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# Launching Relationship-Oriented Behavioral Services for Youth Opioid Use Disorder: Innovations in Medication Decision-Making and Adherence Planning

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## ABSTRACT

This article presents behavioral interventions designed to enhance uptake and retention on medication for opioid use disorder (MOUD) among transition-age youth (16–25 years) enrolled in treatment services. The article describes three relationship-oriented interventions designed to address barriers to MOUD uptake, enhance MOUD adherence planning, and strengthen OUD recovery among youth: *Relational Orientation*; *Medication Education and Decision-making Support*, and *Family Leadership and Ownership of Adherence to Treatment*. These interventions are inter-connected can be delivered flexibly. The article concludes with three case examples that illustrate how these modular interventions can be tailored to meet the needs of diverse client profiles.

## ARTICLE HISTORY

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## KEYWORDS

Family-based interventions; medication; opioid use disorder; transition-age youth

This article presents innovative, relationship-oriented clinical interventions designed to support youth engagement in medication for opioid use disorder (MOUD) services in behavioral care settings. It focuses on “transition-age youth” (TAY), which references the age span from middle adolescence through young adulthood—roughly, ages 16–25 years—for several reasons. There is consensus in developmental neuroscience that cognitive and emotional maturation processes that directly shape risk-taking behaviors are dynamically active throughout this age span (Steinberg, 2014). Also, substance use problems that initiate during this span significantly compromise long-term well-being and show comparatively poor response to intervention efforts (National Center on Addiction and Substance Abuse, 2011). And as described below, TAY with OUD have

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extremely poor rates of medication acceptance and adherence to medication regimens (i.e., medication “uptake”), leaving them highly vulnerable to the health risks posed by OUD.

## **Recent trends in youth opioid use risk and services involvement**

### ***Opioid use prevalence and risk among TAY***

The United States has experienced an opioid epidemic for nearly two decades, and rates of opioid misuse and opioid-related mortality climbed precipitously in 2020 (American Medical Association, 2020). Opioid misuse and related problems are especially alarming among TAY: Between 2002 and 2013 the rate of past-year heroin use more than doubled (Centers for Disease Control and Prevention, 2015), and between 2006 and 2015 the rate of lethal opioid overdoses increased from 3.4 deaths to 5.3 deaths per 100,000 (Ali et al., 2019). National data from 2019 (SAMHSA, 2020a) show that nearly 1,800 youth initiate heroin or pain reliever misuse each day, and almost 300,000 meet diagnostic criteria for OUD.

### ***MOUD services are evidence-based but vastly underutilized by TAY***

MOUD, consisting of opioid agonist or antagonist medication with medication-supportive behavioral counseling, is an evidence-based treatment for OUD (Volkow et al., 2019). MOUD is well-established for all age groups (Blavatnik Institute for Health Care Policy, 2020) and is recommended for TAY by national pediatric healthcare policy (American Academy of Pediatrics, 2016). Initiation onto one of three FDA-approved medications (buprenorphine, naltrexone, methadone) typically occurs during acute crisis-driven episodes of care (e.g., treatment of withdrawal or “detoxification”), after which long-term adherence to a MOUD regimen (“maintenance”) is a standard recommendation to prevent recurrence of opioid use problems (“relapse”). MOUD is often combined with ancillary behavioral counseling and other recovery resources intended to support opioid abstinence and address other substance use and co-occurring mental health problems (Blavatnik Institute for Health Care Policy, 2020). MOUD services can occur within or across a variety of settings (e.g., residential, outpatient, emergency).

The national OUD system of care is moving rapidly to increase MOUD availability for TAY (American Academy of Pediatrics, 2016). Unfortunately, this remains an uphill battle due to multiple well-documented barriers to MOUD acceptance and adherence among TAY. Common *client-level* barriers include low motivation to change substance use habits or seek treatment; weak involvement in the healthcare system;

MOUD-related misinformation and stigma; biases against using medication to treat substance use problems; extended time and effort required for MOUD induction and tapering; and disruptions from untreated co-occurring disorders (Minozzi et al., 2014). Common *system-level* barriers include lack of MOUD knowledge and licensure among primary and secondary care providers; fragmentation between medical and behavioral services; burdensome regulations regarding who can prescribe MOUD, for whom, and under what circumstances; provider misinformation and bias against MOUD; abstinence-only treatment philosophies; and inadequate ancillary services to support MOUD and extended OUD recovery (Sharma et al., 2017).

As a result of these intransigent barriers, only a fraction of youth with OUD receive any treatment, and even fewer receive MOUD (Bagley, Chavez, et al., 2021), even after an opioid overdose episode (Alinsky et al., 2020). Studies of MOUD services report universally low enrollment rates for TAY, in the area of 10–35% among those in need (Alinsky et al., 2020; Borodovsky et al., 2018). Moreover, TAY who do initiate MOUD are significantly less likely to remain medication adherent compared to adults (Fishman et al., 2020). It is especially difficult to support TAY in remaining on MOUD across the months-to-years needed to accrue stable benefits. One-fourth who initiate MOUD leave treatment after one week, and most studies place one-year adherence rates between 9 and 17% (e.g., Chang et al., 2018). Low medication adherence during the OUD recovery phase is highly problematic due to the strong association between MOUD duration and positive outcomes among TAY (e.g., Subramaniam et al., 2011). Altogether, these poor rates of youth MOUD acceptance and adherence undermine national efforts to curb the youth opioid crisis and support effective MOUD and behavioral services.

### **Relationship-oriented approach to MOUD services: a promising fit for TAY**

Current standard-of-care approaches to supporting medication uptake among youth with OUD—client psychoeducation about MOUD, behavioral interventions to support MOUD adherence and address co-occurring issues, and recovery support services to boost MOUD adherence and recovery maintenance—focus almost exclusively on the individual youth. This is true for adults with OUD as well. Unfortunately, given the poor uptake rates described above, even well-designed individual approaches, while laudable, have proven insufficient to date for surmounting MOUD service barriers among the vast majority of TAY.

