them to move to longer term services. With an opioid population prone to overdose, you start engagement immediately—or you may not start at all. Using MI, a staff member can instill a desire to "start work" and begin an arrestee's readiness to change, even within the first brief contact (Stinson & Clark, 2017).

MI has been designated as an evidence-based practice for increasing both *engagement* and *retention* in treatment (NREPP, 2013). This type of engagement is as rapid as it is durable. MI has been called an "effective tool" for use within compressed time frames (Forman & Moyers, 2019). Multiple randomized clinical trials have shown reliable outcomes when it is used in just a single session (McCambridge & Strang, 2004; Diskin & Hodgins, 2009). An investigation conducted among adult patients in an emergency department found a single 30-minute session of motivational enhancement reduced prescription opioid misuse—*including opioid overdose risk behaviors*—for those who had histories of non-fatal overdoses and/or misuse of prescription opioids (Bohnert et al., 2016).

If stabilization can occur with this crisis-response approach, this OIC model seeks to keep the participant for approximately 90 to 180 days. Across this programming, MI can bolster the participant's retention in services. Examples are plentiful; one effectiveness study found that by incorporating MI into a standard substance abuse evaluation, participants were almost twice as likely to return for one additional session (Carroll et al., 2006). Another multi-site effectiveness study found that participants who received a single session of MI had significantly better retention in outpatient substance use treatment at 28 days when compared with controls (Carroll, Libby, Sheehan, & Hyland, 2001). It is important to note that the outcomes for brief interventions of MI are durable; studies that tracked progress over time found gains were still evident at two-, three-, and four-year follow up (Karakula et al., 2016; Schermer, Moyers, Miller, & Bloomfield, 2006; Baer et al., 2001).

2. The nagging question of critical immediacy for OIC first contacts: Can you ruin motivation in three minutes?

Certainly, you can. The contrasted response is that you can also raise motivation in three minutes (Stinson & Clark, 2017). Following arrest, an opioid intervention must measure outcomes in minutes and hours. Little time to intervene means little room for error. Initial contacts made by OIC staff are done with urgency (immediacy), and training in MI can improve the likelihood that short interactions prove helpful.

Many OIC staff have never been trained to gain a working knowledge of motivation (and how to raise it) and the process of human behavior change (and how to influence it). Change can occur by spontaneous remission, where readiness and action immediately follow a dramatic event or epiphany. Yet, most changes do not occur by point-in-time events; they occur by a *process* that follows the change continuum of "importance—confidence—readiness" (Stinson & Clark, 2017). Motivational Interviewing can train staff in skills to increase motivation in each of these three fundamental constructs.

Within this new crisis-response approach, all OIC staff, along with attending physicians, are better served to increase their knowledge of motivation and this continuum of change. One reason for MI's rapid spread across probation, corrections, health care, and SUD work is that MI has helped staff to "raise the odds" to increase the readiness to change in compressed time frames.

For opioid intervention, following arrest and through the first 48 hours, contacts could instill ambivalence (if there is none) or skillfully negotiate both sides of the arrestee's ambivalence (if there is some). All change is self-change, so having the arrestee articulate the person's own reasons for change is paramount. MI places a strong focus on amplifying the arrestee's discrepancy that arises between wants, aspirations, and values of the arrestee—and actual behavior. Considering that these first contacts are made in jail, it is easy to believe most people have a large gap between "what is real and what is their ideal." This forms the MI basis of eliciting a person's own reasons for change (person-centered *evoking)* rather than urging for an assessor's ideas or "good advice" (staff-centered *installing)*.

3. Conventional treatment or Motivational Interviewing (MI) in compressed time frames?

When we suggest to an OIC staff person that MI could be helpful for these first triage encounters, we are met with the response, "This isn't the time for treatment—these screenings happen within hours of an arrest and are brief!" Certainly, a conventional view of "treatment" being a 50-minute session in a provider's office falls short. Forego this conventional view and consider the necessity of skill development to address "critical immediacy" to impact and influence critical decisions in very short time frames.

Initial medical intervention means presenting and explaining a menu of procedural options for MOUD—advising for decisions of safety and stabilization in the face of mortal risk. Questions arise; MOUD or no MOUD? What kind of MOUD? Time tables? Residential assistance needed to stabilize and improve living arrangements? So many critical decisions are required of the new arrestee.

