

Another issue to be aware of is polysubstance use. It is unwise to assume that an individual who reports a history of opioid use is exempt from the potentially life-threatening consequences of alcohol or benzodiazepine withdrawal. Opioid-dependent individuals are likely to use other substances, including alcohol, and may increase their alcohol consumption when they attempt to curtail opioid use. Universal withdrawal severity screening, institutional or community-based, of all persons entering corrections with an established or suspected history of substance use is widely recommended.⁹¹

The use of a standardized brief withdrawal severity assessment can help to stratify risk levels:

- **Low**—should be monitored but does not require medical attention
- **Medium**—requires immediate medical attention but does not have complicating medical conditions
- **High**—requires immediate medical attention and intensive monitoring because of other medical conditions that elevate risk⁹²

STANDARDS, GUIDELINES, AND INFORMATION ON WITHDRAWAL SEVERITY SCREENING

- *Guide to Developing and Revising Alcohol and Opioid Detoxification Protocols*. Kevin Fiscella, MD, MPH, for the National Commission on Correctional Health Care, 2015. www.ncchc.org/filebin/Resources/Detoxification-Protocols-2015.pdf
- *Detoxification of Chemically Dependent Inmates*. Federal Bureau of Prisons clinical practice guidelines, February 2014. www.bop.gov/resources/pdfs/detoxification.pdf
- *TCU Drug Screen V Opioid Supplemental*. Texas Christian University, September 2017. <https://ibr.tcu.edu/forms/tcu-drug-screen>
- *TIP Series 45: Detoxification and Substance Abuse Treatment*. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2006. <https://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA15-4131>
- *Opioid Substitution Treatment in Custodial Settings—A Practical Guide*. World Health Organization and United Nations Office on Drugs and Crime, 2008. www.unodc.org/documents/balticstates/Library/PrisonSettings/OST_in_Custodial_Settings.pdf
- *Managing Opiate Withdrawal: The WOWS Method*. CorrectCare, Summer 2016. www.ncchc.org/filebin/CorrectCare/30-3-WOWS.pdf

Even people who do not require medical attention should have easy access to ample, drinkable fluids.

Common factors that can elevate risk levels include a history of delirium tremens or withdrawal-associated seizures, a history of traumatic brain injury, advanced age, major medical or psychiatric comorbidity, and pregnancy.⁹³ Outpatient medically managed withdrawal treatment is not uncommon for individuals withdrawing from opioids.⁹⁴

In custody settings, the medical consequences of acute withdrawal from alcohol or chemically related sedative/hypnotic drugs (for example, benzodiazepines or barbiturates) can be reduced or eliminated when sound protocols are implemented and followed.⁹⁵ Symptoms of opioid withdrawal should be treated in accordance with correctional health care guidelines. Although deaths from inadequately treated withdrawal are uncommon, such deaths are on the rise.

Although medically managed withdrawal is not treatment and relapse is likely to occur without long-term follow-up services, assisting individuals in custody who are withdrawing from substances is an ethical and medical responsibility. ASAM criteria, endorsed by SAMHSA in its TIP 45: Detoxification and Substance Abuse Treatment, suggests “that for alcohol, sedative-hypnotic, and opioid withdrawal syndromes, hospitalization (or some form of 24-hour medical care) is often the preferred setting for medically managed withdrawal, based on principles of safety and humanitarian concerns. When hospitalization cannot be provided, then a setting that provides a high level of nursing and medical backup 24 hours a day, 7 days a week is desirable.”

Medications combined with psychological support are the standard for medical practice and improve recovery outcomes. To get the best results from medically managed withdrawal, an individual should be immediately connected with medication and counseling. Many medications are used to help ease withdrawal symptoms. The Federal Bureau of Prisons offers clinical guidelines for safe, medically managed withdrawal from alcohol, opioids, barbiturates, and other substances.⁹⁶ These practice guidelines do not differ significantly from community-based medically managed practices. Withdrawal should be assessed using the validated scales previously discussed. It should be treated using FDA-approved medications. These include methadone (when provided through an OTP), buprenorphine, or lofexidine. Systematic reviews suggest that clonidine has some benefit in relieving withdrawal symptoms but is less effective than opioid agonists.⁹⁷

All correctional facilities should make naloxone (Narcan) kits available in the event of an overdose. Ideally, all individuals with OUDs should leave their facilities with such a kit (or a prescription for one). Following an overdose, the individual and his or her family should be educated in how to administer this lifesaving drug.⁹⁸

Alcohol withdrawal is usually treated with short-term, gradually tapering doses of long-acting benzodiazepines. Medications include clonidine; thiamine, also called vitamin B1; and carbamazepine, an antiseizure medication. All

medications should be administered under the supervision of trained medical personnel, particularly considering that many individuals entering corrections may suffer from liver disease, a condition that contraindicates the use of certain medications.

JAIL MAT PROGRAMS SHOULD INCLUDE ONGOING MONITORING THROUGH DRUG SCREENING AND OTHER DIVERSION/RISK MITIGATION STRATEGIES.

Alcohol and drug use during treatment should be carefully monitored as outlined in NIDA's *Principles of Drug Abuse for Criminal Justice Populations*.⁹⁹ Individuals trying to recover from alcohol and drug addiction may experience a relapse and return to drug use. This is considered a part of the recovery process for people with SUDs. Those on MAT, like others in SUD treatment, may relapse, take other drugs, or misuse prescription medication. Individuals on antagonist drugs such as naltrexone may switch to cocaine or other drugs that are not blocked by naltrexone.

Different people have different triggers for relapse, and treatment providers work to identify such triggers. Common triggers include mental stress and associations with peers and social situations linked with drug use. An undetected relapse can progress to serious alcohol and drug misuse and potential overdose. When detected, relapses can present opportunities for therapeutic intervention. Monitoring alcohol and substance use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior and to determine rewards and sanctions to facilitate change and modify treatment plans according to progress. For individuals on medications, it can also ensure that they are taking the correct dosages.

In addition to urine tests, correctional and treatment agencies can employ a range of methods to monitor for return to drug use, including pill or strip counting and behavioral observations. These methods are generally not dissimilar from those used to monitor illicit drug use by other non-MAT participants. Most correctional agencies perform the monitoring themselves and do not rely on treatment programs or correctional health providers.

Once a patient is released from jail, the method and extent of monitoring depends on the type of medication. Patients prescribed buprenorphine typically take home a month's worth of medication, which requires more vigilant monitoring. Methadone patients, on the other hand, typically take their doses in liquid form under observation by clinic medical staff and do not self-administer medication at home until they are well stabilized to safeguard against misuse. Naltrexone cannot be diverted when it is injected by a health care provider, and oral naltrexone has no abuse potential.

States with an operational prescription drug monitoring program (PDMP) collect all Schedule II, III, and IV (and, in some states, Schedule V) controlled substance prescription data that can be accessed by authorized users, including physicians

and pharmacists. By regularly checking the PDMP, providers can become aware if a patient receives a controlled substance from another prescriber and address the possible return to drug use. Every state and the District of Columbia now has an operational PDMP (although Missouri's is not statewide; it is operated by the St. Louis County Department of Public Health and is joined by other counties/jurisdictions). A list of the capabilities for each PDMP can be found at <http://www.pdmpassist.org/content/state-profiles> and at <http://www.pdmpassist.org/content/pdmp-maps-and-tables>.

Jails report a major challenge in terms of contraband drugs, including agonist medications used for opioid treatment. For example, the Ohio Department of Rehabilitation and Correction reported that in December 2016, based on random drug tests conducted on 5 percent of the prisoners, 1 in 20 tested positive for illicit drugs, with marijuana being most common, followed by Suboxone.¹⁰⁰ While many jails have provided methadone to pregnant women for decades, and currently some jails and prisons regularly provide agonist medications to their inmates, at least one jail has found that its MAT program appears to have reduced the demand for illicit drugs within its institutions. However, the same department underscores that the provision of agonist medication requires daily procedures for monitoring the medication dissemination by both nursing and correctional staff.¹⁰¹ An integrated jail/prison system found that continuation of methadone improved postrelease engagement in treatment and reduced disciplinary problems among inmates.^{102, 103}

ENGAGING MEDICAID AND POSTRELEASE FINANCIAL ASSISTANCE

JAILS FACILITATING MAT SHOULD ENGAGE THEIR STATE MEDICAID AGENCIES AND OTHER PUBLIC PAYERS TO FACILITATE HEALTH CARE COVERAGE.