A compelling innovation to boost MOUD uptake is adopting a relationship-oriented approach that prioritizes inclusion of concerned significant others (CSO)—defined broadly as family of origin, romantic partners, and/or family-of-choice members—at each stage of the MOUD services continuum (Hogue, Becker, Wenzel, et al., 2021). There are several evidence-based reasons to endorse a relationship-oriented approach for this age group. Families represent primary risk and protective factors, and contexts of developmental influence, for substance use problems of every kind among youth. Typically, CSO remain highly involved (including financially) with substance-using youth, play a primary role in treatment enrollment, and are emotionally invested in their loved one’s recovery (Hogue, Becker, Wenzel, et al., 2021). Multiple empirical reviews report that CSO-focused interventions are highly effective for promoting treatment engagement and client outcomes among both adolescents and adults (see Ariss & Fairbairn, 2020). Specifically, manualized family therapy models have amassed the strongest empirical support for treating adolescent substance misuse (Hogue et al., 2018), and manualized family- and relationship-oriented models such as CRAFT, network therapy, and behavioral couple therapy have proven effective for adult substance use problems (Hogue et al., 2022). Also, CSO are critical resources for youth recovery capital, that is, for helping youth sustain substance use reductions and achieve health-promoting goals (Ashford et al., 2019). This is especially salient for TAY who are estranged from families-of-origin but have connections with non-family CSO who could reinforce OUD treatment goals.

Despite this compelling rationale, in routine practice settings CSO are rarely incorporated in treatment and recovery activities for youth SUD in general or youth OUD specifically (Bagley, Ventura, et al., 2021). For almost all other health concerns it is considered routine, even obligatory, to help a loved one (especially a family member) who faces challenges and may be having difficulty with optimizing utilization of treatment services. But this is not the case in OUD services, for many reasons. To be sure, prominent barriers against involving CSO exist among both providers (e.g., biases against CSO as causes of OUD problems, lack of skills or motivation to pursue CSO outreach, beliefs that youth with OUD need unilateral individuation from parents, beliefs that only internal insight and motivation can produce behavior change Ventura & Bagley, 2017]) and among CSO themselves (e.g., demoralization about providing support, reticence to engage with substance use services [Kennedy & Horton, 2011]). To overcome these barriers and successfully engage CSO in routine behavioral services for OUD, clinically pragmatic interventions focused on active CSO involvement in MOUD decision-making and adherence planning are needed.

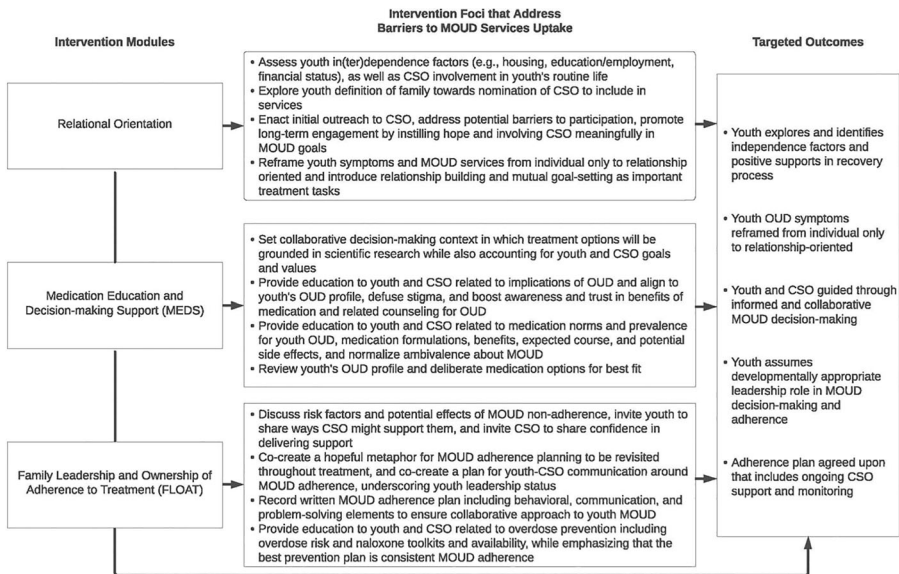
### Three relationship-oriented interventions for increasing MOUD uptake

Despite their exceptional research portfolio, relationship-oriented models for substance use problems have not been widely adopted in mainstream practice. We now describe three relationship-oriented interventions, operating under a coherent developmentally informed theory of OUD, designed to address barriers to MOUD uptake, enhance MOUD adherence planning, and strengthen OUD recovery among youth. Note that clinical flexibility is a hallmark of these interventions, each of which is comprised of four intersecting tasks. Strategies from the interventions can be incorporated into a single session, staggered across sessions, and/or interspersed with other individual- or CSO-focused interventions. The time needed to complete each intervention, and also each constituent task, is meant to vary based on the profile of the given youth and CSO, practice habits of the given clinician, number of constituent tasks delivered, and overall case progress. Also, to account for the wide diversity in CSO configuration experienced by TAY, the Relational Orientation intervention invites clinicians to collaborate with youth in determining whether and which CSO are promising candidates for involvement in MOUD services, and how invited CSO can best serve to support the youth's treatment goals. To be sure, many TAY with OUD have minimal social support networks, and sometimes negligible involvement with CSO of any kind. In such cases, most of the constituent tasks can be delivered with youth alone, which itself advances a relationship-oriented treatment perspective: Even when working individually with a youth client, it is highly valuable for these youth to cultivate CSO-involved treatment and recovery options.

Below are brief descriptions of the rationale and main foci of each intervention and its constituent tasks: Relational Orientation, Medication Education and Decision-making Support (MEDS), and Family Leadership and Ownership of Adherence to Treatment (FLOAT). [Figure 1](#) displays the three interventions, the foci by which each intervention addresses barriers to MOUD services uptake, and targeted youth OUD treatment outcomes. The interventions are designed to work synergistically, and clinicians may move flexibly from one intervention to the next within the same course of treatment. Full protocols are available from the authors.