For those making these initial jail interventions, this effort takes on the characteristics of "first responders" and crisis intervention work. Crisis staff work by the motto, "Let them be alive in the morning." Yet there are naysayers who complain "arrestees aren't able make good decisions" due to their OUD (Clark, 2020a). Their approach would be to make these initial jail contacts more assertive and persuasive. We disagree. Motivational Interviewing believes most arrestees are

ambivalent about their opioid use—part of them wants to stop and, with equal force, part of them does not. A mortal issue is realized because many people suffering an OUD will die in this state of ambivalence. MI cautions helpers that people generally do not overcome the "stuckness" of ambivalence through advice or warnings. Instead, the use of motivational interviewing offers a chance to add to the compassion and zealous drive of these triage jail responders by providing an accelerant of skills to negotiate this decisional balance.

Opioid Interventions Courts need to be organized around the MI principles of client engagement, the resolution of ambivalence, and the use of a guiding style to assist healthy decision-making.

4. Even when actively offering MOUD, there is no guarantee. MOUD needs MI.

The development of new practices always seems to outpace the consideration of client motivation. Implementation bogs down until a program circles back to increase the attention and importance of a participant's buy-in. For any OUD client, "how" these medications are used often dominates any discussion, at the expense of "why" or "if" MOUD is to be used. MI can increase the arrestee's sense of importance to choose, comply with, and continue MOUD (Lewis-Fernandez et al., 2018). Research finds that "managing expectations" of patients for MOUD is an important theme and has much to do with "psychological readiness for treatment," a view shared by both providers and patients (Muthulingam et al., 2019). This 2019 study applied motivational interviewing to help patients resolve ambivalence and problem-solve treatment barriers.

The reluctance of a recent arrestee can be expressed in various ways:

"It is just not a good time."

"Who knows if that would even help?"

"If you take this away, what will I be left with?"

"It is the only thing that helps me to get through the day!"

MI can help those newly arrested to forego the status quo (in this case, continuing with street opioids) by tipping the balance to create an appetite for change. In another 2018 study, receiving one session of brief behavioral treatment that included Motivational Interviewing was associated with higher odds of receiving MOUD (Allison et al., 2018). MOUD needs MI to create willing acceptance and active participation.

5. MI can stand the heat. It has effective methods for individuals with OUD who present as resistant to treatment.

Motivational Interviewing was originally developed for those who are more resistant, angry, or reluctant to change (Clark, 2020b). MI has been found to be a particularly effective approach for working with people who are angry and defensive *at first contact* (emphasis added; Miller & Rollnick, 2013). Multiple resistance-lowering techniques can keep challenging participants moving forward using a non-adversarial approach.

Now add the heat of post-traumatic stress disorders (PTSD). Studies have shown that people with a higher reactance level have a better response to MI than to more directive styles (Miller & Rollnick, 2013). The term "reactance" can mean oversensitivity, touchiness, or even volatility. Consider how many arrestees entering an OIC might suffer from PTSD and the elevated reactance levels so prevalent with this condition.

Another common challenge is the complexity of dual diagnosis where an arrestee may enter an OIC with both a mental health disorder and a substance use disorder. The Center for Behavioral Health Statistics (SAMHSA) cautions that between 40 to 50 percent of those who abuse drugs have a comorbid mental health disorder (SAMSHA, 2011). Results from a 2018 study indicated that MI was associated with increased self-efficacy and treatment completion of dually diagnosed clients (Moore, Flamez, & Szirony, 2018). MI can "stand the heat" that stems from the intensity and complexity of treatment court work.

6. MI has been effectively trained to Peer Support providers and is used to empower peer assistance.

The U.S. Centers for Medicare and Medicaid Services declared peer support an evidence-based practice in 2007 (Eiken & Campbell, 2008). OIC startups are using supportive peers for good reasons; they can resolve the complaints of "you don't understand" by bringing common experience of "been there, lived it, seen it." SUD programs have used peer support for many years, and opioid intervention courts now turn to them as well. Starting in 2001, Georgia was the first state to offer a peer support service as part of the Medicaid State Plan rehabilitative services benefit (Eiken & Campbell, 2008). The Georgia CARES program (certified addiction recovery empowerment specialist) extends training in MI as part of their certification process. Many states have followed Georgia's lead, as MI is considered essential for any peer readiness curriculum (A. Lyme, personal communication, December 20, 2019).