Lack of insurance or gaps in insurance coverage inhibit the use of MAT. For example, according to a 2016 U.S. Government Accountability Office report,¹⁰⁴ out-of-pocket costs for sublingual buprenorphine for individuals who lack insurance coverage for medications can range from \$200 to \$450 a month. The cost of injectable naltrexone can be triple that cost. State Medicaid programs may not reimburse for all three of the approved OUD medications. In some states that cover all or some of the medications, there is a shortage of physicians willing to prescribe medications for persons with substance use disorders.¹⁰⁵ Some states have stringent prior authorization requirements governing the coverage of medications such as buprenorphine or extended-release injectable naltrexone. For example, Idaho requires preauthorization to receive Medicaid coverage for Suboxone, Vivitrol, or oral naltrexone. A breakdown of state coverage (including medications) is contained in *A Comprehensive Listing of What States Cover for Substance Use Disorder* (see <http://www.rsat-tta.com>).¹⁰⁶

Correctional or treatment agency staff members can help ensure that individuals receive the coverage needed to utilize MAT programs, including available state-subsidized medications.

Federal law and regulations do not require states to terminate Medicaid enrollment when a person is incarcerated, but the law does prohibit federal payments for that person's health care costs while he or she is in prison or jail (excluding the inpatient exception). Guidance from the Centers for Medicare & Medicaid Services (CMS) in April 2016 clarifies that states must accept applications from people who are incarcerated and enroll or reenroll them if determined eligible. It encourages states to suspend enrollment or coverage by using markers or other indicators in the claims processing system that help ensure that claims submitted by states are denied for disallowed services provided to people in prisons and jails. Whatever method is used, CMS states that a suspension must be lifted when this exclusion no longer applies—for example, upon a person's release, or when he or she is admitted to a medical institution for treatment that falls within the inpatient exception.¹⁰⁷

In addition, if an individual obtains employment and no longer qualifies for Medicaid, he or she may not be able to afford the subsidized premiums or copays. Such an individual may need additional assistance, such as pharmaceutical company coupons or access to generic versions of buprenorphine.

There are programs for reduced-price medications, some from the pharmaceutical industry itself. There are also federal and state government programs. Congress established the 340B program to allow certain covered entities that serve large numbers of uninsured patients to obtain drugs from pharmaceutical suppliers at the same discounted rates that Medicaid pays (i.e., 25 to 50 percent less). The following website lists 340B-covered entities by state: <http://datawarehouse.hrsa.gov/topics/HealthcareSystems/CE340BDataExplorer.aspx>. Also, some states fund MAT medications for programs that serve correctional populations out of state block grant funding or state appropriations. More than 1,200 Federally Qualified Health Centers are located in inner cities and rural areas and serve uninsured and low-income individuals. Many offer buprenorphine based on discounted fees. The nearest center can be located via <https://findahealthcenter.hrsa.gov>.

THE DIFFERENT TYPES OF ASSISTORS INCLUDE THE FOLLOWING:

- **Navigators**—Navigators receive extensive training from CMS and are responsible for providing unbiased information about public and private health insurance programs in a culturally competent manner. They regularly report on their outreach and consumer education activities and accomplishments. In plan year 2018, the Navigator Program is evolving: Navigators will be encouraged to leverage volunteers as well as strategic partnerships with public and private organizations to identify individuals who would benefit from Exchange coverage. These updates leverage practices from private sector-focused programs like those within Medicare Advantage.
- **Non-navigator assistors (in-person assistors)**—These serve a function similar to navigators, providing in-person assistance and informing consumers about coverage options, but funding for assistors is more flexible than navigator funding. Many states opt to train staff members of existing community-based agencies to carry out in-person assistor duties.
- **Certified application counselors (CACs)**—CMS designates organizations to certify counselors who perform these functions. CACs complete pre-service training and receive ongoing in-service training via CMS webinars and newsletters. They comply with privacy and security standards but have fewer reporting requirements.
- **Brokers, agents, and contracted assistors**—Brokers usually act on behalf of the consumer and are compensated by insurers or consumers. Agents are compensated by insurers. Some states contract with brokers or agents to act as “navigators.” They may be required to forgo compensation or abide by other guidelines that mitigate potential conflicts of interest.

JAIL-BASED MEDICATION-ASSISTED TREATMENT PROGRAMS IN ACTION

SACRAMENTO COUNTY JAIL, CALIFORNIA

ORIGIN AND DEVELOPMENT OF THE PROGRAM

In 2013, the Sacramento County Sheriff's Department Reentry Services Bureau, Sacramento Probation Department, and Correctional Health Services began a pilot program to provide substance use treatment with the administration of naltrexone to a select group of inmates with a history of opiate dependence and/or acute alcohol abuse. The pilot group showed great success. As a result, the program was made available to all consenting inmates who qualified.

PROGRAM PARTICIPATION PROCEDURES

Program participants are identified by self-referrals, reentry specialists, inmates with known drug/alcohol use histories, and referrals from outside sources. When an inmate is identified as a possible program participant, the following screening process is used:

1. A reentry specialist meets with the inmate to explain the program and to obtain consent to proceed.
2. A signed copy of the Sacramento County Correctional Health Services and WellSpace Health Vivitrol Consent Form is placed in the inmate's file, a second copy is forwarded to the reentry resource officer, and a copy is sent to County Health Services and WellSpace Health (the postrelease medical program).
3. Verification is made of participation in a substance use treatment program. If the inmate is not participating in a program, the reentry specialist will coordinate enrollment with the reentry resource officer.
4. Probation verification is made, although probation status is not required for participation.

5. The inmate is referred to the Department of Human Assistance eligibility specialists for eligibility verification for Covered California or other health insurance pursuant to the Affordable Care Act.
6. Correctional Health Services conducts a medical evaluation of the inmate to approve participation in the program.
7. When participation is approved by Correctional Health Services, the doctor prescribes naltrexone to the participant and ensures that the first injection is scheduled for 35 to 40 days prior to release and the second injection for 7 days prior to release.
8. The reentry specialist notifies WellSpace Health of the participant's anticipated injections and release from custody. An appointment is scheduled for the third injection prior to release.
9. The assigned reentry specialist serves the participant postrelease for the duration of his/her use of naltrexone. Reentry services continue based on need after the individual discontinues naltrexone or completes the recommended 6-month participation.
10. If the participant is serving a period of supervised release, the reentry resource officer ensures that the reentry specialist coordinates the individual's program participation with his or her probation officer of record.

OUTCOMES

Of the first 174 total program participants, 54 have been arrested for new offenses (31 percent).

MIDDLESEX JAIL AND HOUSE OF CORRECTION, MASSACHUSETTS

ORIGIN AND DEVELOPMENT OF THE PROGRAM

The Middlesex Sheriff's Office (MSO) Medication-Assisted Treatment and Directed Opioid Recovery (MATADOR) program encourages long-term recovery to improve health outcomes and reduce recidivism. The program, in its current form, was launched in October 2015. The prior attempt at a MAT program resulted in programmatic failure but yielded insights for MATADOR's eventual success. The original Vivitrol program failed because it was missing many of the factors now known to be integral to a successful MAT program:

- The original program lacked buy-in from the correctional officials tasked with overseeing its success.
- It lacked a data collection/performance measures component.
- It had a very limited network of health providers who participated in MAT involving Vivitrol.
- It needed critical casework follow-up to assist participants with navigating medical appointments, health insurance coverage, and other issues associated with life back in the community.

The failure of the initial MAT program provided an opportunity to improve in three areas that became implementation milestones:

- The need for a navigator or recovery coach to remain in touch postrelease
- The need for real-time data to provide areas in need of improvement
- Increased participation by community health providers

PROGRAM DEVELOPMENT

MATADOR has evolved significantly since its October 2015 inception date. One of the major drivers of its success has been the increased participation of community health care providers and substance use counseling centers. The MATADOR program began with four community providers willing to accept patients and administer naltrexone injections. As of May 2017, that number had expanded to 35 providers, 70 support program locations, and four drug courts. In addition to the community support necessary to initiate and sustain a successful MAT program, key stakeholders include data

experts, medical/mental health treatment providers, dedicated recovery navigators/coaches, and courts willing to accept MAT as a legitimate form of relapse prevention and recidivism reduction.

Many MATADOR participants begin with medically managed withdrawal. Just under half (42 percent) of the intakes have drug addictions so severe that they need to be detoxed when they arrive—76 percent of them have some type of opioid in their systems. Following medically managed withdrawal, officers and program staff members provide drug treatment and casework services to treat those suffering from addiction issues. As part of that process, inmates are educated on all forms of MAT, including injectable naltrexone. Individuals interested in participating in MATADOR are educated on program specifics and receive medical screening prior to enrollment.

Prior to release, a participant is given an injection and is in touch with the navigator, who schedules follow-up medical and treatment visits. When an inmate is released from the facility, the program begins in earnest.

At its inception, the MATADOR program required one full-time employee (FTE) as a recovery support navigator and ½ FTE for data collection/analysis. Both initial positions were internal assignments and considered an investment in the program. As the program expanded, a second navigator was hired to keep up with demand. In addition, the program benefited from a grant award that uses Byrne JAG funding to secure two substance use treatment beds for program participants and 20 hours per week for a research assistant to collect data.

It was originally anticipated that the MSO's Residential Substance Abuse Treatment unit would be a natural feeder into the MATADOR program; however, data show that most program participants in the last 3 to 5 months have sought out the program after learning about it through word of mouth in the general population.