#### ***Relational orientation***

The Relational Orientation intervention is used to introduce and secure the value of involving CSO in MOUD service delivery, while simultaneously accounting for autonomy-seeking and independence status as overarching developmental themes for TAY (Arnett, 2005). Central facets of youth independence shape how clinicians engage a given youth in MOUD



**Figure 1.** Intervention modules, foci, and targeted outcomes. *Note.* CSO: Concerned significant other; MOUD: Medication for opioid use disorder; OUD: Opioid use disorder.

services with regard to addressing stigma and perceived treatment value within their social networks, deciding whether and which CSO to involve in MOUD services, and strengthening social support in order to solidify MOUD adherence (Bergman et al., 2016). At the same time, clinicians anticipate how relationship resources and dynamics could impact CSO participation, attempt to outreach and engage with CSO, continuously underscore rationale for CSO participation that accounts for both youth- and CSO-specific concerns, and seek to reframe the youth's OUD problems in a relational context (see Hogue et al., 2017) wherein relationship building and mutual goal-setting are fundamental to MOUD services.

### **Task 1: Youth independence/interdependence assessment**

Youth in(ter)dependence factors, including the degree and salubrity of youth connectedness with family and other social networks, are pervasive in all aspects of TAY functioning. They must be thoughtfully integrated when selecting and implementing strategies to promote MOUD uptake. Accordingly, clinicians assess housing status (e.g., living with caregiver-s/partners, independently, institutionalized), education/employment status, financial status, and CSO involvement in routine life and healthcare practices. These in(ter)dependence factors then serve as cornerstone reference points for all three interventions throughout the course of MOUD services.



**Task 2: Youth nomination of CSO**

Based on results of Task 1, clinicians help youth identify CSO with potential for functional availability and positive support of MOUD uptake. It is important to explore how each youth defines family and to honor broader “family of choice” identifications in the CSO nomination process. It may be valuable to consider inviting more than one CSO to participate in services in order to create balance in perspectives, provide additional support for nominated CSO, and/or build a treatment support network that is as broad as possible. When a supportive CSO is not currently available, and/or a youth is reluctant to nominate potential CSO, clinicians can deliver youth-only elements of MEDS and FLOAT while periodically revisiting whether any CSO are available to invite.

**Task 3: CSO engagement**

To make initial connections with nominated CSO, clinicians can work with youth to support them in making initial overtures, or as indicated, clinicians can enact outreach procedures themselves to address potential logistic and attitudinal barriers and enhance CSO readiness to participate. When CSO participate in a first session, clinicians promote long-term CSO engagement by instilling hope and involving them meaningfully in MOUD service goals. Clinicians join with CSO by showing respect, curiosity, and acceptance; expressing appreciation and empathy regarding past frustrations over the youth’s condition and behavior; using relevant self-disclosure to establish connection; and promoting participation by validating issues they raise. When initial outreach to CSO proves especially challenging, clinicians can work to further understand treatment barriers and/or reticence and suggest rationale for pursuing MOUD services that accounts for specific CSO concerns.

**Task 4: OUD relational reframe**

Clinicians use relational reframe techniques to shift the focus of MOUD services from exclusively fixing youth symptoms to include improving the quality of youth-CSO relations, which can instrumentally strengthen the youth’s OUD treatment and recovery prospects. This typically begins by encouraging youth and CSO to accept relationship building and mutual goal-setting as important treatment tasks. Approaches to delivering a relational reframe include: identifying sequences of behaviors or emotions involving CSO that precede, or directly precipitate, an OUD-related problem; focusing directly on the impact an OUD-related problem has on the actions, thoughts, and feelings of both youth and CSO; and championing relationship repair or improvement as a foundational treatment goal.



### ***Medication education and decision-making support (MEDS)***

MEDS is a shared decision-making intervention. Shared decision-making procedures in healthcare involve clinicians educating and exchanging information with patients about a health problem, identifying patient values and preferences, reviewing treatment options with an emphasis on risks/benefits, and agreeing on a treatment plan (Langer & Jensen-Doss, 2018). It has produced benefits in treatment adherence and satisfaction, goal achievement, and targeted outcomes across a range of health behaviors and is considered especially useful for healthcare options that require strong patient commitment to adhere to treatment tasks (e.g., Reyna et al., 2015). To crystallize a CSO-focused strategy for MOUD decision-making, clinicians use family-based decision coaching (Langer & Jensen-Doss, 2018) to **systematically** process youth and CSO attitudes about MOUD in the context of collaborative benefit-risk decisions about treating OUD.

#### ***Task 1: Set a collaborative decision-making context***

Clinicians explain that every effort will be made to provide all available information about potential benefits and risks of each OUD treatment option, but also, that discussion will focus on options supported by scientific research and recommended by the medical community—the most effective being MOUD. Clinicians invite youth and CSO to share individual and jointly-held goals and values that should be considered during the MOUD decision-making process (e.g., youth feeling better, curbing urges to use, and minimizing side effects; as well as honesty, responsibility, and health), and whether OUD has affected their ability to act in alignment with those goals and values. Clinicians reinforce that goals and values will be continually revisited as treatment decisions and adherence plans are made, prioritizing consistency between MOUD services and youth/CSO preferences.

#### ***Task 2: OUD education***

Using easy-to-digest infographics (available from authors) to prompt interactive discussion, clinicians seek to educate youth and CSO about neurobehavioral, clinical, and developmental implications of OUD; align general facts with the given youth's opioid use profile; defuse moral attributions and other stigma; discuss how the youth's OUD profile might impact health, school/vocational, and social functioning; and boost youth and CSO awareness and trust in potential benefits of medication and related counseling for OUD. These discussions provide important opportunities for youth and CSO to share their knowledge and lived experiences with opioids, and

for clinicians to provide science-based information about OUD and to engender potentially corrective discussions.