Our Center has trained peer support staff and found no differences in their learning uptake as compared to any other training population. This field experience has been affirmed through multiple research investigations, which found comparative learning transfer with peers (Swarbrick, Hohan, Gitlitz, 2019; Crisanti et al., 2016). As with any disciplines working with OUD, peer support specialists can engage and build trust or they can argue and try to dominate. Training in a guiding style of communication and resistance-lowering techniques may bolster their shoulder-to-shoulder support. To empower their personal stories and "lived experience," MI might be one way to help peers prepare the ground before planting the seeds to guide a better life.

7. The use of MI doubles the effect size with minority populations.

Early reports of OIC race/ethnicity numbers find approximately 30 percent of OIC populations are minorities (D. Reilly, personal communication, December 11, 2019). Some treatments do not cross cultures well—yet MI does. Racial and ethnic minorities experience great benefit from its use as *the effect size of MI is doubled when used with minority clients* (Miller, 2018). Persons who have experienced a lack of respect, have been stigmatized by the label of "addict," or marginalized due to their ethnicity and race seem to be most attracted to this client-centered approach and the relational focus of MI.

8. MI is learnable and has a multi-modal training capacity for OICs.

With the imminent threat of overdose, it is critical that *all* OIC staff share in the treatment mission. MI has been trained to all treatment court roles—helping them to increase their skills for engagement and enhancing motivation. Large rooms of treatment court judges have enthusiastically joined day-long trainings in Motivational Interviewing (Center for Strength-Based Strategies, 2021). A cadre of treatment court judges are now receiving coaching in MI to improve their dialogue and efforts from the judicial Bench in program

review hearings (Center for Strength-Based Strategies, 2022).

MI training has been delivered to people in all roles: prosecutors, defense counsel, as well as coordinators, probation officers, peer support, and case managers. The Buffalo OIC judges received brief, improvised MI training (Carey, van Wormer, & Johnson, 2022); more Opioid Intervention Courts may want to follow Buffalo's lead and add more tailored and comprehensive MI training as a treatment "multiplier." Opioid intervention courts cannot afford to have some staff boring holes in the bottom of the treatment boat (overly directive, dominating) while others are trying to sail to a desired destination (establishing a high-quality working alliance, increasing the readiness for change).

A helpful research finding is that one's ability to learn MI is not contingent on experience, education, or professional field. You do not have to have years of seniority or advanced degrees (Stinson & Clark, 2017). This approach also has well-established fidelity measures to determine if it is being used correctly by team members (competency) and to what quality and extent (proficiency).

9. MI complements other evidence-based practices a treatment court may be using.

There are over 200 clinical trials and several meta-analyses showing MI's effectiveness as a stand-alone treatment (Miller, 2019). Research has found that when MI is added to another evidence-based practice (EBP), *both become more effective*—and the effect size is sustained over a longer period of time (Miller, 2018). Combining MI with another EBP appears to cause both approaches to be more effective for two reasons: first, with MI in place, people are also more responsive to participate; and second, participants are more likely to complete what is intended by implementing the EBP treatments in tandem.

Discussion

OICs emerge with a pre-plea model, extending a non-adversarial approach. If one considers that this rapid court engagement model tries to avoid sanctions and coercion, then engagement strategies and resistance-lowering techniques—the strengths MI is known for—play an even more critical role in bolstering cooperation and commitment by participants. The tenth benefit we review is that MI is designed to fit a non-adversarial approach.

Providers facing retirement may remember a vastly different field of SUD treatment here in the United States, as William R. Miller, the architect of Motivational Interviewing, reminds us in a past commentary (Walters, Clark, Gingerich, & Meltzer, 2007). In the 1970s it was acceptable, even commendable, to abuse those suffering from addiction—the abuse was believed good for them, it was what they needed, the only way to get through to them. This resulted in the boot camp atmosphere of California's Synanon, to name a famous example, with the yelling of insults and obscenities, confrontation for denial busting, and the attitude that you had to "tear them down to build them back up."

Fortunately, over time and partly in response to research, a punitive and dominating stance that was common in U.S. treatment has given way to a much more respectful and collaborative approach. Many things probably contributed to this change, including evidence that it was not very effective. It is hard to pinpoint the causes of seismic shifts in a professional field, but the field's amazing receptiveness to MI is at least a reflection of this profound change. Across several decades, treatment has changed, restoring hope and humanity to those suffering with substance use disorder.