The MATADOR program director is a licensed nurse practitioner in the process of becoming a licensed recovery support navigator. Through this unique combination of training and expertise, the program provides clinical/medical guidance while establishing the rapport necessary for a successful postrelease relationship between the participant and the navigator. Potential participants are educated in all forms of MAT (Vivitrol, Suboxone, and methadone) and, if chosen, are provided with only Vivitrol (first injection prerelease) behind the walls of the Middlesex Jail and House of Correction.

The MATADOR team has gone to great lengths to establish open lines of communication with health care providers in the community, including identifying a primary point of contact at each community health care provider's and support program's office. This allows for a streamlined flow of information and, when necessary, the adjustment of treatment options,

services, and health insurance plans. Communication between the health care provider and the program is initiated when the program navigator notifies a provider of a new participant and schedules a medical follow-up appointment. If an appointment is missed, the MSO's research team is notified via phone call. The health care provider attempts to reengage the participant; failure to do so results in a call to a navigator, who attempts to reach the individual separately.

MATADOR team meetings provide ongoing communication among the MSO's research staff, executive staff, and navigators to ensure program integrity. The MATADOR program navigator works in conjunction with nearly 90 community health care providers, support programs, and drug courts throughout Massachusetts. The engagement and collaboration of these critical health care and criminal justice stakeholders have made a key difference in the success of the program reboot.

OUTCOMES

Of the 370 individuals who have completed the program, 81 percent had not been rearrested for new crimes as of January 2018.

LOUISVILLE METRO DEPARTMENT OF CORRECTIONS, KENTUCKY

ORIGIN AND DEVELOPMENT OF THE PROGRAM

The Louisville Metro Department of Corrections (LMDC) began experiencing a significant influx of high-need drug users among the jail population. Heroin-related arrests skyrocketed from 120 in 2010 to 1,501 arrests in 2014. In 2015, the county had the most overdose deaths of any Kentucky county (268) and the most heroin-related overdose deaths (131). In 2016, LMDC was funded to expand the in-jail substance use treatment program Enough is Enough and MAT (Vivitrol) for eligible opioid addicts returning to the community.

IMPLEMENTATION

In the spring of 2016, LMDC partnered with Correct Care Solutions (CCS), its contracted medical/mental health provider, to launch its MAT program. Flowcharts, consent-to-treat forms, and informational handouts were developed, and training for medical staff was provided. Originally, the program was designed to be provided only to inmates who were active participants in Enough is Enough, a 90-day voluntary drug treatment program. Shortly thereafter, staff members realized

that the program would also benefit inmates who could not be enrolled in Enough is Enough because of shorter incarceration periods. LMDC partnered with the courts and prosecutors to refer pretrial inmates interested in Vivitrol treatment and continued treatment in the community in lieu of further custodial sentencing. A senior social worker/coordinator for the MAT program established contacts with community providers who committed to taking on the task of the care continuum for MAT program participants.

Although the program started slowly, it quickly gained momentum and speed once word spread to the jail population. State funding pays for hepatic function panel (liver enzyme) labs, drug screens, Vivitrol injections, and days inmates participate in the Enough is Enough program.

Once an inmate has volunteered as a potential participant for MAT who will be released from LDMC custody within a month, the program coordinator requests hepatic function panel labs to be collected by medical staff members. Once the lab results return, the doctor or nurse practitioner clears or denies prescription based on the results. If prescription is denied, the referral source and the inmate are notified. If cleared, approximately 1 week before the potential release date, the program coordinator conducts a drug screen and has the inmate sign consent-to-treat and release-of-information forms. At that time, medical staff members are informed that the inmate is ready to receive Vivitrol. The nurse administers the naltrexone (pill) and, after the inmate is observed for possible side effects, the first Vivitrol injection is administered. The program coordinator forwards the lab results and the signed consent form to the community provider, and the inmate receives an appointment for follow-up care.

OUTCOMES

As of January 2018, 200 individuals have graduated from either the pretrial or posttrial MAT program. Of these, 47 percent have remained arrest-free in the community; only 4 percent of the individuals were arrested more times after release than before they entered the program.

LESSONS LEARNED

The program must:

- Develop effective collaboration with community providers.
- Keep ongoing meetings with all involved for troubleshooting purposes and progress discussions (LMDC holds biweekly meetings to discuss the program).
- Keep open and continued discussions with the judges, prosecutors, and public defenders.

SNOHOMISH COUNTY JAIL, WASHINGTON

ORIGIN AND DEVELOPMENT OF THE PROGRAM

The Snohomish County Jail initiated its buprenorphine MAT program in January 2018, beginning with a buprenorphine/naloxone (marketed as Suboxone) detox program. The program became necessary because of a huge increase over the past few years in people being arrested who were addicted to opioids. The jail's 24-bed medical unit was overwhelmed with individuals in need of medically managed withdrawal.

PROGRAM DEVELOPMENT

The jail found it was conducting withdrawal watches for 40 to 50 percent of those arrested, mostly for opioids. The medical unit was operating at more than 200 percent capacity. To ease cravings and mitigate the symptoms of withdrawal, the jail began Washington State's first pilot program to provide medically managed withdrawal with Suboxone. Individuals feel the ameliorative effects of 8 mg of buprenorphine within 30 minutes to 2 hours, and it takes 5 days before they are tapered off. Before receiving buprenorphine, individuals complete urine screens and medical exams to screen out those on other drugs, including benzodiazepines and alcohol, or those who have liver disease and other conditions.

The use of the medication has allowed the jail to move these individuals to the general population to free up medical beds and ease the correctional resources required for this special unit. The use of buprenorphine for medically managed withdrawal also introduces the individuals to MAT and gives them a picture of what treatment could include when they leave jail. Upon release, detoxed individuals are connected with treatment and medication providers in the community. Pregnant inmates are provided with buprenorphine without naloxone (marketed as Subutex).

If entering individuals are already on prescribed methadone or buprenorphine, they are maintained until they leave the jail, even if sentenced for the 3 to 6 months typically imposed for jail inmates.

Once through medically managed withdrawal, inmates who will be at the jail for at least 6 weeks (including those sentenced as well as those held pretrial) are offered Suboxone treatment 10 to 14 days before they are released. Three jail staff nurse practitioners and a physician at the jail prescribe the medication for both medically managed withdrawal and maintenance. The nurses carefully provide the medication each day under the supervision of correctional officers who provide direct supervision of inmates.

When individuals are released, they are picked up at the door by a community provider who continues to provide medication and counseling. At their release, the jail provides a prescription for 3 days of Suboxone, which gives the treatment provider time to begin prescribing. It generally takes a day for those on Medicaid to have it reinstated, so medication costs are initially covered by the treatment provider.

These same community providers also conduct group and individual counseling for the in-house jail treatment program, so those referred postrelease are already familiar with them. The jail has four community treatment providers to whom inmates are referred upon release.

Initially, the jail limited the program to 25 inmates to ensure smooth implementation and protection against any diversion of the medication. The inmates selected are well-known to the jail staff, since most have been in and out of jail previously for opioid abuse.

OUTCOMES

The pilot is too new to generate long-term outcome data. However, officials say the medically managed withdrawal program is easing the strain on deputies by getting inmates into the general population quicker and is much more humane. As the health administrator reported to local media, "They started their medication yesterday and within a couple hours were night and day difference. They went from vomiting, nausea, diarrhea, body aches to feeling well, eating, drinking, and wanting to shower. So, big difference."¹⁰⁸ Although the jail pays for the Suboxone tablets, the overall cost of the medication is less than the amount the jail paid for the medications previously used to ease withdrawal symptoms.

RHODE ISLAND

CORRECTIONAL FACILITIES

ORIGIN AND DEVELOPMENT OF THE PROGRAM

The Rhode Island Department of Corrections (RIDOC) operates a combined jail/prison system. Data documented that 21 percent of the state's overdose victims in 2014 and 2015 were incarcerated in the 2 years prior to death (up from 9 percent in 2009). More than 250 individuals were entering the system on agonist medication, either methadone or buprenorphine.

Traditionally, RIDOC allowed inmates on methadone to be maintained on their doses for an initial 30 days. That time span was increased to 60 days several years ago. After that period, inmates were tapered off the medication.

In 2016, as the opioid epidemic grew across the state, RIDOC initiated a program to target this high-risk population. All incoming inmates are screened and assessed for MAT. Now, MAT is initiated upon commitment, as needed, or continued for individuals already on methadone or buprenorphine for 6 to 12 months. For those not on agonist maintenance, naltrexone is provided prior to release.

IMPLEMENTATION

This program required an immediate increase in staffing for substance use disorder services. RIDOC hired three temporary chemical dependency professionals to initiate the screening of detainees upon arrival and to conduct follow-up assessments on those identified as needing it. RIDOC worked with The Providence Center, a treatment program, to place two recovery coaches to work with inmates involved in the MAT program. All levels of RIDOC staff, from the director to frontline nurses and correctional officers, are involved in the program. RIDOC encouraged collaboration among security, medical, and behavioral health personnel, as well as outside vendors. In addition, RIDOC engaged MAT community vendors to ensure continued care and medication upon release for all three FDA-approved opioid medications.