### ***Task 3: MOUD education***

Using easy-to-digest infographics (available from authors) to prompt interactive discussion, clinicians address medication norms and prevalence for youth OUD; medication formulations (e.g., SL buprenorphine, XR-buprenorphine, XR-naltrexone) and their initiation and dosing procedures; medication benefits, expected course, and potential side effects; and other factors that impact MOUD stigma and inform decision-making. Of prime emphasis is the fact that MOUD is the only scientifically proven treatment option for OUD, while behavioral counseling and recovery supports may enhance the effectiveness of MOUD. Clinicians offer youth and CSO ample opportunity to share opinions and personal experiences related to MOUD, being sure to normalize ambivalence about MOUD and wariness about side effects while instilling hope that MOUD can help alleviate a given youth's unique problems. When presenting a typical MOUD treatment sequence, clinicians explain that the treatment team would closely monitor dose, therapeutic effects, and side effects at every step, and that youth would retain the option to discontinue MOUD under medical supervision if needed or wanted.

### ***Task 4: MOUD decision-making***

Clinicians talk with youth and CSO about the many considerations related to starting MOUD: medication benefits, route of administration, side effects, stigma-related questions about using medications to address substance problems, the youth's capacity to remain abstinent without medication, and medication costs. Youth, CSO, and clinicians together review the given youth's MOUD profile and deliberate which medication option appears to be the best fit, reviewing MOUD infographics as needed. Clinicians ask all members to account for key factors likely related to a given youth's adherence capability, such as consistency of habits for taking medications, MOUD misuse potential, access to a MOUD prescriber, ability to travel to a clinic, and misuse of other substances. Clinicians also process decisions by youth not to initiate MOUD, including projected outcomes of alternative decisions, while looking to establish MOUD as a consensus back-up option.

### ***Family leadership and ownership of adherence (FLOAT)***

Clinicians engage with youth and CSO to support developmentally appropriate youth leadership on their own needs with regard to OUD services generally and to decisions about MOUD (Bergman et al., 2016). Leadership

begins with helping youth formulate personally meaningful service goals that encompass their unique views and concerns while accounting for potential value and practical considerations of CSO involvement in services. Clinicians help youth gain incremental authority of educational facts related to OUD and MOUD risks and benefits, such as those described above in MEDS, with the goal of establishing ownership of MOUD adherence and the course of their OUD recovery. Clinicians also work with youth and CSO to specify a collaboratively drawn MOUD Adherence Plan that reflects the given youth's OUD profile, aims to leverage at-hand recovery capital strengths and supports, and establishes benchmarks for MOUD retention, harm reduction, and incremental recovery progress. Essential to all MOUD adherence planning is delivering standardized layperson-targeted interventions to educate youth and CSO about naloxone toolkits and overdose prevention (Bagley et al., 2015).

#### ***Task 1: MOUD treatment adherence***

Clinicians, youth, and CSO share or revisit risk factors for and potential effects of MOUD non-adherence. In doing so clinicians check for the affective impact of naming non-adherence risks, normalize the presence of such risks for any person seeking SUD treatment, invite youth to share ways in which CSO might support them, invite CSO to share their confidence about being supportive, and make a concrete plan to address whatever questions they cannot currently answer. They also emphasize the difference between collaboratively choosing to alter or cease a MOUD regimen—which should be undertaken only with prescriber input and a monitoring plan—versus choosing to do so without prescriber input.

#### ***Task 2: Promote youth leadership in MOUD adherence planning***

Clinicians, youth, and CSO co-create a hopeful metaphor for MOUD adherence planning (e.g., ship, forest, sports team) that includes the role and function of each member and ways in which they will relate to one another; youth occupy the main leadership role (e.g., captain). The metaphor can be revisited throughout services as a way to monitor the adherence plan (e.g., “Is the coach checking with the assistant coaches?”) and maintain a cooperative approach. As youth become more sophisticated in their leadership, they can learn to accept the limits of their judgement. Clinicians also scaffold cooperative MOUD adherence planning by co-creating a plan for youth-CSO communication around MOUD use. To do so, they engineer in-session practice of basic youth-CSO relationship skills such as mutual validation, positive communication, and joint

problem-solving focused on MOUD adherence, being sure to underscore the leadership status of youth in these exercises.

### **Task 3: Collaboratively formulate an MOUD adherence plan**

Clinicians utilize information about youth and CSO risk and resources for MOUD adherence to record a written MOUD Adherence Plan. The Plan involves collaborative monitoring of the youth's MOUD status by identifying and refreshing MOUD adherence goals, tracking success in meeting these goals, and verbally reinforcing adherence success. The Plan should contain *behavioral* elements such as type of medication chosen, where medication will be kept at home (if applicable), what time of day it will be taken (if daily), whether and how the CSO will be notified when taken, and dates for upcoming prescriber and therapy appointments. It should include *communication* elements specifying processes for members to communicate with one another when there are real or perceived missteps in the plan. It should include *problem-solving* elements acknowledging that the future will include struggle with adherence (e.g., positive drug screens, missed appointments or medication pickups) and specifying solutions to anticipated problems. To solidify a collaborative and family-empowering approach to MOUD adherence, clinicians invite youth and CSO to select a regular time outside of provider meetings to confer with one another about the Plan, in addition to scheduled Plan monitoring and revision meetings with providers.

### **Task 4: CSO-involved overdose prevention education**

Clinicians use infographics (available from authors) to review and/or educate youth and CSO about OUD overdose risk, naloxone toolkits, and overdose prevention. This includes corrective information related to myths of naloxone availability (e.g., having access to naloxone will increase likelihood of youth relapse). Clinicians also emphasize that the best overdose prevention is consistent MOUD adherence. They work to achieve consensus between youth and CSO on network-wide safety and overdose prevention plans that are suited to current and planned youth living arrangements. Youth and CSO practice overdose training in session under the hands-on guidance of clinicians.

### **Case example 1: Kendra**

Kendra is a 21-year-old cis queer Latina woman receiving outpatient OUD treatment after being briefly hospitalized for a non-fatal opioid overdose. She was prescribed sublingual buprenorphine/naloxone but has struggled to adhere to treatment recommendations and take her medication daily.