It is within the context of this profound transformation that one can better understand the pre-plea involvement of the OIC and the non-adversarial approach; these courts attend to this opioid epidemic *as a health-care crisis*. It is here that you will find overlap between the foundational "spirit of MI"[3] and the fundamental nature of these new opioid intervention courts. MI can offer the know-how and techniques to help OICs deliver treatment with a non-adversarial, non-punitive guiding style. MI has been a leader in developing and delivering this non-coercive approach across several decades, reminding all that progress and change do not have "sides."

References

Allison J., Ober, K., Watkins, E., McCullough, C., Setodji, C., Osilla, K., & Hunter, S. (2018). Patient predictors of substance use disorder treatment initiation in primary care. *Journal of Substance Abuse Treatment, 90*, 64-72.

ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. (2020). *Journal of Addiction Medicine*, 14, 1–91. https://doi-org.proxy2.cl.msu.edu/10.1097/ADM.0000000000000633

Baer, J., Kivlahan, D., Blume, A., McKnight, P., & Marlatt, G. (2001). Brief intervention for heavy drinking college students: 4-year follow-up and natural history. *American Journal of Public Health, 91*,1310-1316.

Bohnert, A., Bonar, E., Cunningham, R., Greenwald, M., Thomas, L., Chermack, S., Blow, F., & Walton, M. (2016). A pilot randomized clinical trial of an intervention to reduce overdose risk behaviors among emergency department patients at risk for prescription opioid overdose. *Drug and Alcohol Dependence*, *163*, 40-47. https://doi.org/10.1016/j.drugalcdep.2016.03.018.

Carey, S., van Wormer, J., & Johnson, A. (2022). Responding to a state of emergency: The creation of a new triage to treatment court model to address the opioid crisis. *Journal for Advancing Justice*, *4*, 5-21.

Carroll, K., Ball, S., Nich, C., Martino, S., Frankforter, T., Farentinos, C., Kunkel L., … (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*(3), 301-312. https://doi.org/10.1016/j.drugalcdep.2005.08.002.

Carroll, K. M., Libby, B., Sheehan, J., & Hyland, N. (2001). Motivational interviewing to enhance treatment initiation in substance abusers: An effectiveness study. *The American Journal on Addictions*, *10*, 335–339. http://dx.doi.org/10.1111/j.1521-0391.2001.tb00523.x

Center for Court Innovation. (2019). The 10 essential elements of opioid intervention courts.https://www.courtinnovation.org/sites/default/files/media/document/2021/Report_The10EssentialElements_07132021.pdf

Center for Strength-Based Strategies. (2021). [*2-day Motivational Interviewing training for treatment court judges.* North Carolina Judicial Branch.] Unpublished raw data.

Center for Strength-Based Strategies. (2022). [Phase one: *Judicial training for NY Treatment Court Judges. Phase two: Move to MI evaluation of judicial dialogue recordings from treatment court review hearings. Phase three: virtual coaching based on Judge's interventions*. New York State Unified Court System] Unpublished raw data.

Clark, M. (2020a). Human motivation and opioid treatment: A critical ingredient left behind. In *Treatment courts 2020 vision: Improving health, justice and communities.* Symposium conducted at the meeting of the New York Association of Treatment Court Professionals (NYATCP), Sarasota Springs, NY.

[3] The spirit of MI has been called the four habits of the heart. Together they form the acronym of PACE; Partnership, Acceptance, Compassion and Evocation. Acceptance has four aspects, absolute worth, accurate empathy, autonomy/support, and affirmation.

Clark, M. (2020b). Finding the balance: The case for motivational interviewing to improve probation and parole. *Journal for Advancing Justice*, *3,* 85-97.

Clark, M., Roberts, T., & Chandler, T. (2020). Motivational interviewing for community corrections: Expanding a relationship-based approach with exemplar implementation. *Federal Probation*, *84*(35), 35-43.

Crisanti, A., Murray-Krezan, C., Karlin, L., Sutherland-Bruaw, K., & Najavits, L. (2016). Evaluation of an evidence-based practice training for peer support workers in behavioral health care. *Cogent Psychology*, *3*(1), 1212453. https://doi.org/10.1080/23311908.2016.1212453

Diskin, K. M., & Hodgins, D.C., (2009). A randomized controlled trial of a single session motivational intervention for concerned gamblers. *Behavior Research and Therapy*, *47*, 382-388.