Internal communication is supported by the establishment of a MAT process team; weekly and biweekly meetings are held with administration, security, rehabilitative services, and medical staff members. External communication is supported by members of the MAT process team serving on committees such as the treatment subcommittee of the Governor's Overdose Prevention and Intervention Task Force and the Narcan distribution subcommittee.

Each day, inmates are organized into separate medical lines to be provided with methadone or buprenorphine, carefully monitored by correctional officers. At first, buprenorphine was provided in pill form but it was switched to strips (Suboxone) that dissolve faster and are less easily diverted by inmates. The strips are counted every shift to prevent diversion.

Initially, security staff were resistant to the use of Suboxone out of concern for diversion. The medical director and several staff members met with the jail warden and other administrators to educate them about MAT and to listen to concerns. These meetings went a long way in alleviating fears about the program.

OUTCOMES

During the 12 months between October 1, 2016, and September 30, 2017, RIDOC provided MAT to 896 individuals. Of these, 63.5 percent were on MAT at entry and were continued on MAT, and 36.5 percent were initiated on MAT soon after entry. Most (61 percent) received methadone, and 39 percent received buprenorphine. After release, at least 72 percent were confirmed to have continued with MAT—95 percent of those who were on it at time of entry and 32 percent of those induced after entry. Research showed that this program reduced postrelease deaths by 60 percent and all opioid-related deaths in the state by more than 12 percent.¹⁰⁹

APPENDIX I: SUBSTANCE USE DISORDER SCREENING TOOLS

The National Institute on Drug Abuse (2015) offers a list of screening tools that have been found to be effective for adults and adolescents.

FOR ALCOHOL

- Alcohol Screening and Brief Intervention for Adolescent and Youth: A Practitioner’s Guide
- Alcohol Use Disorders Identification Test (AUDIT)
- Alcohol Use Disorders Identification Test-C (AUDIT-C)
- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)
- Center for Adolescent Substance Abuse Research: CRAFFT
- CRAFFT (Part A)
- Helping Patients Who Drink Too Much: A Clinician’s Guide
- NIDA Drug Use Screening Tool
- NIDA Drug Use Screening Tool: Quick Screen
- Screening to Brief Intervention (S2BI)

FOR DRUGS

- Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)
- CRAFFT
- CRAFFT (Part A)
- DAST 20: Adolescent Version
- Drug Abuse Screen Test (DAST-10)
- NIDA Drug Use Screening Tool
- NIDA Drug Use Screening Tool: Quick Screen
- Opioid Risk Tool
- S2BI

APPENDIX II: SUBSTANCE USE DISORDER TREATMENT PROGRAMS

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

NIDA lists the following substance use disorder treatment programs:

- Behavioral therapies, including multisystemic therapy (MST)¹¹⁰
- Cognitive behavioral therapy (CBT)
- Community reinforcement approach (CRA) plus vouchers
- Contingency management (CM) interventions/motivational incentives
- Family behavior therapy (FBT)
- The Matrix Model
- Motivational enhancement therapy (MET)
- Therapeutic communities (TC)
- Twelve-step facilitation therapy

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA lists the following research-based alcohol and substance use disorder treatment programs for youth (aged 18–25) and adults (aged 26–55) in correctional facilities:

- Buprenorphine Treatment Practitioner Locator¹¹¹
- Correctional therapeutic community (CTC) for alcohol and substance abusers 6 months from prison release
- Creating Lasting Family Connections Fatherhood Program (CLFCFP), family reintegration for men
- Forever Free for women
- Helping Women Recover and Beyond Trauma for Women (manual-driven treatment)
- Interactive journaling
- Living in Balance (LIB) (manual-based)
- Moral Reconciliation Therapy (MRT) (cognitive behavioral approach)
- Opioid Treatment Program Directory¹¹²

- Texas Christian University (TCU) Mapping-Enhanced Counseling (MEC), a communication and decision-making technique to support the delivery of treatment services¹¹³

U.S. DEPARTMENT OF JUSTICE

Crime Solutions, the Justice Department registry of research-based programs and practices, lists the following practices as “effective,” mostly for reducing drug and substance use, specifically for individuals involved in the criminal justice system:

- Incarceration-based therapeutic communities for adults (effective for reducing crime and delinquency)
- Mentoring at-risk youth (effective for reducing crime and delinquency, promising for reducing drug and substance use)
- Motivational interviewing for substance use (effective for reducing drug and substance use)
- Opiate maintenance therapy for dual heroin-cocaine abusers (effective for reducing drugs and substance use for heroin/opioids)

Crime Solutions also includes the following practices found to be “promising,” also mostly for reducing drug and substance use:

- Adult drug courts (reducing crime and delinquency)
- Cognitive behavioral therapy for moderate to high-risk adults (reducing crime and delinquency)
- Incarceration-based narcotics maintenance treatment (reducing drug and substance use but no effect on crime and delinquency)¹¹⁴

It should be noted that the practices involving MAT have not been shown to be effective in reducing crime and delinquency outcomes. However, as noted in MAT’s description of “meta-analysis outcomes” relating to the finding that incarceration-based narcotics maintenance treatment has not been found to be effective in reducing crime and delinquency, this finding is influenced by the presence of a negative outlier. When this outlier is removed, the difference is no longer significant in terms of recidivism.¹¹⁵

APPENDIX III: ADVISORY ROUNDTABLE

MEMBERSHIP

Advisory Roundtable, February 3, 2017

FEDERAL PARTICIPANTS

- Co-Chair Stephen Amos, Chief, Jails Division, National Institute of Corrections
- Co-Chair Ruby Qazilbash, Associate Deputy Director, Bureau of Justice Assistance
- Anita Grant, Captain, United States Public Health Service, National Institute of Corrections
- Sandora Cathcart, Correctional Program Specialist, National Institute of Corrections
- Ronald Taylor, Chief of the Prisons Division, National Institute of Corrections
- Tim Jeffries, Senior Policy Advisor, Bureau of Justice Assistance
- DeAnna Hoskins, Policy Advisory, Bureau of Justice Assistance
- June Sivilli, Division Chief, Public Health & Public Safety, Office of National Drug Control Policy
- Nataki MacMurray, Public Health & Public Safety Analyst, Office of National Drug Control Policy
- Sidney Hairston, Public Health Advisor, Division of Pharmacological Therapies, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration
- Jennie Simpson, Policy Advisor, Substance Abuse and Mental Health Services Administration
- Annie Hollis, Health Insurance Specialist, Division of Benefits and Coverage, Centers for Medicare and Medicaid
- Tisha Wiley, Health Services Administrator, National Institute on Drug Abuse

REPRESENTATIVES FROM MODEL MAT PROGRAMS

PRISONS

- Chris Bina, Director, Pharmacy Services, Health Services Division, Bureau of Prisons
- Chris Mitchel, Assistant Deputy Commissioner, Massachusetts Department of Correction
- Kevin Pangburn, Director, Division of Substance Abuse, Kentucky Department of Corrections
- Jennifer Clarke, Medical Programs Director, Rhode Island Department of Corrections
- Shannon Robinson, Senior Psychiatry Supervisor, California Department of Corrections and Rehabilitation

SHERIFFS/JAILS

- Brad Rose, Sergeant, Sacramento County Sheriff's Department, California
- Peter Koutoujian, Sheriff, Middlesex County House of Correction, Massachusetts
- Dennis Wilson, President, Sheriffs' Association of Texas, Sheriff of Limestone County, Texas
- Carolina Montoya, Director, Office of Rehabilitation Services, Miami-Dade County Department of Corrections and Rehabilitation, Florida
- Cornita Riley, Jail Administrator, Orange County, Florida

DRUG COURTS

- Kimberly Kozlowski, Project Director, Syracuse Community Treatment Court & Onondaga City Family Treatment Court
- Hon. Robert Ziemian, District Court Judge, Massachusetts

POLICE/ PRETRIAL DIVERSION

- Fred Ryan, Chief, Arlington, Massachusetts, Police Council Chair, Police Assisted Addiction Recovery Initiative
- Elizabeth Simoni, Executive Director, Maine Pretrial Services
- Kathleen O'Toole, Chief of Police, Seattle, Washington

PROBATION AND PAROLE

- Sue De Lacy, Administrative Manager, Orange County Probation, California
- Alison Morgan, Deputy Director, Colorado Department of Parole

CORRECTIONAL AND RELATED ASSOCIATIONS

- Veronica Cunningham, Executive Director, American Probation and Parole Association
- Maeghan Gilmore, Program Director, Health, Human Services and Justice, National Association of Counties
- Jonathan Thompson, Executive Director, National Sheriffs' Association
- Jessica Vanderpool, Special Projects Director, National Sheriffs' Association
- Wayne Dickey, President, American Jail Association, Administrator, Brazos County Jail, Texas
- James Martin, Accreditation Specialist, National Commission on Correctional Health Care
- Beth Haynes, Manager, Quality and Science, American Society of Addiction Medicine
- Jeffrey Locke, Senior Policy Analyst, Homeland Security & Public Safety Division, National Governors Association