Kendra has been in foster care since her mother ejected her from the family home when she was 17 after she came out as queer. Kendra has been in her current foster home for two years and is beginning to prepare to live independently. She has been diagnosed with Post-traumatic Stress Disorder and Generalized Anxiety Disorder.

### ***Relational orientation module***

#### ***Task 1: Youth independence/interdependence assessment***

During the assessment phase of treatment, the therapist asked Kendra to share the important people in her life and how much contact she currently had with each. Using an eco-map tool, Kendra expressed feelings of love and care for many people but little contact with anyone outside of some peers and professionals.

#### ***Task 2: Youth nomination of CSO***

In the context of exploring her plan for independent living, treatment goals were developed that included increasing communication with friends and reaching out to her paternal grandmother Monica as a potential future support for managing her OUD and mental health difficulties. Kendra reported feelings of admiration for her grandmother and some fond memories of her from childhood. The therapist explored her openness to including her grandmother in therapy and Kendra was initially hesitant, citing not wanting to burden or worry her. After role playing a few scenarios for reaching out, Kendra and the therapist developed a plan to text her to share some fond memories and invite her to attend one treatment session.

#### ***Task 3: CSO engagement***

Kendra initially struggled to send the message and the therapist followed up for several sessions in a row; ultimately, Kendra sent the text during a session. The therapist praised her for managing this outreach process and for her courage in making this connection. Monica joined a session a few weeks after she and Kendra began communicating about it, and the therapist prepared with Kendra for how they would spend the time in session, including what information about Kendra's OUD would be shared and what treatment goals discussed. When she joined the session, Monica expressed gratitude for being included.

#### ***Task 4: OUD relational reframe***

The therapist hypothesized that the development of OUD was influenced by key relational factors that led to social isolation, especially the death of

her father at age 4 and rejection and homophobia from her mother. Her progression from cannabis to opioid use and its consequences created further isolation, and a recursive process emerged. Positive connection with people in her life was identified as the foundation of her short- and long-term recovery.

### ***MEDS module***

***Task 1: Set a collaborative decision-making context; task 2: OUD education; task 3: MOUD education***

After an initial session with Monica, Kendra and the therapist collaboratively decided to invite her in periodically. Kendra was initially reluctant to review her decision-making about MOUD, citing commitment to resume buprenorphine/naloxone and adhere to daily use. She agreed to continue the dose she was prescribed upon discharge from the hospital but also proved willing to engage in an expansive conversation about all her options.

***Task 4: MOUD decision-making***

Kendra reiterated her decision to continue sublingual buprenorphine and expressed feeling more confidence in her current MOUD choice and knowledgeable about the risks of diversion and/or missing a dose.

### ***FLOAT module***

***Task 1: MOUD treatment adherence***

When exploring what has been in the way of successful MOUD adherence, Kendra cited feelings of hopelessness, urges, and decisions to use opioids. Kendra also expressed feeling judged harshly by previous treatment providers, case managers, and a previous foster parent for using MOUD.

***Task 2: Promote youth leadership in MOUD***

Kendra participated actively in discussing her vulnerabilities for MOUD adherence, including not wanting to involve her foster parent and the fact that she remained mostly isolated socially despite her goal of working on relationships. The therapist affirmed her insight into these vulnerabilities and spent extensive time discussing them and exploring possible collaborative problem-solving strategies.

***Task 3: Collaboratively formulate an MOUD adherence plan***

Kendra's written plan included reliable treatment attendance, prescriber meetings, alarm set on her smart phone, and a plan to update her

grandmother about her experience in treatment and MOUD progress whenever they spoke. Kendra agreed to share this aspect of the plan with her grandmother, and to give her permission to ask about her MOUD plan if Kendra didn't volunteer that information herself.

#### ***Task 4: CSO-involved overdose prevention education***

Kendra also agreed to share with her grandmother information on local training for overdose prevention. Despite her continued commitment not to worry her grandmother, her investment in this relationship and belief in the value of scientific information made her open to sharing this community resource.

### **Case example 2: Brian**

Brian is a 21-year-old cis straight white man recently discharged from inpatient treatment for OUD who started intensive outpatient treatment. His mother Gloria is divorced, lives with Brian's younger brother Greg (17 years old), and works as a paralegal. Brian began using cannabis and alcohol at 14 after struggling with social isolation and difficulties with emotion regulation; experimentation with non-prescribed opioids led to OUD, including intravenous heroin use by age 20. Brian initially declined MOUD and a sober living facility and upon inpatient discharge moved back in with Gloria and Greg.

#### ***Relational orientation module***

##### ***Task 1: Youth independence/interdependence assessment***

After entering treatment as a result of an ultimatum from his mother (agree to enter care or leave the family home), Brian expressed ambivalence about recovery and anger about feeling coerced into treatment. He was able to identify the goal of independent living as important, and also stated the importance of abstinence from heroin for independent living. The therapist explored ways in which he was independent (distinct personal and political beliefs from his family, some long-term friendships) and, not independent (reliant on his mother for housing and money), as well as concrete steps for what full independence might look like. Brian was initially very reluctant to include family members in his treatment. He expressed feeling angry at his mother, past difficult experiences in family therapy in which he felt blamed and shamed, and that family involvement in treatment was incompatible with his independence goals. He described the current relationship with his mother as strained, with either very little communication or explosive conflicts. Since Brian moved back home, his mother had taken



a position that she needed to detach with love, and further, that any support beyond housing, which for her was contingent upon abstinence, would be “enabling” him. Brian’s therapist explored potentially inviting his father, who was currently residing in a different state, to a session. Brian expressed resentment towards his father for not supporting him when his mother began to anger and impose consequences for his substance use that he experienced as harsh. Brian also expressed disdain toward his father for not staying close to him and Greg after Gloria had an extramarital relationship that led to marital dissolution.