Eiken, S., & Campbell, J. (2008). Medicaid coverage of peer support for people with mental illness: Available research and state examples. New York, Thomson Reuters. Available at www.wicps.org/uploads/1/8/1/4/1814011/peersupport_reuters.pdf

Forman, D. P., & Moyers, T. P. (2019). With odds of a single session, Motivational Interviewing is a good bet. *Psychotherapy, 56*(1), 62-6. ProQuest. Web. 26 Dec. 2019.

Karakula, S., Weiss, R., Griffin, M., Borges, A., Bailey, A., & McHugh, K. (2016). Delay discounting in opioid use disorder: Differences between heroin and prescription opioid users. *Drug and Alcohol Dependence, 169*, 68-72. https://doi.org/10.1016/j.drugalcdep.2016.10.009.

Kirchner, L. (April 25, 2014). Remembering the drug court revolution. *Pacific Standard*. Retrieved 2019-12-10.L

Lewis-Fernandez, R., Coombs, A., Balan, I., et al. (2018). Motivational Interviewing: Overcoming disparities in pharmacotherapy engagement. *Journal of Clinical Psychology*, 79(3),18ac12150.

McCambridge, J., Strang, J. (2004). The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: Results from a multi-site cluster randomized trial. *Addiction*, *99*, 39-52.

Miller, W. R. (2018, October). Conference plenary—Motivational Interviewing: A metamorphosis. Symposium conducted at the 2018 International meeting of the Motivational Interviewing Network of Trainers—MINT Forum. New Orleans, Louisiana, USA.

Miller, W. R., & Rollnick, S. (2013). *Motivational Interviewing: Helping people change* (3rd ed.). New York: Guilford Press. p. 207.

Miller, W. R. (2019). Controlled clinical trials involving Motivational Interviewing—updated 6/1/2019. Unpublished manuscript.

Moore, M., Flamez, B., Szirony, G. M. (2018). Motivational interviewing and dual diagnosis clients: Enhancing self-efficacy and treatment completion. *Journal of Substance Use*, *23*(3), 247–253.

Moyers, T. (2015). MINT Oceanic (producer). *Beyond motivational interviewing: What MI has contributed to the broader field of psychotherapy.* [Workshop podcast]. Retrieved from https://vimeo.com/137430269

Moyers, T. B., Rowell, L. N., Manuel, J. K., Ernst, D., & Houck, J. M. (2016). The motivational interviewing treatment integrity code (MITI 4): Rationale, preliminary reliability and validity. *Journal of Substance Abuse Treatment, 65*, 36–42. https://doi.org/10.1016/j.jsat.2016.01.001.

Muthulingam, D., Bia, J., Madden, L. M., & Farnum, S. O. (2019). Using nominal group technique to identify barriers, facilitators, and preferences among patients seeking treatment for opioid use disorder: A needs assessment for decision making support. *Journal of Substance Abuse Treatment, 100,*18-28.

National Drug Court Institute (Producer). (2019). Educating drug courts on medication assisted treatment (MAT) [Online Course]. Available from http://www.NDCRC.org/

NREPP. Motivational Interviewing. Intervention summary retrieved on April 15, 2013, from the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices, http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=130

Schermer, C., Moyers, T., Miller, W., & Bloomfield, L., (2006). Trauma center brief interventions for alcohol disorders decrease subsequent driving under the influence arrests. *Journal of Trauma, 60,* 29-34.

Stinson, J. D., & Clark, M. D. (2017). Motivational interviewing with offenders: Engagement, rehabilitation, and reentry. New York, NY: The Guilford Press.

Swarbrick, M., Hohan, M., Gitlitz, R. (2019). Peer health navigators support individuals with an opioid use disorder transitioning from prison. *Drug and Alcohol Dependence*, *203,* 88-91.

United States Department of Substance Abuse and Mental Health Administration SAMHSA). (2011). http://www.samhsa.gov/data/sites/default/files/2011MHFDT/2k11MHFR/Web/NSDUHmhfr2011.htm#Ch4

*US Fed News Service, Including US State News, (*Oct 30, 2019). Do opioid intervention courts work? University at Buffalo study will provide the answer. *ProQuest.* Web. 26, Dec. 2019.

Walters, S. T. (2007). *Motivating offenders to change: a guide for probation and parole.* U.S. Dept. of Justice, National Institute of Corrections.