RESIDENTIAL SUBSTANCE ABUSE TREATMENT TRAINING AND TECHNICAL ASSISTANCE

- Facilitator, Andrew Klein, Project Director, Advocates for Human Potential
- Steve Valle, President, AdCare Criminal Justice Services
- Lisa Talbot Lundrigan, RSAT Faculty (ACA), Vice President, AdCare Criminal Justice Services
- Neal Shifman, President & CEO, Advocates for Human Potential
- Niki Miller, Senior Research Associate, Advocates for Human Potential

POLICY RESEARCH ORGANIZATIONS AND RESEARCHERS

- Richard Cho, Director of Behavioral Health, Council of State Government Justice Center
- Cynthia Reilly, Director of Prescription Drug Abuse Project, The Pew Charitable Trusts
- Joshua Lee, Associate Professor, New York University School of Medicine
- Mary Alice Conroy, Distinguished Professor of Psychology, Clinic Director, Sam Houston State University

REFERENCES

1. National Institute on Drug Abuse. (2016). Advancing addiction science, effective treatment for opioid addiction. <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction>
- Substance Abuse and Mental Health Services Administration. (2018). Tip 63: Medications for opioid use disorders. (HHS Publication No. [SMA] 18-5063EXSUMM). Rockville, MD. <https://store.samhsa.gov/product/SMA18-5063EXSUMM>
2. Gelber, S., & Rinaldo, D. W. (2013, June). Report III: FDA-approved medications indicated for the treatment of opioid dependence: Literature reviews on effectiveness and cost-effectiveness, Treatment Research Institute (TRI), 2013. In American Society for Addiction Medicine (Ed.), *Advancing Access to Addiction Medications*. http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final
- National Institutes of Health. (1997, November 19). Effective medical treatment of opiate addiction. NIH Consensus Statement, 15(6), 15–17. <http://consensus.nih.gov/1997/1998TreatOpiateAddiction108PDF.pdf>
- Executive Office of the President, Office of National Drug Control Policy. (1996, March). Treatment protocol effectiveness study. <https://www.ncjrs.gov/ondcppubs/publications/treat/trmtprot.html>
- National Institute on Drug Abuse. (2016, November 1). Effective treatments for opioid addiction. <https://www.drugabuse.gov/effective-treatments-opioid-addiction-0>
- Fu, J. J., Zaller, N. D., Yokell, M. A., Bazazi, A. R., & Rich, J. D. (2013, May–June). Forced withdrawal from methadone maintenance therapy in criminal justice settings: A critical treatment barrier in the United States. *Journal of Substance Abuse Treatment*, 44(5), 502–505. doi: 10.1016/j.jsat.2012.10.005
- Kakko, J., Svanborg, K. D., Kreek, M. J., & Heilig, M. (2003, February 22). 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: A randomised, placebo-controlled trial. *The Lancet*, 361(9358), 662–668. doi: 10.1016/S0140-6736(03)12600-1
3. Cornish, J. W., Metzger, D., Woody, G. E., Wilson, D., McLellan, A. T., & Vandergrift, B. (1997). Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment*, 14, 529–534.
- Dolan, K. A., Shearer, J., White, B., Zhou, J., Kaldor, J., & Wodak, A. D. (2005). Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, re-incarceration and hepatitis C infection. *Addiction*, 100, 820–828.
- Gordon, M. S., Kinlock, T. W., Schwartz, R. P., Fitzgerald, T. T., O’Grady, K. E., & Vocci, F. J. (2008). A randomized clinical trial of methadone maintenance for prisoners: Findings at 6 months post-release. *Addiction*, 103, 1333–1342.
- Kinlock, T. W., Gordon, M. S., Schwartz, R. P., & O’Grady, K. E. (2008). A study of methadone maintenance for male prisoners: Three-month postrelease outcomes. *Criminal Justice & Behavior*, 35, 34–47.
- Lee, J., McDonald, R., Grossman, E., McNeely, J., Laska, E., Rotrosen, J., & Gourevitch, M. N. (2015). Opioid treatment at release from jail using extended release naltrexone. *Addiction*, 110(6), 1008–1014.
- Magura, S., Lee, J. D., Hershberger, J., Joseph, H., Marsch, L., Shropshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post-release: A randomized clinical trial. *Drug & Alcohol Dependence*, 99, 222–230.
- O’Brien, C. P., & Cornish, J. W. (2006). Naltrexone for probationers and prisoners. *Journal of Substance Abuse Treatment*, 31, 107–111.
- Rich, J. D., McKenzie, M., Larney, S., Wong, J. B., Tran, L., Clarke, J., ... Zaller, N. (2015). Methadone continuation versus forced withdrawal on incarceration in a combined U.S. prison and jail: A randomized, open-label trial. *The Lancet*, 386(9991), 350–359.
- Stallwitz, A., & Stover, H. (2006). The impact of substitution treatment in prisons—A literature review. *International Journal of Drug Policy*, 18, 464–474.
4. Pope, L. (2018, January 24). The role of jails in combatting the opioid crisis (Think Justice blog). Vera Institute of Justice. <https://www.vera.org/blog/the-role-of-jails-in-combatting-the-opioid-crisis>

5. National League of Cities and National Association of Counties. (2016). A Prescription for Action: Local Leadership in Ending the Opioid Epidemic. <http://opioidaction.org/report>
6. SAMHSA, op. cit. ES-3.
7. Smith, K., & Strashny, A. (2016, April 26). Characteristics of criminal justice system referrals discharged from substance abuse treatment and facilities with specially designed criminal justice programs. The CBHSQ Report. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/sites/default/files/report_2321/ShortReport-2321.html
8. An agonist is a drug that activates certain receptors in the brain. Full agonist opioids activate the opioid receptors in the brain fully, resulting in the full opioid effect. Examples of full agonists are heroin, oxycodone, methadone, hydrocodone, morphine, and opium. An antagonist is a drug that blocks opioids by attaching to the opioid receptors without activating them. Antagonists cause no opioid effect and block fully agonist opioids. Examples are naltrexone and naloxone. Naloxone is sometimes used to reverse a heroin overdose. Buprenorphine is a partial agonist, meaning that it activates the opioid receptors in the brain, but to a much lesser degree than a full agonist. https://www.naabt.org/faq_answers.cfm?ID=5
9. Wesson, D. R., & Ling, W. (2003). The clinical opiate withdrawal scale (COWS). *Journal of Psychoactive Drugs*, 35(2), 253–259.
10. Cunningham, C., & Fishman, M. The ASAM national practice guideline for the use of medications in the treatment of addiction involving opioid use. <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-pocketguide.pdf?sfvrsn=0>
11. Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989). Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction*, 84, 1353–1357.
12. Heinzerling, K. G., Ober, A. J., Lamp, K., De Vries, D., & Watkins, K. E. (2016). SUMMIT: Procedures for medication-assisted treatment of alcohol or opioid dependence in primary care. The RAND Corporation and the National Institute on Drug Abuse. http://www.integration.samhsa.gov/clinical-practice/mat/RAND_MAT_guidebook_for_health_centers.pdf
13. Institute of Behavioral Research. (2014). Texas Christian University Drug Screen V. <https://ibr.tcu.edu/forms/tcu-drug-screen/>
14. Clark, K. J. (n.d.). PCSS MAT training, MAT in the OTP setting: Integrating the three approved medications (methadone, buprenorphine, ER naltrexone), Slide 41, American Society of Addiction Medicine. <http://pcssmat.org/wp-content/uploads/2014/09/ASAM-PCSS-MAT-KClark-yo-updated-final-revision3.pdf>
15. Binswanger, I. A., Blatchford, P. J., Mueller, S. R., & Stern, M. F. (2013). Mortality after prison release: Opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. *Annals of Internal Medicine*, 159(9), 592-600.
16. Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., ... Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies. *BMJ*, 357, j1550.
17. Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., ... Ozonoff, A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. *BMJ*, 346, f174.
18. Standards for opioid treatment programs in correctional facilities. (2016). Standard O-E-02 Health Assessments. Chicago, IL: National Commission on Correctional Health Care.
19. Tanum, L., Klemmetsby Solli, K., e-Huma Latif, Z., Saltyte Benth, J., Opheim, A., Sharma-Haase, K., & Kunøe, N. (2017). Effectiveness of injectable extended-release naltrexone vs. daily buprenorphine-baloxone for opioid dependence: A randomized clinical noninferiority trial. *Journal of the American Medical Association Psychiatry*. 74(12):1197–1205. <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2657484>
20. Diversion Control Division, Drug Enforcement Administration, U.S. Department of Justice. Narcotic Treatment Programs Best Practice Guideline. <https://www.deadiversion.usdoj.gov/pubs/manuals/narcotic/appendixa/treatment.htm>
21. For information for physicians on the waiver application and management process to prescribe or dispense buprenorphine for opioid dependency treatment, see <https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver>.
22. Cunningham, C., & Fishman, M. The ASAM national practice guideline for the use of medications in the treatment of addiction involving opioid use. <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-pocketguide.pdf?sfvrsn=0>
23. Highlights of prescribing information [for Vivitrol]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/021897s020s023lbl.pdf
24. Mattick, R. P., Breen, C., Kimber J., & Davoli, M. (2014, February). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence, Cochrane. http://www.cochrane.org/CD002207/ADDICTN_buprenorphine-maintenance-versus-placebo-or-methadone-maintenance-for-opioid-dependence