### ***Task 2: Youth nomination of CSO***

The therapist inquired about holding a session with both his mom and Greg in which the focus could be on family connections rather than Brian’s difficulties with substance use or the notion of enablement. Brian expressed feeling hopeless that his mother would be able to manage her anger towards him even in the presence of his brother, for whom Brian demonstrated love and affection, and declined this option.

### ***Task 3: CSO engagement***

The therapist validated Brian’s feelings about family involvement during the assessment process and asked permission to revisit the question later in treatment, to which Brian agreed. When asked if he’d be willing to provide his mother information on training in overdose reversal, he initially refused, citing her reactivity and his own belief that she’d interpret the training materials as a sign that he was intending to use heroin again. The therapist offered to supply his mother education materials related to communication skills rather than substance use or overdose, to which he agreed.

### ***Task 4: OUD relational reframe***

As Brian’s goals for independence crystallized, he and the therapist noted that difficulties managing his anger when communicating with his mom were causing him great distress. Because similar distress historically created urges to use substances, it was important to improve his emotion regulation and develop effective communication skills to use with his mother when he felt blamed or judged. While Brian initially rejected the idea that their relationship dynamic could change, he agreed to practice some skills in session and experiment with using them at home.

## ***MEDS Module***

### ***Task 1: Set a collaborative decision-making context***

After Brian expressed a history of feeling coerced by his mother and previous providers, the therapist was very intentional about building rapport,

relevant self-disclosure, and amplifying Brian's unique goals and history. Brian struggled to attend sessions and also began to resume heroin use periodically. The therapist advocated for his case to remain open despite the program's expectations about attendance and his supervisor's concerns that Brian would require a higher level of care.

### ***Task 2: OUD education***

When Brian attended sessions, the therapist devoted much time to providing education on OUD in a collaborative way, that is, as embarking on a co-discovery mission to explore gaps in Brian's knowledge about substance use and resolve uncertainties Brian might be holding. When Brian was feeling ambivalent about treatment goals and/or attendance, these education activities allowed him to be engaged in a more comfortable way than accessing vulnerable emotions.

### ***Task 3: MOUD education***

Brian and the therapist co-created a check-in for their sessions in which Brian was invited to share about his days using opioids since the previous session. They also used a rating scale to gauge Brian's openness to MOUD on that particular day: 1 = MOUD is not at all for me; and 10 = Extremely committed to MOUD initiation and would begin the medication today if possible. During sessions in which Brian reported a 4 or higher, his therapist engaged in an education process about different MOUD options and their pros and cons. When Brian struggled to attend sessions, the therapist asked him to rate his openness via text message exchange and offered another appointment.

### ***Task 4: MOUD decision-making***

The therapist periodically expressed curiosity about what Brian's mother and brother might be wondering about MOUD, and how much Brian felt this was his sole decision versus one that could involve input from family members. When Brian eventually expressed anxiety about his mother ejecting him from the house, and withdrawal and craving symptoms that felt very hard to manage, he agreed to initiate methadone.

## ***FLOAT Module***

### ***Task 1: MOUD treatment adherence***

After first balking at the expectations attached to methadone treatment, Brian became motivated by the possibility of a take-home option upon meeting initial adherence expectations. Brian and the therapist began using

a new rating scale in which Brian reported his hopefulness about meeting MOUD expectations. Brian's treatment goals expanded from financial independence to include building new relationships in recovery. Brian and the therapist completed a life map in which independence and improved relationships were all connected to his recovery.

***Task 2: Promote youth leadership in MOUD adherence planning***

Brian was initially pessimistic about his mother's reaction to him beginning methadone treatment, citing her belief that MOUD was substituting one drug for another, as well as their history of conflict. After discussion, he became open to role playing in-session how to communicate this decision to his mother. In addition, Brian and the therapist role played how he might ask for his mother's support in attending treatment daily. The therapist emphasized that more positive communication between them was a different goal than repairing the long-standing hurt between them. The therapist further invited him to take an experimental, not-knowing stance, even suggesting he be curious about his mother's experience.

***Task 3: Collaboratively formulate an MOUD adherence plan***

Brian and the therapist developed a plan for his adherence to MOUD that included his mother being aware of his current medication regimen and Brian inquiring about her willingness to help him occasionally with transportation to the clinic in bad weather. The therapist suggested that Brian invite his mother into session to share his plan with her, and while he again disagreed, he permitted the therapist to send an email to both him and his mother expressing enthusiasm for the plan. Brian was able to articulate how MOUD could serve his goal of increased independence and an improved relationship with his brother. While as predicted Brian's mother was not enthusiastic about methadone maintenance, Brian reported that the conversation between them was not explosive, which was remarkable given that she also was non-committal to helping him with transportation.

***Task 4: CSO-involved overdose prevention education***

The therapist reinforced Brian's willingness to both develop a plan and tolerate his mother not helping with transportation. Given that Gloria did not react to his MOUD adherence plan with anger or punishment, the therapist again raised the idea of offering her information on overdose prevention. Whereas Brian again declined to link his mother to this information, he did agree to accept the information himself. Although Brian's family members never attended sessions, his treatment focused on both improving

relationships and maximizing independence. The therapist also worked to shift Brian's affect in session from contempt or apathy towards both MOUD and his mother, toward curiosity or even acceptance.

### **Case example 3: Chris**

Chris is a 24-year-old cis straight Black man seen by a counselor in preparation for discharge from residential OUD treatment to an outpatient program. Chris' girlfriend Victoria (also 24) is a cis straight Black woman. Chris and Victoria started dating when they were in high school and have broken up and reunited several times over six years. Prior to entering treatment, Chris was living with Victoria and her older sister. While preparing for discharge, Chris stated a wish to return to that home as he pursued outpatient treatment and employment. Victoria agreed to him living there temporarily but worried about him relapsing and about conflict developing between them. Substance use and treatment experiences have interfered with Chris's hoped-for educational and vocational trajectory. He began using non-prescription opioids and cannabis while struggling with depression in high school when his older brother, who subsequently died of an overdose, introduced opioids to him. Prior to entering treatment, Chris' drug of choice was speedballs and he was using 6–8 times a day.

#### ***Relational orientation module***

##### ***Task 1: Youth independence/interdependence assessment***

Chris was feeling very hopeful about the future of his relationship with Victoria and wanted to have a child with her. He was aware that Victoria was feeling less hopeful about his recovery and was leaning away from their relationship. The therapist was curious about other people Chris might identify as his support system, aside from Victoria. While expressing anxiety that he couldn't name anyone other than Victoria, and to some extent her sister, he was adamant that his family of origin was either unable to support him, or that he was afraid to lean on them given how much they were traumatized by his brother's death. The therapist supported him in identifying important goals for the future and ways in which those goals (fatherhood, a college degree, playing music with others, a career as a teacher) were connected to building a social support system on which he could rely during his recovery.

##### ***Task 2: Youth nomination of CSO***

Over several sessions, Chris and the therapist explored pros and cons of inviting Victoria to participate in one or more sessions with him. As pros,

Chris identified her past willingness to attend medical appointments with him and his trust in her not violating his privacy; as con, his wanting to be as independent as possible. They discussed how a therapy session with Victoria could serve to clarify the boundaries in their relationship, rather than setting the stage for discussions about increasing their closeness.

### ***Task 3: CSO engagement***

Chris and the therapist explored the best way to invite Victoria to join a session. Chris wanted to invite Victoria himself via text message, sharing that he felt too vulnerable to ask her face-to-face or over the phone. Victoria then joined a session with Chris via video platform. Chris and the therapist suggested Chris share his plans for care upon discharge. Victoria was eager to hear them and expressed frustration and sadness in feeling left out of Chris' plans unless he needed something concrete, like money or a place to stay. Chris quickly shut down, expressed his regret that he had invited Victoria, and asked to end the session early. The therapist worked to validate both participants and led the three of them in a breathing exercise to ground them. The therapist then offered either to meet individually with Victoria to hear her concerns, or to set up a few conjoint meetings in which they could each express their feelings. While initially he expressed wanting to protect Victoria's time and peace of mind, Chris chose to have meetings together and Victoria agreed. She also expressed wanting to meet individually with Chris' therapist at some point. The therapist offered his hope that they could both feel heard and have clear boundaries moving forward.

### ***Task 4: OUD relational reframe***

In a subsequent individual session, the therapist and Chris processed what the session with Victoria felt like. Chris expressed regret that he had asked for support and named feeling deep shame. When the therapist asked what the shame felt like, Chris expressed wanting to hide. The therapist asked him if perhaps there was a cycle in which Chris has a need, material or otherwise, then feels shame about needing to rely on others and withdraws as a result. He then struggles and perhaps uses drugs because the need is not met, and then inevitably experiences a need again, resulting in him asking for help only when truly desperate. Chris agreed, and named experiences of racism and models of masculinity from his youth as factors contributing to this shame of having needs. The therapist validated this experience and was adamant that everyone deserves and requires the support of others. The therapist asked how knowing whether someone was giving freely versus over-extending themselves could help break this cycle,

and Chris said it would help. They then discussed goals of setting boundaries, assertive communication, and making positive requests as part of the treatment agenda.

### ***MEDS module***

#### ***Task 1: Set a collaborative decision-making context***

During a session in which Victoria was scheduled to join for the final 20 minutes, the therapist invited Chris to share what would be most helpful to discuss with her. He mentioned Victoria sharing with him her hope that he would be leaving treatment “drug free” and her fear of him dying. They collaboratively discussed the benefits of tabling more high-emotion content for a later, and Chris decided to focus on his decision to continue the buprenorphine/naloxone on which he was inducted after withdrawal at the beginning of residential treatment. Chris asked the therapist to share certain information but stated he wanted to be the one to explain the importance of medication for him.

#### ***Task 2: OUD education***

When Victoria joined the session, the therapist asked her to share current ideas about OUD and presented education slides to create a conversation between Chris and Victoria about stigma and OUD. Victoria expressed feeling that Chris had internalized stigma, sharing her own sadness that his self-esteem seemed so low. Chris expressed surprise that Victoria had observed these shifts in him since high school, and cited experiences of being shamed by prior healthcare professionals and in 12-step meetings. The therapist praised their ability to speak candidly and invited them to continue noticing the impact of stigma on their lives, and to keep discussing it.

#### ***Task 3: MOUD education***

In a subsequent session in which Victoria joined for the entire time, the therapist invited Victoria to share her current feelings and beliefs about MOUD. Victoria initially demurred, sharing she didn’t want to feel responsible for Chris’ decisions. The therapist proposed they first discuss different MOUD options and how they function differently in the brain. Victoria and Chris both agreed, and Chris spoke poignantly about why he believed past MOUD regimens had failed for him. The therapist asked both how it felt to be in this conversation together. Chris expressed feeling grateful to Victoria but anxious about her feeling overwhelmed or burdened by the amount of information. Victoria shared that she had always wanted to

know more but had felt shut out, stating that reliable information about MOUD is difficult to get.

#### ***Task 4: MOUD decision-making***

Chris and the therapist finalized a discharge protocol of 16 mg of buprenorphine/naloxone in individual sessions. Initially Chris was ambivalent about this dosage, and his therapist stressed the importance of MOUD as not an ancillary part of his recovery plan but in fact the backbone, highlighting the value of MOUD for reducing cravings. Chris and the therapist explored how shame had previously led him to behave as if he needed to endure cravings and urges without medication, and even to refrain from discussing them with anyone. Chris and the therapist talked about how he had felt during medication decision-making processes in the past (ambivalent, reluctant, and disempowered) and planned together how he might be able to identify different feelings during the current process (aspiring to be hopeful, knowledgeable, and in charge).