25. Sordo, L., Barrio, G., Bravo, M. J., Iciar Indave, B., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017, April 26). Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies, *BMJ*, 357, j1550.
26. Gibson, A. E., Degenhardt, L. J., (2007). Mortality related to pharmacotherapies for opioid dependence: a comparative analysis of coronial records. *Drug and Alcohol Review*, 26(4), 405-410.
27. Lee, J., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson, R. A., & O'Brien, C. P. (2016, March 31). Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. *New England Journal of Medicine*, 374, 1232–1242.
28. Laroche, M. R., Bernson, D., Land, T., Stopka, T. J., Wang, N., Xuan, Z., & Walley, A. Y. (2018). Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: a cohort study. *Annals of Internal Medicine*, 169(3), 137-145.
29. Lee, J., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson, R. A., & O'Brien, C. P. (2016, March 31). Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. *New England Journal of Medicine*, 374, 1232–1242.
30. Volkow, N. D., Koob, G. F., & McLellan, A. T. (2018). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine*, 374(4), 363-371.
31. Substance Abuse and Mental Health Services Administration. (2016). Sublingual and transmucosal buprenorphine for opioid use disorder: Review and update. SAMHSA Advisory, 15(1), 1–12. <http://store.samhsa.gov/shin/content//SMA16-4938/SMA16-4938.pdf>
32. American Society of Addiction Medicine. (2015, June 1). The ASAM national practice guideline for the use of medications in the treatment of addiction involving opioid use. <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>
33. Fiellin, D. A., Schottenfeld, R. S., Cutter, C. J., Moore, B. A., Barry, D. T., & O'Connor, P. G. (2014, December). Primary care–based buprenorphine taper vs. maintenance therapy for prescription opioid dependence: A randomized clinical trial. *JAMA Internal Medicine*, 174(12), 1947–1954. doi: 10.1001/jamainternmed.2014.5302
34. Center for Substance Abuse Treatment. (2005). Medication-assisted treatment for opioid addiction in opioid treatment programs. Treatment Improvement Protocol (TIP) Series 43 (HHS Publication No. [SMA] 12-4214). Rockville, MD: Substance Abuse and Mental Health Services Administration. <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>
- D. Mee-Lee (Ed.). (2013, October 24). The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions (e-page 293). Rockville, MD: American Society of Addiction Medicine. (Noting that “the notion that the duration of treatment varies . . . is a foundational principle of the ASAM criteria.”)
35. National Institute on Drug Abuse. (2016, November 1). Effective treatments for opioid addiction. <https://www.drugabuse.gov/effective-treatments-opioid-addiction-0>
36. National Institute on Drug Abuse. (2018, January 17). Principles of drug addiction treatment: A research-based guide (third edition). <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition>
37. Potter, J. S., Dreifuss, J. A., Marino, E. N., Provost, S. E., Dodd, D. R., Rice, L. S., & Weiss, R. D. (2015). The multisite prescription opioid addiction treatment study: 18-month outcomes. *Journal of Substance Abuse Treatment*, 48(1), 62–69.
- Weiss, R. D., Potter, J. S., Griffin, M. L., Provost, S. E., Fitzmaurice, G. M., McDermott, K. A., & Carroll, K. M. (2015). Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. *Drug and Alcohol Dependence*, 150(1), 112–119.
38. Lee, J. D., Friedmann, P. D., Kinlock, T. W., Nunes, E. V., Boney, T. Y., Hoskinson, Jr., R. A., & O'Brien, C. P. (2016, March 31). Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. *New England Journal of Medicine*, 374, 1232–1242. doi: 10.1056/NEJMoa1505409
39. Agency for Healthcare Research and Quality. (August 2016). Pharmacotherapy for adults with alcohol use disorder in outpatient settings. <https://effectivehealthcare.ahrq.gov/topics/alcohol-misuse-drug-therapy/policymaker>
40. Peitras, S., Azur, M., & Brown, J. (2015, November 25). Review of medication-assisted treatment guidelines and measures for opioid and alcohol use (Appendix B, Table B 1 from SAMHSA and NIAAA: Brief guide to medication for the treatment of alcohol use disorder). <https://aspe.hhs.gov/system/files/pdf/205171/MATguidelines.pdf>
41. Cochrane Primary Care. Naltrexone effective for alcohol dependence. <https://www.cochranepriarycare.org/pearls/naltrexone-effective-alcohol-dependence>
42. Centers for Disease Control and Prevention. (2003, July 18). Incorporating HIV prevention into the care of persons living with HIV. <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>
43. Federal Guidelines for Opioid Treatment Programs. <https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP>
44. American Society of Addiction Medicine. (2013, October 26). Drug Testing: A White Paper of the American Society of Addiction Medicine (ASAM). <http://www.asam.org/docs/default-source/public-policy-statements/drug-testing-a-white-paper-by-asam.pdf>
45. American College of Obstetricians and Gynecologists. Opioid use and opioid use disorder in pregnancy. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>

46. Center for Substance Abuse Treatment. (2009). Substance abuse treatment: Addressing the specific needs of women. Treatment Improvement Protocol (TIP) Series, No. 51. (HHS Publication No. [SMA] 14-4426). <http://store.samhsa.gov/shin/content/SMA14-4426/SMA14-4426.pdf>
47. American College of Obstetricians and Gynecologists. (2012, May). ACOG Committee Opinion No. 524: Opioid abuse, dependence, and addiction in pregnancy. *Obstetrics & Gynecology*, 119(5), 1070–1076. <https://www.ncbi.nlm.nih.gov/pubmed/22525931>
48. National Institutes of Health, U.S. National Library of Medicine. (2015). Neonatal abstinence syndrome. www.nlm.nih.gov/medlineplus/ency/article/007313.htm
49. Jones, H. E., Martin, P. R., Heil, S. H., Kaltenbach, K., Selby, P., Coyle, M. G., & Fischer, G. (2008, October). Treatment of opioid-dependent pregnant women: Clinical and research issues. *Journal of Substance Abuse Treatment*, 35(3), 245–259. doi: 10.1016/j.jsat.2007.10.007
50. American College of Obstetricians and Gynecologists. (2012, May). ACOG Committee Opinion No. 524: Opioid abuse, dependence, and addiction in pregnancy. *Obstetrics & Gynecology*, 119(5), 1070–1076. <https://www.ncbi.nlm.nih.gov/pubmed/22525931>
51. Unger, A., Metz, V., & Fischer, G. (2012). Opioid dependent and pregnant: What are the best options for mothers and neonates? *Obstetrics and Gynecology International*, Article ID 195954. doi: 10.1155/2012/195954
52. National Commission on Correctional Health Care. (2014, October 19). Women's health care in correctional settings (position statement). <http://www.ncchc.org/womens-health-care>
- American College of Obstetricians and Gynecologists. (2011, November, reaffirmed 2016). Health care for pregnant and postpartum incarcerated women and adolescent females. Committee Opinion, Number 511. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Pregnant-and-Postpartum-Incarcerated-Women-and-Adolescent-Females>
53. Sigmon, S. C., Ochalek, T. A., Meyer, A. C., Hruska, B., Heil, S. H., Badger, G. J., & Higgins, S. T. (2016, December 22). Interim buprenorphine vs. waiting list for opioid dependence. *New England Journal of Medicine*, 375, 2504–2505. doi: 10.1056/NEJMc1610047
54. Crime Solutions, the U.S. Justice Department National Institute of Justice registry of evidence-based programs. <https://www.crimesolutions.gov/>
55. Godley, S. H., White, W. L., Diamond, G., Passetti, L. L., & Titus, J. C. (2001). Therapist reactions to manual-guided therapies for the treatment of adolescent marijuana users. *Clinical Psychology Scientific Practice*, 8, 405–417. doi: 10.1093/clipsy.8.4.405
56. Dowden, C. & Andrews, D. A. (2004, April 1). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practice. *International Journal of Offender Therapy and Comparative Criminology*, 48 (2), 203–214. doi: 10.1177/0306624X03257765
57. Substance Abuse and Mental Health Services Administration. (2015, March). Federal guidelines for opioid treatment programs. (HHS Publication No. [SMA] PEP15-FEDGUIDEOTP). Rockville, MD. <http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf>
58. Taxman, F., Thanner, M., & Wesburd, D. (2006, January 1). Risk, need, and responsivity (RNR): It all depends. *Crime & Delinquency*, 61(9), 1.
59. Bonta, J., & Andrews, D. (2007). Risk-Need-Responsivity model for offender assessment and rehabilitation, 2007–06. Canada: Public Safety Canada & Carleton University.
60. Lowenkamp, C., & Latessa, E. (2005). Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential placement. *Criminology & Public Policy*, 4(2), 263–290.
61. Andrews, D., Bonita, J., & Wormith, S. (2011, June). The Risk-Need-Responsivity (RNR) Model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice Behavior*, 38(7), 735–755.
62. Anglin, M. D., Prendergast, M., & Farabee, D. (1998, March 23–25). The effectiveness of coerced treatment for drug-abusing offenders. Presented at the Office of National Drug Control Policy's Conference of Scholars and Policy Makers. Washington, DC.
- Coviello, D. M., Zanis, D. A., Wesnoski, S. A., Palman, N., Gur, A., Lynch, K. G., & McKay, J. R. (2013, April). Does mandating offenders to treatment improve completion rates? *Journal of Substance Abuse Treatment*, 44(4), 417–425. doi: 10.1016/j.jsat.2012.10.003
63. Friedman, S., & Wagner-Goldstein, K. (2015). Medication-assisted treatment in drug courts: Recommended strategies. Center for Court Innovation, State of New York Unified Court System, and Legal Action Center. <https://lac.org/wp-content/uploads/2016/04/MATinDrugCourts.pdf>
64. Ibid.
65. An agonist is a drug that activates certain receptors in the brain. Full agonist opioids activate the opioid receptors in the brain fully, resulting in the full opioid effect. Examples of full agonists are heroin, oxycodone, methadone, hydrocodone, morphine, opium, and others. An antagonist is a drug that blocks opioids by attaching to the opioid receptors without activating them. Antagonists cause no opioid effect and block fully agonist opioids. Examples are naltrexone and naloxone. Naloxone is sometimes used to reverse a heroin overdose. Buprenorphine is a partial agonist, meaning that it activates the opioid receptors in the brain, but to a much lesser degree than a full agonist. https://www.naabt.org/faq_answers.cfm?ID=5