### ***FLOAT Module***

#### ***Task 1: MOUD treatment adherence***

Chris invited Victoria to an additional session to share his decision about MOUD and to speak together about planning for adherence once he moved into Victoria and her sister's home. Whereas Chris was reluctant to spend time writing a detailed plan, stating that his commitment and determination should make the plan good enough, he tentatively agreed when Victoria said she wanted clarity. Using the communication skills of perspective taking and "I" statements, which Victoria and Chris had learned and practiced in a prior session, they each expressed how they wanted the process of medication treatment adherence planning to unfold. Victoria expressed hope that Chris would not become defensive and would trust her, and Chris expressed hope that Victoria would not become angry and that he wanted to feel trusted.

#### ***Task 2: Promote youth leadership in MOUD adherence planning***

The therapist invited Chris to share his current ideas about pros of MOUD and his particular regimen. Validating the uncertainty and worry that both Victoria and Chris felt, the therapist invited them to collaborate in identifying a metaphor to capture how they wanted to relate to one another regarding Chris' MOUD regimen. Chris settled on the metaphor of a football team. Chris liked the idea of not being teammates with Victoria necessarily, but rather that he was the quarterback and she could function like a



‘water girl,’ staying close to the field and offering water or a towel but not having a major impact on the game or the plays called by the quarterback. Victoria initially felt she deserved a more important role, especially if he was living with her, but the therapist guided the conversation until she understood more meaningfully Chris’ intent to protect her from being overly responsible for his well-being and to allow him to feel empowered.

### ***Task 3: Collaboratively formulate an MOUD adherence plan***

With the metaphor of football in hand, the therapist led a conversation on details for Chris’ medication regimen, including where he would keep the medication at home, what time of day he would take it, and importantly, that he would communicate with Victoria when he took it daily. Chris and Victoria were able to communicate effectively about what would feel like a helpful response from Victoria after letting her know that he took the medication, but they struggled when exploring how she should proceed if she didn’t get confirmation. Chris expressed not wanting to feel babysat, and Victoria expressed not wanting to feel like a cop or babysitter. Ultimately, they decided that if she did not hear from him, she would reach out once via text message to inquire, and they would try this plan for one month and then revisit. The therapist wrote down these details to email both participants. The therapist also stated the importance of distinguishing between not adhering to a plan versus making a new decision, and invited both Victoria and Chris to utilize their positive communication skills in the event of uncertainty.

### ***Task 4: CSO-involved overdose prevention education***

In addition to encouraging clear and specific communication between them, the therapist explored Victoria’s support system, including how she was communicating with her sister about the plan for Chris’ return home. Victoria expressed feeling determined to care for herself and her future as the top priority, and not in competition with supporting Chris’ recovery. The therapist provided Victoria with digital resources geared towards loved ones of persons struggling with OUD, highlighting the potential value for such resources regardless of her future relationship with Chris. She indicated interest in learning more despite being anxious about how Chris might interpret her pursuing more support. Chris and Victoria together expressed being hopeful about the discharge plan and the possibility that they could rebuild a supportive relationship outside of couplehood.

## Conclusions and limitations

CSO involvement is developmentally crucial for effecting positive MOUD outcomes and sustaining recovery among TAY. If properly recruited and integrated into MOUD services, families/CSO could shift the balance toward efficient services engagement, help consolidate active treatment gains, and facilitate successful recovery planning. To be sure, comprehensive roadmaps of evidence-based practices for involving CSO in SUD treatment and recovery exist (e.g., SAMHSA, 2020b). Discovering how to put those practices to work—achieving adoption and implementation success with clinicians, provider organizations, regulatory agencies, and families—is the challenge before us. Beyond aspiration, actually transforming MOUD systems of care to become relationship-oriented will require greater system-wide attunement to CSO relationships and to cultural context characteristics that shape user experiences of MOUD services (Kirmayer et al., 2016). In this vein, providers can counter potentially iatrogenic service effects by helping TAY and CSO recognize societal constraints on personal agency, identify strengths and resiliencies, and especially for TAY in oppressive contexts, act as allies for clients aiming to resist internalized oppression and navigate system challenges (McDowell et al., 2017). Providers should also be attuned to potential harms, but also conditional benefits, of involving CSO in contexts of child abuse/neglect, interpersonal violence, and other CSO-related trauma.

Despite their strong research base, manualized CSO-focused models for SUD have not been widely adopted in everyday care, in large part because they are costly and cumbersome to implement due to multicomponent training and quality procedures (Hogue et al., 2013). The interventions articulated here are intended to be integrated into usual care as enhancements to routine services, without prescribing rigid implementation and quality benchmarks (Hogue et al., 2013). As described above, they are designed to be independently and flexibly selected based on the given clinician's practice preferences and the given client's needs. Even so, as with any behavioral treatment protocol, in order for these interventions to be viable options within the youth MOUD service system, there need to be substantive procedures for training and monitoring clinicians to deliver them with fidelity. As a result, their ultimate feasibility and scalability will be limited by corresponding limitations in agency resources, training capacity, and clinician time, as well as the degree to which providers prioritize family involvement.

Three final observations seem germane. First, the current landscape of behavioral services offers little in terms of a framework for what optimal family/CSO relationships for TAY can or should look like during recovery (Ashford et al., 2019). This deficit should be corrected. Second, emerging

telehealth strategies can be adopted to substantially increase CSO involvement (Hogue, Bobek, Levy, et al., 2021). All three relationship-oriented interventions described in this article can be readily tailored for, and subsequently maneuvered within, MOUD behavioral services that are deployed in small or large part via telehealth. This includes services enrichment from direct-to-family tele-supports that can be used to supplement provider-delivered interventions. These comprise both synchronous tele-supports (remote interactions that occur in real time) such as helplines and online support groups; and asynchronous tele-supports such as automated text messaging, self-directed internet-based courses, and digital web support (Ashford et al., 2020). Third, the interventions described in this article, though derived from evidence-based treatment protocols and principles, have not yet been tested as a unified protocol. The authors are currently conducting a pilot study to examine the effectiveness of these interventions in MOUD programs located in both urban and rural settings (R24DA051946; PI: Hogue).

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