66. Gordon, M. S., Kinlock, T. W., Schwartz, R. P., Fitzgerald, T. T., O'Grady, K. E., & Vocci, F. J. (2014, September 1). A randomized controlled trial of prison-initiated buprenorphine: Prison outcomes and community treatment entry. *Journal of Drug and Alcohol Dependence*, 142, 33–40. doi: 10.1016/j.drugalcdep.2014.05.011
67. Substance Abuse and Mental Health Services Administration. (2015, March). Federal guidelines for opioid treatment programs. (HHS Publication No. [SMA] PEP15-FEDGUIDEOTP). <https://store.samhsa.gov/product/PEP15-FEDGUIDEOTP>
68. Substance Abuse and Mental Health Services Administration. (2014). National Survey of Substance Abuse Treatment Services (N-SSATS): 2013. Data on Substance Abuse Treatment Facilities. (BHSIS Series S-73, HHS Publication No. [SMA] 14-489). Rockville, MD. Retrieved from https://www.samhsa.gov/data/sites/default/files/2013_N-SSATS/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services.pdf
69. Pennsylvania Department of Corrections. (2015, October). MAT expansion plan: PA DOC strategies for expanding the use of MAT for justice-involved individuals. <http://www.cor.pa.gov/General%20Information/Documents/Medication%20Assisted%20Treatment/MAT%20Expansion%20Plan.pdf>
70. Substance Abuse and Mental Health Services Administration. (2015, March). Federal guidelines for opioid treatment programs. (HHS Publication No. [SMA] PEP15-FEDGUIDEOTP). Rockville, MD. Available at <http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf>
71. Cognitive behavioral therapies should be considered specifically for correctional populations.
72. Substance Abuse and Mental Health Services Administration. (2015, March). Federal guidelines for opioid treatment programs. (HHS Publication No. [SMA] PEP15-FEDGUIDEOTP). Rockville, MD. <http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf>
73. For more information on these standards, visit <https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs>.
74. Gordon, A. J., Lo-Ciganic, W. H., Cochran, G., Gellad, W. F., Cathers, T., Kelley, D., & Donohue, J. M. (2015, November–December). Patterns and quality of buprenorphine opioid agonist treatment in a large Medicaid program. *Journal of Addiction Medicine*, 9(6), 470–477. doi: 10.1097/ADM.0000000000000164
75. Substance Abuse and Mental Health Services Administration. (2015). National Survey of Substance Abuse Treatment Services (N-SSATS): 2014. Data on Substance Abuse Treatment Facilities. (BHSIS Series S-79, HHS Publication No. [SMA] 16-4963). http://www.samhsa.gov/data/sites/default/files/2014_National_Survey_of_Substance_Abuse_Treatment_Services/2014_National_Survey_of_Substance_Abuse_Treatment_Services/2014_National_Survey_of_Substance_Abuse_Treatment_Services.pdf
76. Telepractice Standards for OASAS Designated Providers. New York State Office of Alcoholism and Substance Abuse Services. <https://www.oasas.ny.gov/regis/documents/TelepracticeStandards.pdf>
77. Coviello, D. M., Zanis, D. A., Wesnoski, S. A., Palman, N., Gur, A., Lynch, K. G., & McKay, J. R. (2013). Does mandating offenders to treatment improve completion rates? *Journal of Substance Abuse Treatment*, 44(4), 417–425. <http://doi.org/10.1016/j.jsat.2012.10.003>
78. Friedmann, P. D., Ducharme, L. J., Welsh, W., Frisman, L., Knight, K., Kinlock, T., & Pankow, J. (2013, December 19). A cluster randomized trial of an organizational linkage intervention for offenders with substance use disorders: Study protocol. *Journal of Health and Justice*, 1(6). doi: 10.1186/2194-7899-1-6
- Friedmann, P. D., Wilson, D., Knudsen, H. K., Ducharme, L. J., Welsh, W. N., Frisman, L., & Vocci, F. J. (2015, March). Effect of an organizational linkage intervention on staff perceptions of medication-assisted treatment and referral intentions in community corrections. *Journal of Substance Abuse Treatment*, 50, 50–58. doi: 10.1016/j.jsat.2014.10.001
- Welsh, W. N., Knudsen, H. K., Knight, K., Ducharme, L., Pankow, J., Urbine, T., & Friedmann, P. D. (2016, January). Effects of an organizational linkage intervention on interorganizational service coordination between probation/parole agencies and community treatment providers. *Journal of Administration and Policy in Mental Health and Mental Health Services Research*, 43(1), 105–121. doi: 10.1007/s10488-014-0623-8
79. Gordon, M., Kinlock, T. W., Schwartz, R. P., O'Grady, K. E., Fitzgerald, T. T., & Vocci, F. J. (2017). A randomized clinical trial of buprenorphine for prisoners: Findings at 12-months post-release. *Drug and Alcohol Dependence*, 172, 34–42.
80. Merrall, E. L., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M. Marsden, J. ... Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction*, 105(9) 1545-1554.
81. Green, T. C., Clarke, J., Brinkley-Rubinstein, L., Marshall, B., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). Postincarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system. *JAMA Psychiatry*, 75(4) 405-407.
82. Substance use disorder treatment for adults and adolescents (position statement). (2016). Chicago, IL: National Commission on Correctional Health Care. <https://www.ncchc.org/substance-use-disorder-treatment-for-adults-and-adolescents>
83. Moore, K. E., Oberleitner, L., Smith, K. M. Z., Maurer, K., & McKee, S. A. (2018). Feasibility and effectiveness of continuing methadone maintenance treatment during incarceration compared with forced withdrawal. *Journal of Addiction Medicine*, 12(2), 156–162.
84. Rich, J. D., McKenzie, M., Larney S., Wong, J. B., Tran, L., Clarke, J., ... Zaller, N. (2015). Methadone continuation versus forced withdrawal on incarceration in a combined U.S. prison and jail: A randomised, open-label trial. *Lancet*, 386(9991), 350–359.

85. Alex, B., Weiss, D. B., Kaba, F., Rosner, Z., Lee, D., Lim, S., ... MacDonald, R. (2017). Death after jail release: matching to improve care delivery. *Journal of Correctional Health Care*, 23(1), 83-87.
86. Green, T. C., Clarke, J., Brinkley-Rubinstein, L., Marshall, B., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). Postincarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system. *JAMA Psychiatry*, 75(4) 405-407.
87. Standards for opioid treatment programs in correctional facilities. (2016). Chicago, IL: National Commission on Correctional Health Care.
88. Kinlock, T. W., Gordon, M. S., Schwartz, R. P., Fitzgerald, T. T., & O'Grady, K. E. (2009, October). A randomized clinical trial of methadone maintenance for prisoners: Results at 12 months post release. *Journal of Substance Abuse Treatment*, 37(3), 277-285.
89. Alderks, C. (2017, August 22). Trends in the use of methadone, buprenorphine, and extended-release naltrexone at substance abuse treatment facilities: 2003-2015 (update). The CBHSQ Report. Retrieved from the Substance Abuse and Mental Health Services Administration website: https://www.samhsa.gov/data/sites/default/files/report_3192/ShortReport-3192.html
90. Substance Abuse and Mental Health Services Administration. (2006). Detoxification and substance abuse treatment. Treatment Improvement Protocol (TIP) Series, No. 45. (HHS Publication No. [SMA] 134131). <https://store.samhsa.gov/shin/content/SMA13-4131/SMA13-4131.pdf>.
- Roberts, A., Hayes, A., Carlisle, J., & Shaw, J. (2007). Review of drug and alcohol treatments in prison and community settings: A systematic review conducted on behalf of the Prison Health Research Network. England: University of Manchester.
91. Rich, J. D., McKenzie, M., Larney, S., Wong, J. B., Tran, L., Clarke, J., & Zaller, N. (2015, July 25). Methadone continuation versus forced withdrawal on incarceration in a combined U.S. prison and jail: A randomised, open-label trial. *The Lancet*, 386(9991), 350-359. doi: 10.1016/S0140-6736(14)62338-2.
- Maradiaga, J. A., Nahvi, S., Cunningham, C. O., Sanchez, J., & Fox, A. D. (2016, March). "I kicked the hard way. I got incarcerated." Withdrawal from methadone during incarceration and subsequent aversion to medication-assisted treatments. *Journal of Substance Abuse Treatment*, 62, 49-54. doi: 10.1016/j.jsat.2015.11.004
92. Wilcox, T. (2016, Summer). Managing opiate withdrawal: The WOWS method. *CorrectCare*. <http://www.ncchc.org/filebin/CorrectCare/30-3-WOWS.pdf>
- Substance Abuse and Mental Health Services Administration. (2016). Pocket guide: Medication-assisted treatment of opioid use disorder (HHS Publication No. [SMA] 16-4892PG). <http://store.samhsa.gov/product/Medication-Assisted-Treatment-of-Opioid-Use-Disorder-Pocket-Guide/SMA16-4892PG>
93. Fiscella, K. (2015, September). Guide to developing and revising alcohol and opioid detoxification protocols. <http://www.ncchc.org/filebin/Resources/Detoxification-Protocols-2015.pdf>
94. Fiscella, K., Moore, A., Engerman, J., & Meldrum, S. (2004). Jail management of arrestees/inmates enrolled in community methadone maintenance programs. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 81(4), 645-654.
95. Substance Abuse and Mental Health Services Administration. (2006). Detoxification and substance abuse treatment. Treatment Improvement Protocol (TIP) Series, No. 45. (HHS Publication No. [SMA] 134131). <https://store.samhsa.gov/shin/content/SMA13-4131/SMA13-4131.pdf>
96. Federal Bureau of Prisons. (2014, February). Detoxification of chemically dependent inmates: Federal Bureau of Prisons clinical practice guidelines. <https://www.bop.gov/resources/pdfs/detoxification.pdf>
97. Cochrane. Clonidine, lofexidine, and similar medications for the management of opioid withdrawal. http://www.cochrane.org/CD002024/ADDICTN_clonidine-lofexidine-and-similar-medications-management-opioid-withdrawal
98. Centers for Disease Control and Prevention. Reverse overdose to prevent death. <https://www.cdc.gov/drugoverdose/prevention/reverse-od.html>
99. Fletcher, B., & Chandler, R. (2014, April). Principles of drug abuse treatment for criminal justice populations: A research-based guide. National Institute on Drug Abuse, No. 11-5316. https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf
100. Johnson, A. (2017, April 16). Addiction drug Suboxone is popular prison contraband. *Columbus Dispatch*. <http://www.dispatch.com/news/20170416/addiction-drug-suboxone-is-popular-prison-contraband>
101. Rhode Island Department of Corrections. (2016, April 22). Distribution of suboxone protocol, women's facility, 9.14-8, 18.20-2 & 18.52-3, April 22, 2016; (2016, April 16). Distribution of suboxone protocol SOP, supplements policy, 9.14-8, 18.20-2 & 18.52-3.
102. Rich, J. D., McKenzie, M., Larney, S., Wong, J. B., Tran, L., Clarke, J., ... Zaller, N. (2015). Methadone continuation versus forced withdrawal on incarceration in a combined U.S. prison and jail: A randomised, open-label trial. *Lancet*, 386(9991), 350-359.
103. Moore, K. E., Oberleitner, L., Smith, K. M. Z., Maurer, K., & McKee, S. A. (2018). Feasibility and effectiveness of continuing methadone maintenance treatment during incarceration compared with forced withdrawal. *Journal of Addiction Medicine*, 12(2), 156-162.
104. U.S. Government Accountability Office. (2016, September). Opioid addiction: Laws, regulations, and other factors can affect medication-assisted treatment access: Report to the Majority Leader, U.S. Senate. <http://www.gao.gov/assets/690/680050.pdf>

105. Haffajee, R. L., Bohnert, A. S. B., Lagisetty, P. A. (2018). Policy pathways to address provider workforce barriers to buprenorphine treatment. *American Journal of Preventive Medicine*, 54(6S3), S230-S242. [https://www.ajpmonline.org/article/S0749-3797\(18\)30074-6/fulltext](https://www.ajpmonline.org/article/S0749-3797(18)30074-6/fulltext)
106. Miller, N. (n.d.) A Comprehensive Listing of What States Cover for Substance Use Disorder, including Medications. www.rsat-tta.com
107. Council of State Governments Justice Center. Critical Connections —Getting people leaving prison and jail the mental health care and substance use treatment they need: What policymakers need to know about health care coverage, p. 22. <https://files.csgjusticecenter.org/critical-connections/Critical-Connections-Full-Report.pdf>
108. Scott, H. (2018, January 24). Snohomish County taking new approach to opioid crisis. Seattle: MYNorthwest. <http://mynorthwest.com/878895/snohomish-co-opioid-crisis>
109. Green, T. C., Clarke, J., Brinkley-Rubinstein, L., Marshall, B., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). Postincarceration fatal overdoses after implementing medications for addiction treatment in a statewide correctional system. *JAMA Psychiatry*, 75(4) 405-407.
110. National Institute on Drug Abuse. (2018, January 17). Principles of drug addiction treatment: A research-based guide (3rd edition). <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition>. These programs are described in Appendix II.
111. For more information about this resource, please see <https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator>.
112. For more information about this resource, please see <http://dpt2.samhsa.gov/regulations/smalist.aspx>.
113. National Institute on Drug Abuse. (2018, January 17). Principles of drug addiction treatment: A research-based guide (3rd edition). <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition>
114. National Institute of Justice. (n.d.). All programs & practices. <http://www.crimesolutions.gov/Programs.aspx#practices>
115. Ojmarrh, M., Wilson, D. B., & MacKenzie, D. L. (2012, November 1). The effectiveness of incarceration-based drug treatment on criminal behavior: A systemic review. *Campbell Systematic Reviews*, 18. doi: 10.4073/csr.2012.18



ABOUT THE NATIONAL SHERIFFS' ASSOCIATION

Chartered in 1940, the National Sheriffs' Association (NSA) is a professional association dedicated to serving the Office of Sheriff and its affiliates. NSA represents thousands of sheriffs and deputies in our nation's 3,300 jails, as well as other law enforcement and public safety professionals and concerned citizens nationwide. Guided by a board of directors and 17 committees, NSA addresses the full range of issues of importance to law enforcement in fulfillment of its mission to support and enhance the professionalism of those whose job it is to serve and protect. It provides its 20,000-plus members with a wide range of services, information, trainings and technical assistance, including a professional magazine, an e-newsletter, and an annual and winter conference. <http://www.sheriffs.org>



ABOUT THE NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

NCCHC is a not-for-profit 501(c)(3) organization working to improve the quality of care in our nation's jails, prisons, and juvenile detention and confinement facilities. NCCHC establishes standards for health services in correctional facilities, operates a voluntary accreditation program for institutions that meet these standards, produces and disseminates resource publications, offers a quality review program, conducts educational trainings and conferences, and offers a certification program for correctional health professionals. NCCHC is supported by the major national organizations representing the fields of health, law and corrections. <http://www.ncchc.org>

TO FIND THIS RESOURCE ONLINE, VISIT WWW.NCCHC.ORG/JAIL-BASED-MAT.

TO REQUEST MAT-RELATED TECHNICAL ASSISTANCE

Visit the Residential Substance Abuse Treatment (RSAT) for State Prisoners Program Training and Technical Assistance page at www.rsat-tta.com/On-Site-TA-Teleconferences/Training-and-Technical-Assistance-Request-Form.aspx. This website is funded through a grant from the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice.