Lightning Intro Session
Prisons & Jails
Part 2

PRESENTERS

1. **Todd Molfenter**
2. **Helen Jack**
3. **Elizabeth Evans**
4. **Rosemarie Martin**
5. **Michele Staton**
6. **Michael Dennis**
7. **Joseph Carpenter**
8. **Paige Shaffer**

JCOIN
Justice Community Overdose Innovation Network

Testing MOUD Scale-Up Strategies in Criminal Legal Settings
University
of Wisconsin Hub

Principal Investigators;

Todd Molfenter, PhD
University of Wisconsin

Rosemarie Martin, PhD
UMass Chan Medical School

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University of Wisconsin

Qualitative Statistician
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Statistician
Roger Brown, PhD
University of Wisconsin

Data & Statistical Analysist
Kendra Clark, PhD
George Mason University

Our Team

Overall Purpose of the Trial

Purpose: Conduct research on replicable scaleup approaches

Scaleup
"Deliberate efforts to increase the impact of successfully tested health innovation so as to benefit more people and to foster policy and program development on a lasting basis." (WHO, 2010, p.2)

Scaleup Models Influencing the Research
● Weber et al, (2022). Development of a Framework for Scaling up Community-based Health Promotion: A Best Fit Framework Synthesis. *International Journal of Environmental Research and Public health.*

● World Health Organization (WHO) (2010). Nine steps for developing a scaling-up strategy. *World Health Press*

Slide based on scale-up lit review form Merve Ulukaya, PhD

Evaluate a systems-change approach for scaling MOUD use in criminal legal settings with State Department of Corrections (DOCs) & prison staff

- Cluster randomized control trial

- Two-Year Study
  - 12-month intervention phase / 12-month sustainability phase

- Test the impact of two implementation approaches for scaling MOUD use
  - SAMHSA State Policy Academy
  - Multi-Site Provider Learning Collaborative

- Recruit 12 DOCs and 120 prisons nationwide

- Three (3) Study Arms
  - Arm 1: SAMHSA State Policy Academy (4 States / 40 prisons)
  - Arm 2: Multi-Site Provider Learning Collaborative (4 States / 40 Prisons)
  - Arm 3: Standard Practice as Usual (Control) (4 States / 40 Prisons)

Aims & Outcomes

Aim 1. Engage stakeholder and dissemination board to integrate diverse lived experience perspectives from people living and working in incarcerated settings into the research design and analysis for the non-control arms

Aim 2. Test the differences between use of the Policy Academy Bundle, provider LC, and control using RE-AIM

Reach: Number of MOUD standardized medication units purchased by prisons in a state using a national pharmaceutical purchasing database (Primary Outcome)

Effectiveness: Number of disciplinary infractions and individuals participating in SUD programming (Secondary Outcome)

Adoption: Percentage of prisons who use MOUD (Secondary Outcome)

Implementation: Assess ability to integrating medications for addiction treatment, Cascade of Care performance (prison), Implementation of EBIs (DOC) and level of partnering between DOC and prisons (Secondary Outcome)

Maintenance: Reach, Effectiveness, Adoption, and Implementation measures will be tracked in post-implementation Ms13–24

Aim 3. Conduct a qualitative exploration to aid interpretation of quantitative results and gain an in-depth understanding of the factors that promote or impede the scale-up of MOUD in prison settings

Aim 4. Estimate the implementation and sustainment costs associated with each intervention and assess their relative economic value from a state-policymaker perspective after accounting for downstream cost-offsets

OPTIMIZING OPIOID USE DISORDER TREATMENT IN PRISONS: STRATEGIES FOR DIAGNOSIS AND TREATMENT

Helen Jack, MD
University of Washington

STUDY TEAM

University of Washington

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Washington Department of Corrections
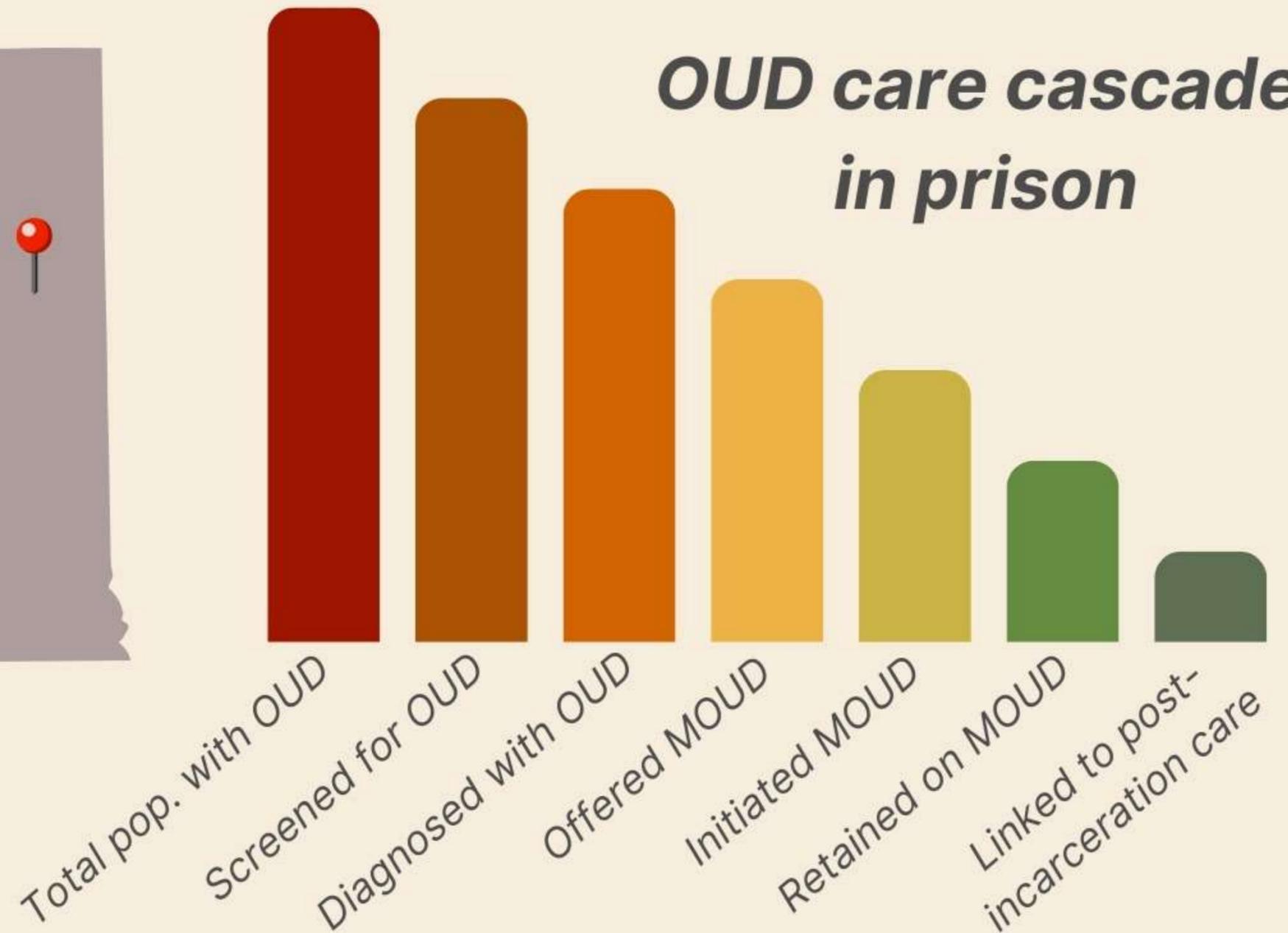
Courtney Bagdon-Cox, PhD
Research Lead

Catherine Smith, DO
Director: Addiction Medicine

Consultants: Liba Blumberger, DrPH (Johns Hopkins University), Gary Zarkin, PhD (RTI International), Kathryn Porter, JD and Devan Duenas, MA (Seattle Children's Hospital)
Working on establishing **advisory board** of people who are currently incarcerated in WA DOC

SETTING & APPROACH

Washington state prisons

OUD care cascade in prison

Total pop. with OUD

Screened for OUD

Diagnosed with OUD

Offered MOUD

Initiated MOUD

Retained on MOUD

Linked to post-incarceration care

adapted from Williams et al., 2019

AIM 1: DIAGNOSIS

Determine the performance of brief, practical tools for diagnosing OUD in prison relative to a reference standard of a clinical interview (primary) and prior-to-incarceration records (secondary).
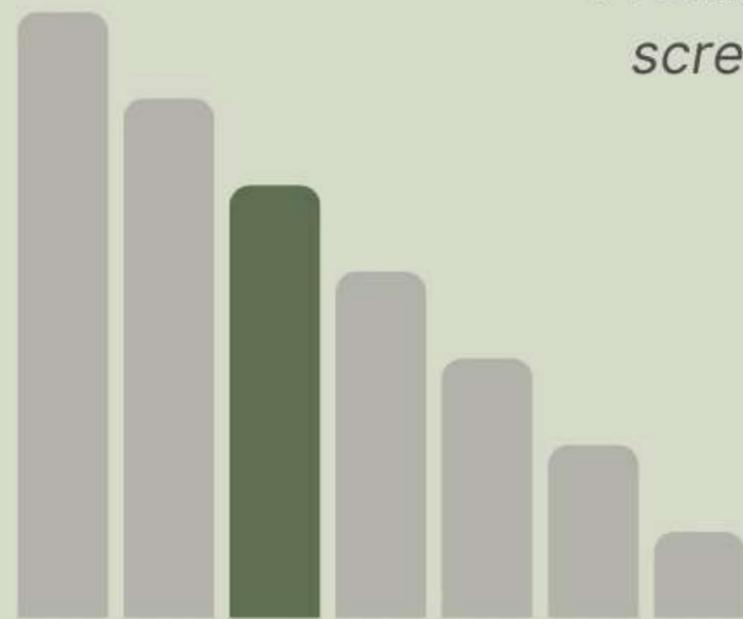
Preliminary OUD screening tool

The information we gather here will be used to offer treatment. It will not be shared with custody staff. It will be kept private by your medical team.

In the 12 months before or since being in prison or jail, how often have you used street opioids?
1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily

In the 12 months before or since being in prison or jail, how often did you take more opioid medications than your doctor told you to take?
1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily

Diagnosis

Brief OUD screen

if positive

Symptom checklist

if positive
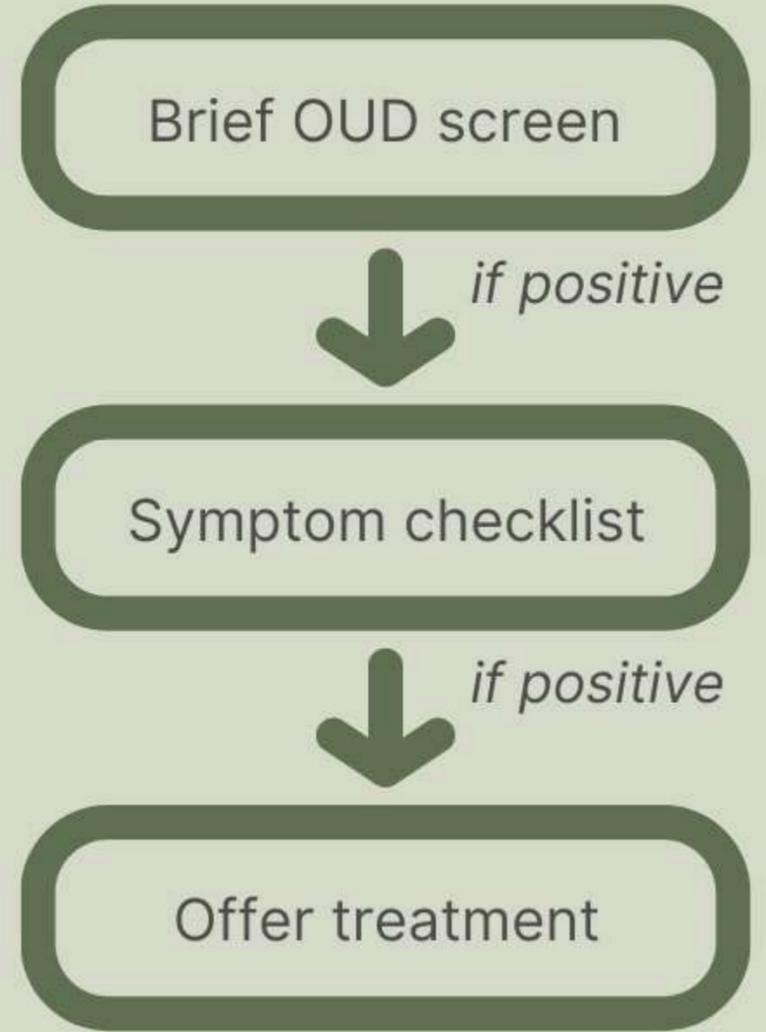
Offer treatment

AIM 2: TREATMENT

Test the effectiveness of offering shared decision-making for MOUD in prison on receipt of MOUD prior to release.

Sample: People with OUD at 3 prisons releasing in next 6 mos
Intervention: 1 session of SDM followed by 2 follow-up contacts
Control: No contact with research group
Primary outcome: Receipt of MOUD prior to release
Secondary outcomes: Days of MOUD received prior to release, days of buprenorphine post-release, in-prison and post-release infractions, reincarceration, mortality

Total eligible population with OUD
n=737

randomized

control group

Usual care (MOUD, no SDM)
n=369

intervention: offered shared decision-making

Est. 30% decline
n=~110

Est. 70% consent to SDM
n=~258

Offered MOUD
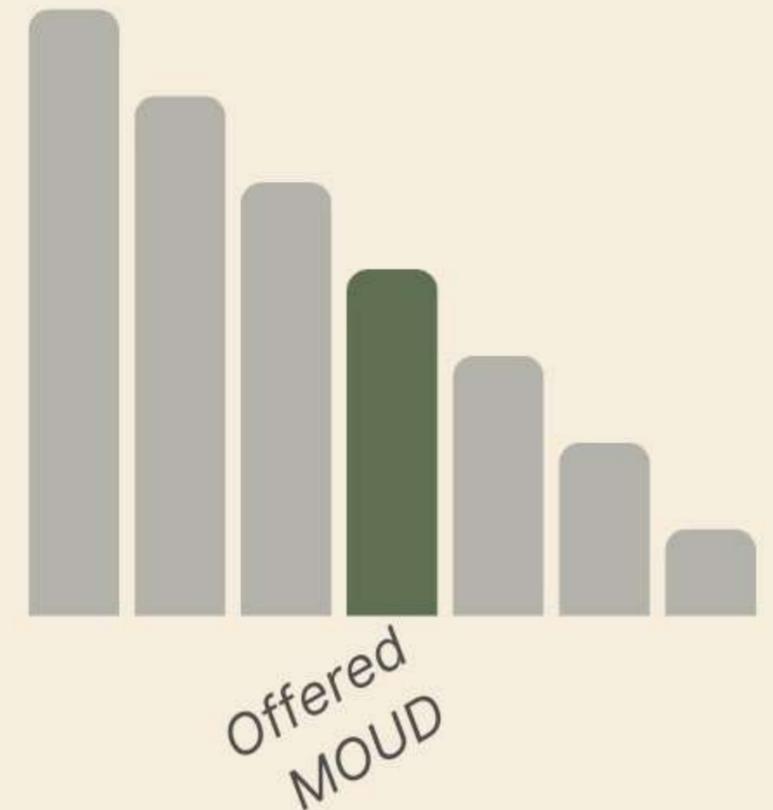
Massachusetts
Justice Community Overdose Innovation Network (Mass JCOIN) Phase 2

Principal Investigators:

Elizabeth A. Evans PhD, MA   **Ekaterina Pivovarova, PhD**

Mass JCOIN Phase 2: Research Team

Investigators
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  Co-I: Michal Horny, PhD
  Co-I: Aaron Sarvet, PhD

UMass Chan
  mPI: Kate Pivovarova, PhD
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  Co-I: Daniel Mullin, PsyD, MPH

Tufts University
Co-I: Tom Stopka, PhD, MHS

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Levin Schwartz, MSW

MA Department of Public Health
Dana Bernson
Devon Dunn

Research Staff
UMass Amherst
Randy Hoskinson
Elyse Bianchet
Emily Moner
Danish Humayan
Lily Bialkin

Community Treatment Partners:
Agencies located throughout Franklin, Hampden, Middlesex and Suffolk Counties

Correctional Partners
Franklin County:
Sheriff Streeter
Dr. Ruth Potee
Nicole Guertin
Jen Brzezinski

Hampden County:
Sheriff Cocchi
Dr. Thomas Lincoln
Nicole Harrington

Middlesex County:
Sheriff Koutoujian
Tom Senst

Suffolk County:
Sheriff Tompkins
Rachelle Steinberg

Mass JCOIN Phase 2: Background and Settings

- Federal Medicaid Inmate Exclusion Program (MIEP) – removes Medicaid eligibility during incarceration

- 2022 – MA received MIEP waiver
  - Allows Medicaid to restart 90 days prior to jail release
 - Start date – Fall 2025

- Pilot program in 4 county jail systems*
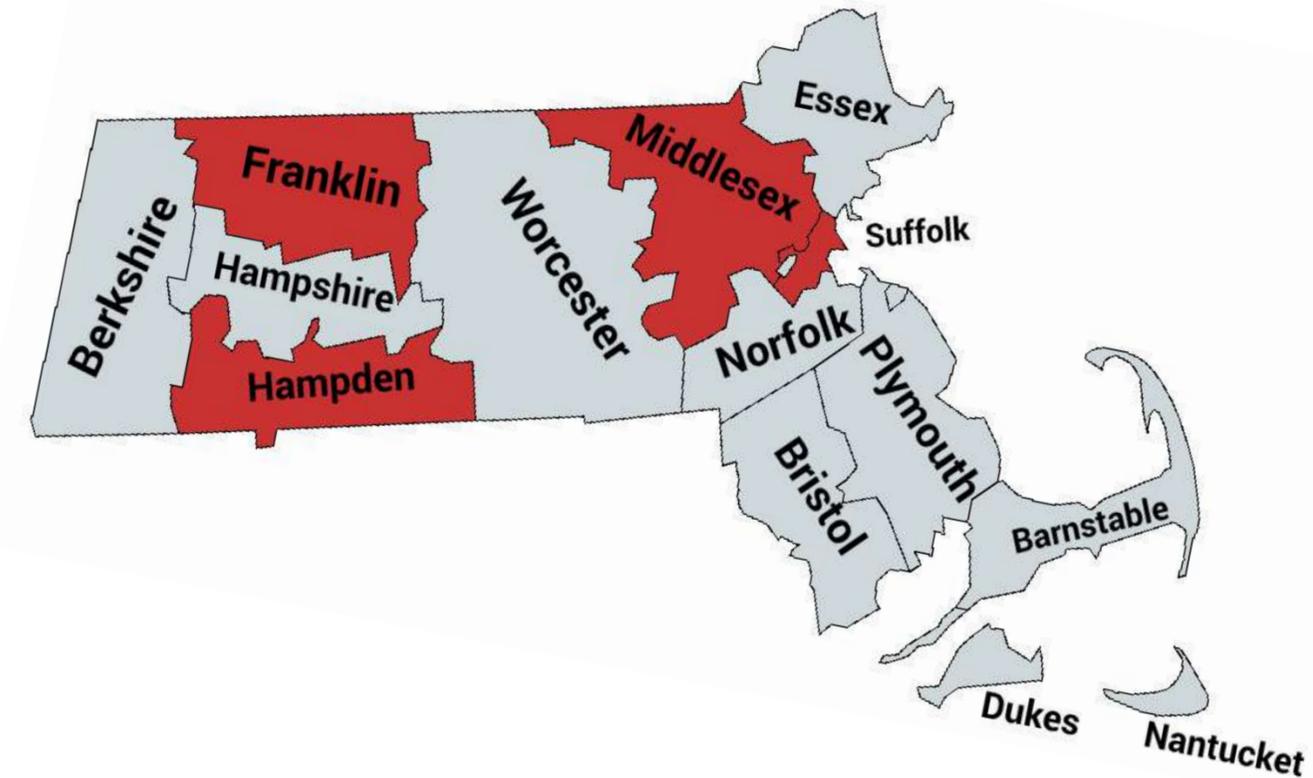
Includes jails and Houses of Correction

Mass JCOIN Phase 2: Specific Aims

Aim 1a: examine factors impacting MIEP waiver implementation and its impact on service delivery.

Aim 1b: use cross-agency linked data from MA Public Health Data warehouse to assess community outcomes for people with OUD transitioning to the community from MIEP pilot and other jails.

Aim 1c: estimate cost of implementing and sustaining the MIEP waiver and associated services and the downstream cost offsets
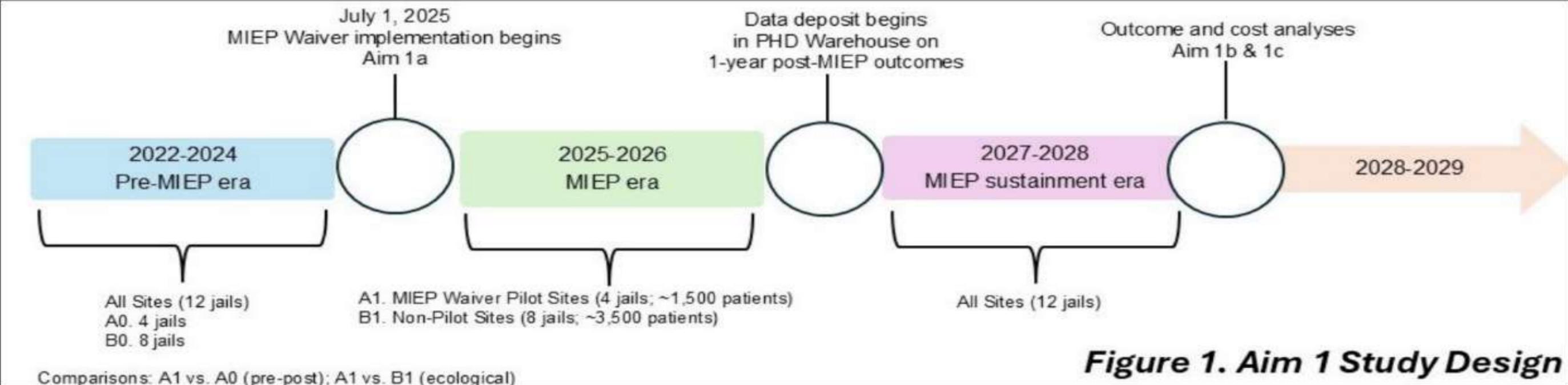
Figure 1. Aim 1 Study Design

Mass JCOIN Phase 2: Specific Aims

Aim 2: Adapt an evidence-based CBT for OUD intervention for reach-in telehealth format provided by community providers to jailed individuals receiving MOUD within 90 days before release and community transition

Aim 3: Perform a clinical trial of the reach-in telehealth CBT intervention.

Hypothesis: Reach-In CBT will enhance MOUD initiation, engagement and retention and reduce opioid overdose, reincarceration, and mortality over the 12 months post-release.

Year	Yr 1: 2025-2026			Yr 2: 2026-2027							Yr 3: 2027-2028		Yr 4: 2028-2029		Yr 5: 2029-2030	
Mon	1-9	10-12	13-15	16-18	19-21	22-24	25-27	28-30	31-33	34-36	37-39	40-48	49-51	52-57	58-60
Site 1	Initial data collection (Aim 1) Intervention adaptation (Aim 2)	Usual Care	Intervention (Aim 3)						Obs 12-month outcomes					Outcome analysis	Close out
Site 2				Intervention (Aim 3)						PHD warehouse data deposit					
Site 3					Intervention (Aim 3)						Measure sustainment				
Site 4						Intervention (Aim 3)									

Team

UMass Chan
MEDICAL SCHOOL

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Bio-Statistician

Grace Ryan, PhD, MPH
Qualitative Methodologist

AATOD
American Association for the Treatment of Opioid Dependence, Inc.

Linda Hurley, MA

Mark Parrino, M.P.A.

UNM HEALTH SCIENCES
Project ECHO

Weill Cornell Medicine

WISCONSIN
UNIVERSITY OF WISCONSIN–MADISON

ACA FOUNDED 1870
American Correctional Association
Advance. Connect. Achieve.
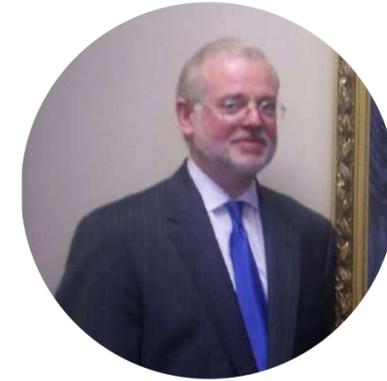
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Karla Thorton, MD, MPH

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Cost Lead

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Kathleen Maurer MD, MPH, MBA

Jennifer Clarke, MD, MPH

40 rural jails and community-based treatment providers

Jail Ecosystem

Approach & Setting

DESIGN: Type 2 hybrid stepped wedge design

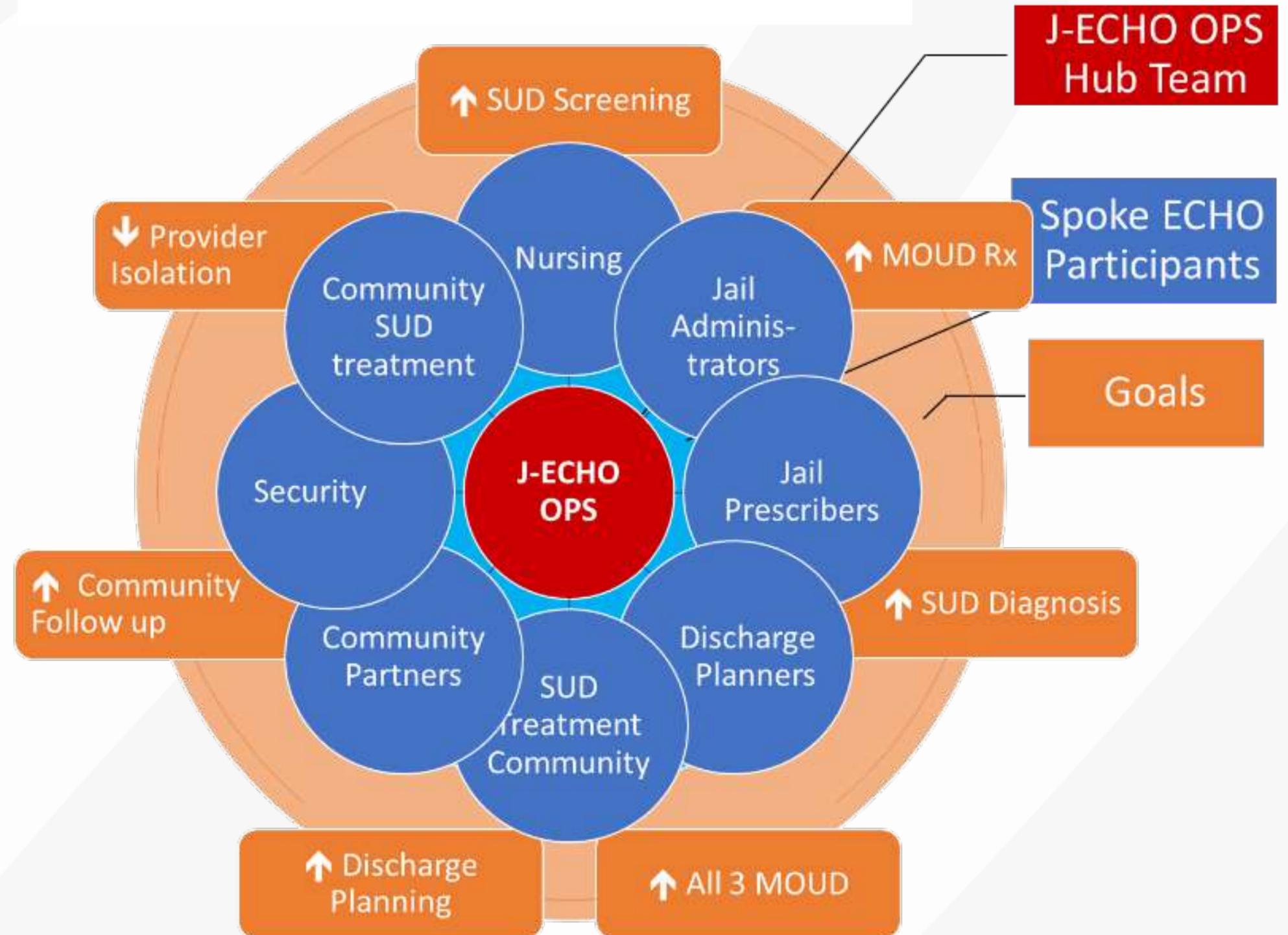10 ECHO cycles: 4 jails and community providers

12 Sessions over 6 months

Months 7-18 monthly ECHO (sustainment phase)

Project ECHO®
- Didactic
- Case Presentation
- Discussion

All Teach, All Learn

Month	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48	51	54
Cycle 1	Start up											x				x		x
Cycle 2													x				x	x
Cycle 3														x				x
Cycle 4															x			x
Cycle 5...																x		x

ECHO CORE   Sustainment Phase   **x = Assessment**

J-ECHO Core Sessions Months 1-6	Focus	Partici-pants	Agenda months 7-18
1. Introduction to ECHO and MOUD	MOUD & OUD Foundation	Administrative	Quality Improvement & Expansion
2. Screening and Assessment for OUD			Data Collection & Outcomes
3. MOUD Program Implementation Strategies			Screening 2
4. Funding and Sustainability	Program Challenges		Buprenorphine
5. Staffing and Training Requirements			Methadone
6. Security and Diversion Prevention			Naltrexone
7. Legal and Ethical Considerations			Peer Navigators
8. Medication Types	Clinical both Jails and Community	Clinical	Trauma
9. Community Continuity of Care			Pregnancy
10. Special Populations & Considerations			Pain Management
11. Overcoming Stigma & Misconceptions			MOUD and CBT
12. Mental Health and MOUD			Nonopioid Substance Misuse

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MEDICAL SCHOOL

Aims/Outcomes

Aim 1: *To test the effectiveness of J-ECHO OPS in terms of implementation outcomes: MOUD reach, penetration, adoption, sustainability, and cost.*

Secondary Aim 1. *Evaluate J-ECHO OPS on organizational climate outcomes: diversion, disciplinary infractions, violence involving staff and residents, and conveyance of drug contraband.*

Aim 2: *To test the effectiveness of J-ECHO OPS in terms of jail and community workforce-level outcomes: MOUD negative attitudes, readiness for change, efficacy, and commitment.*

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OUTCOME	Month BL	6	18	DESCRIPTION
Implementation Outcomes				
Reach	X	X	X	# MOUD doses administered per month
Penetration	X	X	X	Availability of types of MOUD
Penetration	X	X	X	Percent of population screened
Adoption	X	X	X	MOUD written policy.
Sustainability			X	The continuation MOUD programs
Sustainability			X	Continued participation in ECHO
Staff Outcomes				
Readiness for Change	X		X	Staff readiness to implement MOUD
Negative Attitudes	X		X	MOUD standardized stigma scales.
Workforce Efficacy	X		X	Staff confidence to implement a program
Commitment	X		X	Commitment to MOUD for routine care
Knowledge & Attitudes	X		X	Knowledge & attitudes toward MOUD
Organizational Climate				
Diversion	X		X	Measured through facility-reported data
Disciplinary Infractions	X		X	Overall and violent infractions over time
Drug Contraband	X		X	Instances of drug contraband

Kentucky Women's Justice Community Overdose Innovation Network (WJCOIN-II)

MPIs:
Michele Staton, PhD & Carrie Oser, PhD
Department of Behavioral Science, College of Medicine, University of Kentucky

University of Kentucky

Kentucky WJCOIN-II Team

MPIs

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Contact PI

Dr. Carrie Oser

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Dr. Hannah Knudsen

Dr. Kathryn McCollister

Dr. Katie Thompson

Dr. Martha Tillson

Dr. William Stoops

Partners

Sarah Johnson
Kentucky Director of Substance Use Disorder Treatment

Van Ingram
Executive Director, Kentucky Office of Drug Control Policy

Voices of Hope Recovery Community Center

University of Kentucky

University of Kentucky

Setting and Population

Women with a history of opioid and/or stimulant use disorders (N=300) recruited from three jails in rural Appalachian KY

- Rowan County Detention Center
- CMHC: Pathways, Inc
- FQHC: PrimaryPlus Clinic
- OTP: Brightview Addiction Treatment
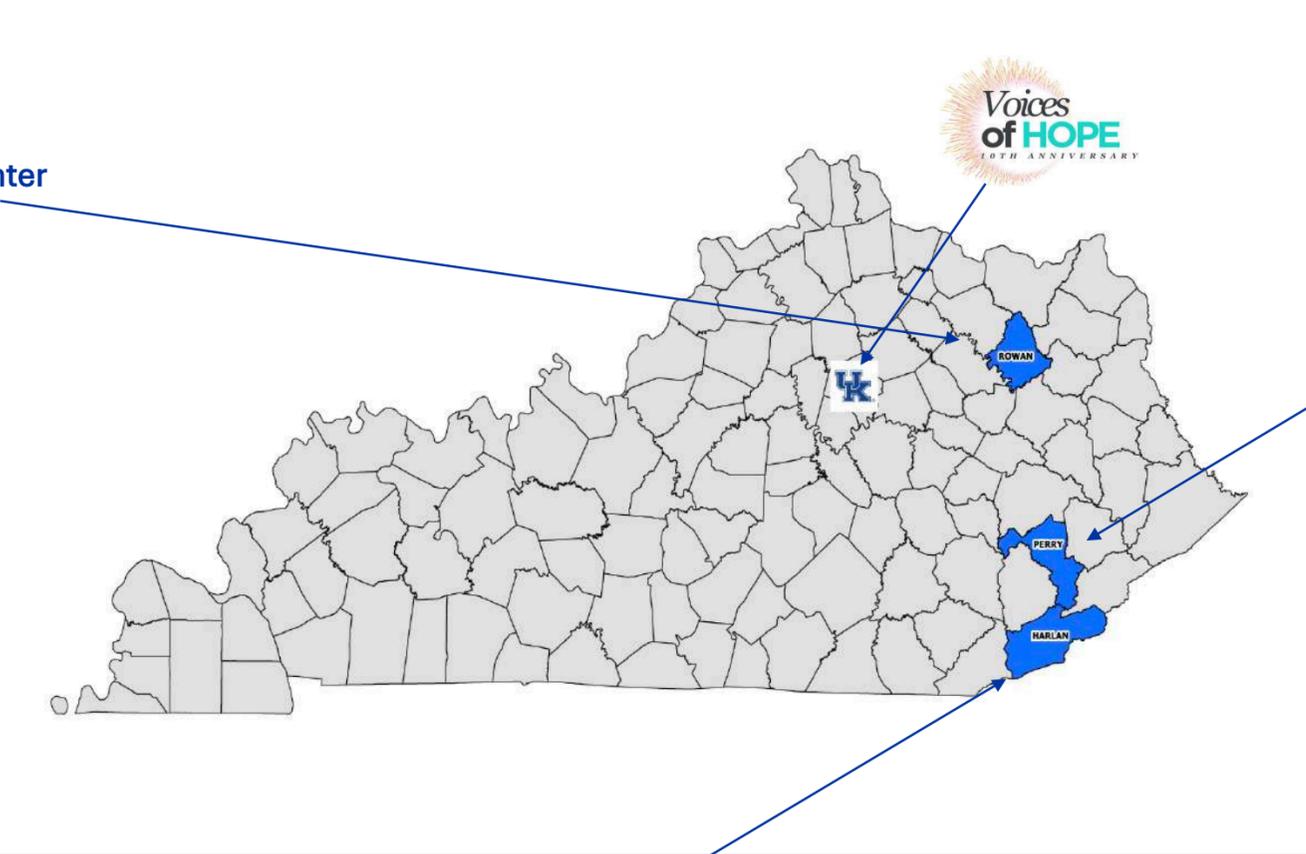
KY River Regional Jail
CMHC: Kentucky River
FQHC: Mountain Health Alliance
OTP: Brightview Addiction Treatment

- Harlan County Detention Center
- CMHC: Cumberland River
- FQHC: Mountain Comprehensive
- OTP: Brightview Addiction Treatment

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Approach and Interventions

SUD Cascade of Care for Overdose Prevention
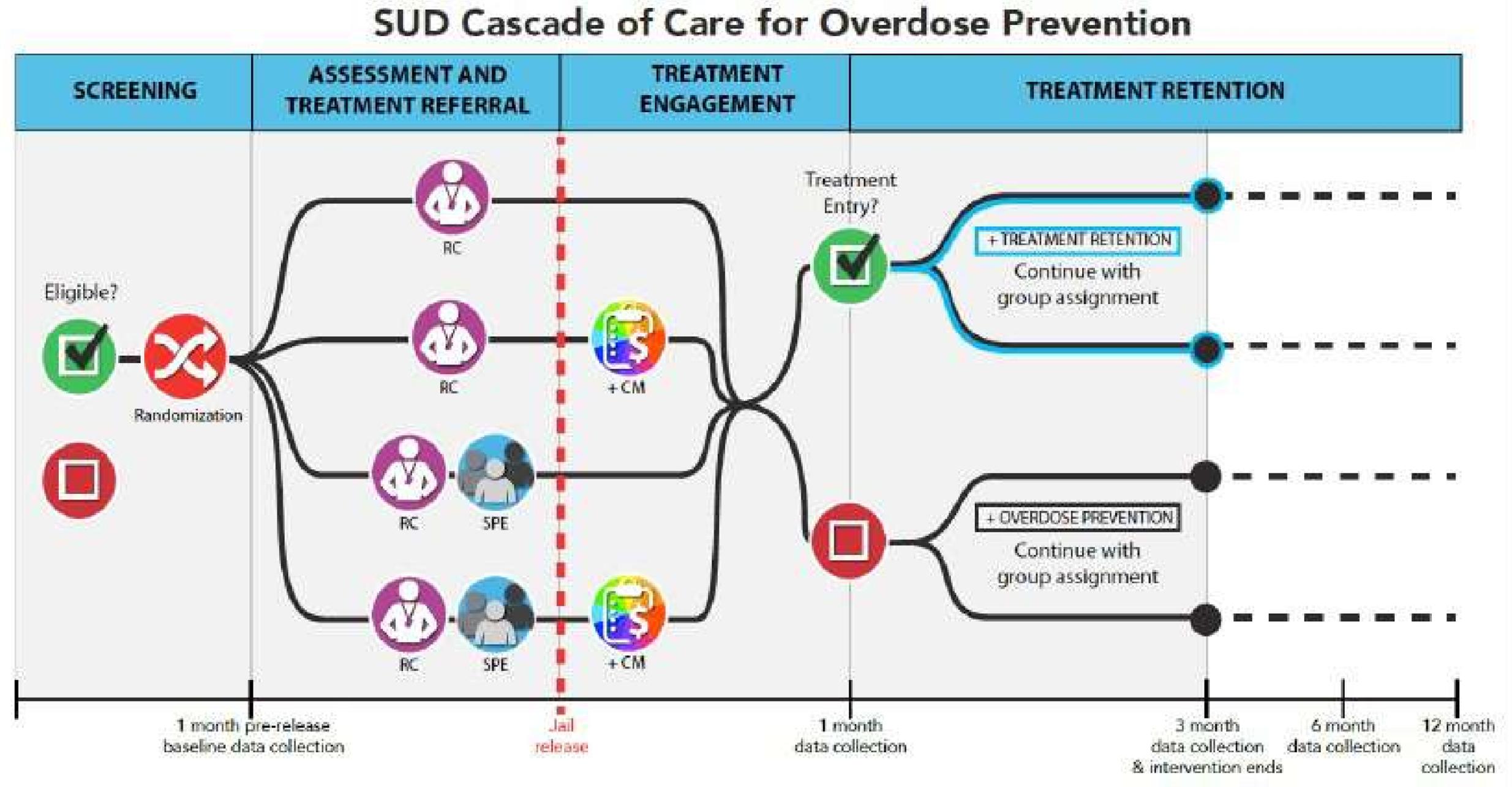
RC=Recovery Coaching; SPE=Support Person Engagement; CM=Contingency Management

Brief Overview of Aims and Outcomes

- Aim 1: Compare the effectiveness of <u>pre-release</u> RC to RC+SPE in decreasing women's overdose risk during re-entry to rural communities.

- Aim 2: Compare the additive effectiveness of CM initiated <u>post-release</u> to RC alone and RC+SPE in decreasing overdose risk and increasing treatment entry and retention among women during re-entry to rural communities.

- Aim 3: Contextualize effectiveness of intervention components by examining the roles of perceived acceptability and appropriateness and identify barriers and facilitators to intervention implementation across the re-entry continuum.

- Aim 4: Examine economic impact of the WJCOIN-II OPIP intervention components pre-release and post-release in reducing women's overdose risk in rural communities.

Primary outcomes include:
- Overdose risk (continuous ORBS-2 score at 1-, 3-, 6-, 12- months post release; validated with drug screening result)
- Treatment entry (dichotomous measure of any formal treatment entry at 1-month

Secondary outcomes include:
- Treatment retention
- Overdose knowledge, harm reduction, recovery supports, recidivism
- Implementation measures of acceptability and appropriateness

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Recovery Management Checkups – Scalability and Sustainability (RMC-SS) Hybrid Experiment: Evaluating Comparability of Client and Implementation Outcomes in Community Organizations Post-Arrest
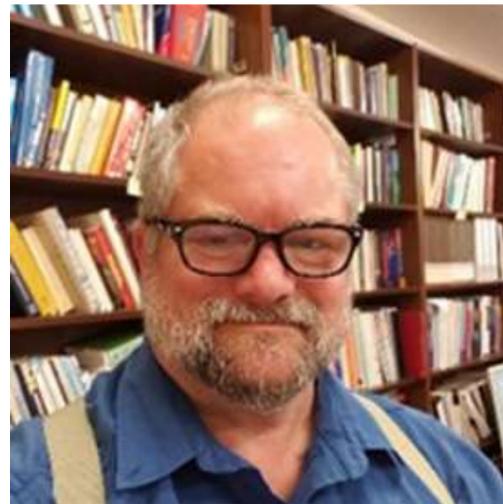
MPIs: Michael L. Dennis, Christine E. Grella, & Dennis P. Watson

Institution: Lighthouse Institute, Chestnut Health Systems, Chicago, IL

Collaborators: Cook County Sheriff, community-based "RMC Adopters" and SUD treatment providers in each community

NIDA Grant no. UM1DA064526

RMC
Recovery Management Checkups

CHESTNUT
HEALTH SYSTEMS
LIGHTHOUSE INSTITUTE

Recovery Management Checkup Model:
Earlier detection and re-intervention improves long-term outcomes

PERSONALIZED SUPPORT

- Chronic disease management approach
- Consistent, personalized, long-term (12 - 48 months) monitoring
- Early intervention and re-intervention
- Goals:
  - Detect need for treatment and relapse
  - Shorten time to treatment entry and re-entry
  - Improve retention and long-term outcomes
- 6 prior clinical trials (including JCOIN I) and 2 quasi-experiments over 2 decades have established RMC's effectiveness with diverse populations

RMC Key Components: LIFT-UP

- **L**inkage Managers
  - Conduit to treatment; establish goals
- **I**nspirational and Motivational Techniques
  - Trained in MI; ongoing monitoring; MI Spirit
- **F**ollow-up through Regular Checkups
  - Establish & sustain connection; share journey; safety net
- **T**reatment Connections
  - Rapid access to treatment; help with transportation, paperwork, other barriers
- **U**nwavering and Ongoing Support
  - Always there for client; partnership through ups & downs
- **P**roactive Re-Linkage
  - Able to relink to treatment or change provider as needed

Hybrid Type 2 Equivalence Effectiveness-Implementation Design:

600 individuals will be recruited following arrest at Cook County First Appearance Court and randomly assigned (2|1 ratio) to receive RMC from linkage managers in: 1) community-based "RMC Adopters" in one of 4 high-risk neighborhoods or 2) Lighthouse Institute (research comparison)

AOD-Related Deaths Per Sq Mile by Zip Code
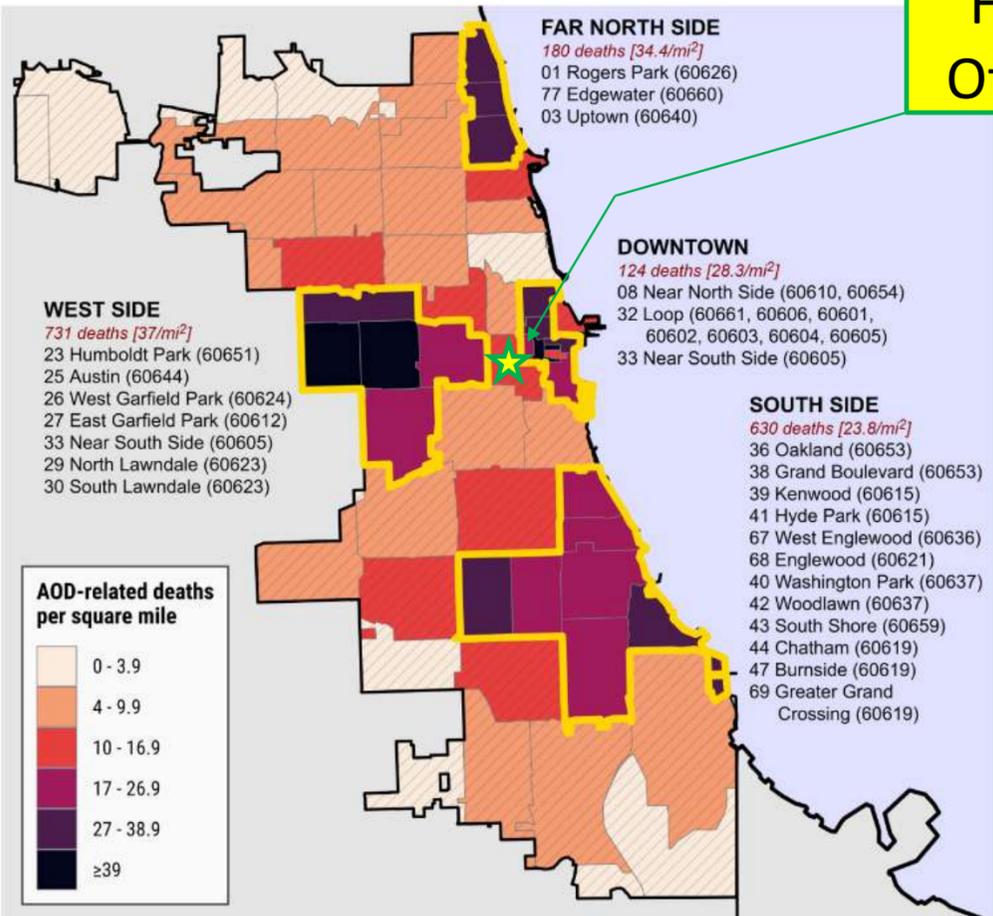
Hub Office

AOD-Related **Crime** Reports /Sq Mile by Zip Code

FAR NORTH SIDE
180 deaths [34.4/mi²]
01 Rogers Park (60626)
77 Edgewater (60660)
03 Uptown (60640)

DOWNTOWN
124 deaths [28.3/mi²]
08 Near North Side (60610, 60654)
32 Loop (60661, 60606, 60601,
   60602, 60603, 60604, 60605)
33 Near South Side (60605)

WEST SIDE
731 deaths [37/mi²]
23 Humboldt Park (60651)
25 Austin (60644)
26 West Garfield Park (60624)
27 East Garfield Park (60612)
33 Near South Side (60605)
29 North Lawndale (60623)
30 South Lawndale (60623)

SOUTH SIDE
630 deaths [23.8/mi²]
36 Oakland (60653)
38 Grand Boulevard (60653)
39 Kenwood (60615)
41 Hyde Park (60615)
67 West Englewood (60636)
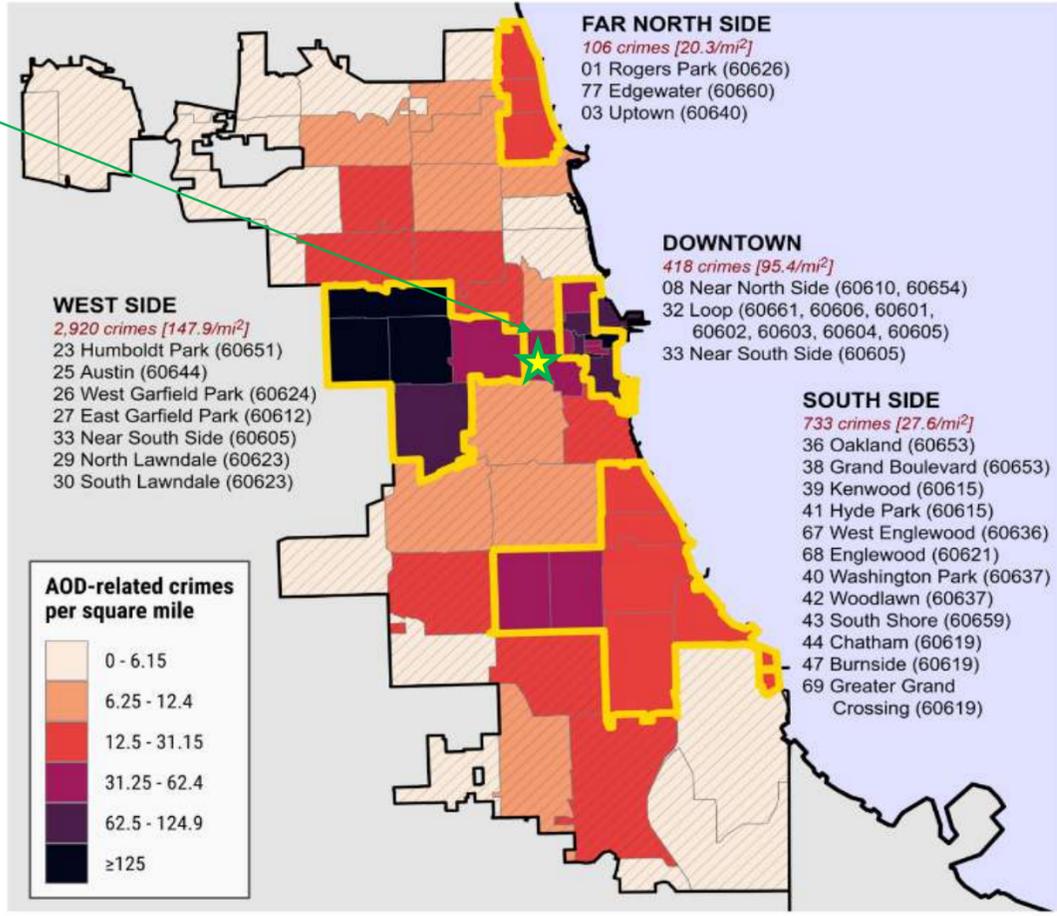68 Englewood (60621)
40 Washington Park (60637)
42 Woodlawn (60637)
43 South Shore (60659)
44 Chatham (60619)
47 Burnside (60619)
69 Greater Grand
   Crossing (60619)

AOD-related deaths per square mile
- 0 - 3.9
- 4 - 9.9
- 10 - 16.9
- 17 - 26.9
- 27 - 38.9
- ≥39

Alcohol and other drug (AOD)-related death rates for the two-year period 10/1/2022 – 9/30/2024, by 2021 ZIP code tabulation areas (ZCTA). Data from Cook County Medical Examiner's Office, available at https://datacatalog.cookcountyil.gov/Public-Safety/Medical-Examiner-Case-Archive/cjeq-bs86/about_data. AOD-related deaths were defined as deaths where alcohol or another drug was mentioned in a primary cause of death. Target areas (gold outlines) include ZCTAs where the rate of deaths/mi² was more than 125% the citywide rate. For each target area, labels include two-year number [and area-normalized rate] of AOD deaths and the Chicago community areas (and ZIP codes) comprising the target area.

FAR NORTH SIDE
106 crimes [20.3/mi²]
01 Rogers Park (60626)
77 Edgewater (60660)
03 Uptown (60640)

DOWNTOWN
418 crimes [95.4/mi²]
08 Near North Side (60610, 60654)
32 Loop (60661, 60606, 60601,
   60602, 60603, 60604, 60605)
33 Near South Side (60605)

WEST SIDE
2,920 crimes [147.9/mi²]
23 Humboldt Park (60651)
25 Austin (60644)
26 West Garfield Park (60624)
27 East Garfield Park (60612)
33 Near South Side (60605)
29 North Lawndale (60623)
30 South Lawndale (60623)

SOUTH SIDE
733 crimes [27.6/mi²]
36 Oakland (60653)
38 Grand Boulevard (60653)
39 Kenwood (60615)
41 Hyde Park (60615)
67 West Englewood (60636)
68 Englewood (60621)
40 Washington Park (60637)
42 Woodlawn (60637)
43 South Shore (60659)
44 Chatham (60619)
47 Burnside (60619)
69 Greater Grand
   Crossing (60619)

AOD-related crimes per square mile
- 0 - 6.15
- 6.25 - 12.4
- 12.5 - 31.15
- 31.25 - 62.4
- 62.5 - 124.9
- ≥125

Alcohol and other drug (AOD)-related crime reports for the one-year period 10/23/2023 – 10/20/2024, by 2021 ZIP code tabulation areas (ZCTA). Data from Chicago Police Department, available at https://data.cityofchicago.org/Public-Safety/Crimes-One-year-prior-to-present/x2n5-8w5q/about_data. AOD-related crime reports were defined as those with a primary description of "narcotics," "other narcotic violation," or "liquor law violation." Target areas (gold outlines) include ZCTAs where the rate of deaths/mi² was more than 125% the citywide rate. For each target area, labels include one-year number [and rate per mi²] of AOD crime reports and the Chicago community areas (and ZIP codes) comprising the target area.

RMC-SS Specific Aims

Aim 1 Effectiveness: Evaluate the **equivalence** of RMC provided by community organizations and research teams in terms of:

1a) days of **any SUD treatment** (primary outcome)
1b) structural equation modeling (SEM) invariance of effects on:

- o **SUD intervention dose** (medication, other SUD treatment, mutual-help group, overdose prevention)
- o **public health outcomes** (substance use, SUD symptoms, overdose, risk behaviors)
- o **public safety outcomes** (types of drug-related, property and interpersonal/violent crime and days of illegal activity).

Aim 2 Implementation: Assess the impact of **multi-component facilitation-based strategies** in supporting RMC integration across Pre-implementation, Implementation, and Sustainment phases on:

2a) how **pre-implementation** and **implementation-phase** strategies impacted the final site intervention **fidelity score** (primary outcome)

2b) impact of pre-implementation- and implementation-phase duration and proportion of activities completed on RMC Adopter's **time to competency**

2c) organizational-level determinants of achieving and maintaining RMC **sustainment**.

Our Team

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Samayah Boynton, MS

Roesheen McGilvery, BSc

Graduate RAs

Sneha Amaresh, MPH Candidate

Roland Berg, MPH Candidate

Statistician

Tim Moran, PhD

Setting

- Metro Atlanta

- High throughput, short LOS jails

- ~5,000 population, >50k/year

- 75% SUD prevalence

- Strong partnerships with Grady Health System, Southside Medical Center (FQHC)

- Existing peer coach + telehealth infrastructure from hospital-based R01

Approach + Intervention

|	Year 1	Year 2	Year 3	Year 4	Year 5
Hire and train study staff					
Complete regulatory tasks					
Finalize protocols, databases					
Qualitative Interviews					
Implementation Quantitative Data Collection					
RCT Enrollment					
RCT Data Collection					
RCT Analysis					
Cost Analysis					
Manuscript Submission					
Academic Conference Presentation					

- Telehealth-based peer coaches. 3 Jails, 5 sites.

- Hybrid Type 2 effectiveness-implementation design
  - Implementation guiding framework: (E)PIS, outcomes via Proctor et al framework
    - Interviews and surveys with staff, leadership, community partners
    - Establish local change teams, streamlined communications
    - Fidelity checklists, post-session assessments of perceived therapeutic alliance
  - Effectiveness: Stepped wedge cluster-randomized trial
    - Enroll in jail. Officers paid to escort participants to attorney-client rooms
    - Eligible for contact and ongoing linkage post-release
    - Follow up: 1 year
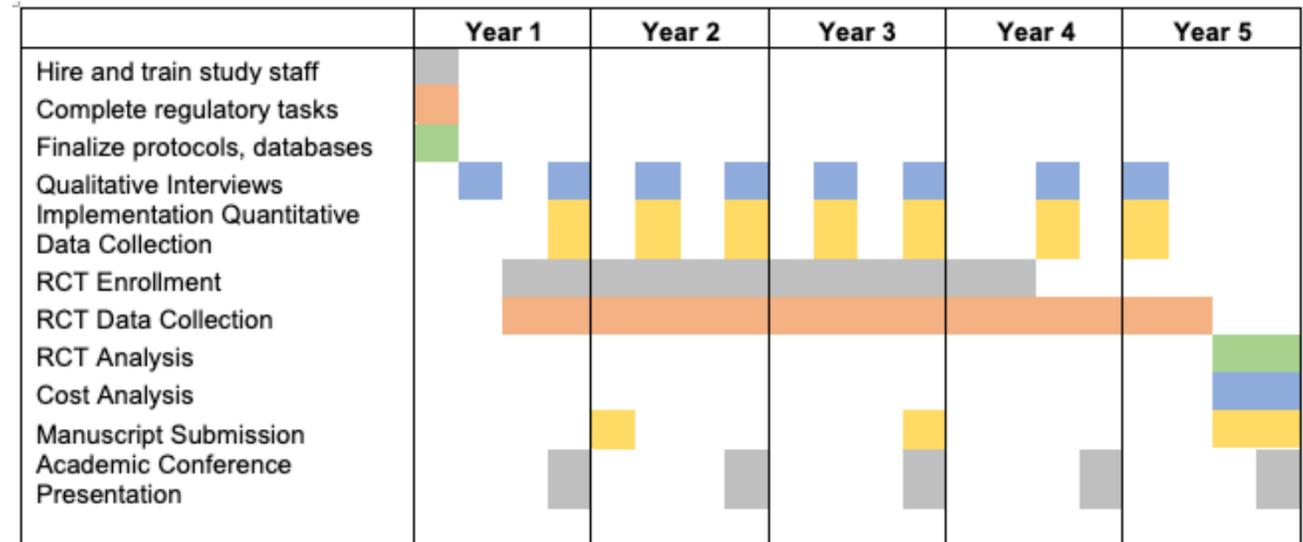
Aims + Outcomes

- Aim 1: Implement and rigorously evaluate a PRC program tailored to meet the needs of justice involved patients living with SUD.
  - Rapid qualitative analysis of interview transcripts
  - Serial surveys on readiness for change, attitudes towards MOUD, implementation

- Aim 2. Determine the effectiveness of PRCs in the jail setting.
  - Target enrollment ~550
  - Primary outcome: Engagement with at least one recovery resource at 30 and 90 days
  - Secondary outcomes: Many. Focus on JCOIN core measures. Data collection out to 12 months.

- Aim 3: Conduct a cost effectiveness analysis of the jail PRC program.
  - To be finalized in collaboration with ERRC
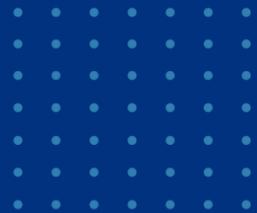
Thank You!

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SUPPORTING TREATMENT ACCESS AND RECOVERY IN RE-ENTRY (STAR-R) - 1R01DA064494-01

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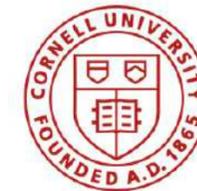Co-Investigator

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Study Design

POPULATION	Comorbid SUD + MH at re-entry from jail
STUDY DESIGN	Hybrid Type 1 RCT
Intervention	MISSION (multicomponent integrated treatment for comorbid SUD+MH+CJ delivered by case manager and peer specialist team), control condition=peer linkage support
GEOGRAPHY	Central and Western MA
SAMPLE SIZE	RCT=240 patients Aim 4 qualitative work (n=20 participants, n=12 staff)
Recruitment	RAs will recruit a sample of n=240/120 per condition over 36 months
DATA TIME POINTS	BL, 3 M, 6, 9, 12 (9 and 12 post treatment)
Measures	ASI, TSR, fidelity tracking, OdRI/overdose surveillance data, SCID-5, BASIS-24, TLFB, CIM, LSI-R,

Study Aims

Aim 1 (RCT)	Aim 2 (Mechanism Analysis)	Aim 3 (Economic Evaluation)	Aim 4 (Qualitative Interviews)
Compared to PLS, those receiving MISSION-CJ are hypothesized to show: **(1a)** Greater engagement in treatment **(1b)** Reduced substance use, reduced overdose risk, reduced overdoses, and reduced mental health symptoms; **(1c)** Less CL recidivism	Mediators (i) Recidivism risk; (ii) Increased affiliations with prosocial peers; (iii) Reduced affiliations with antisocial peers; and (iv) Increased community integration; Moderators 1. Demographics 2. Medication, and COD severity.	(i) Estimate the full implementation (start-up and ongoing) costs associated with MISSION-CJ and PLS, and (ii) Evaluate the cost-effectiveness of MISSION-CJ compared to PLS, from the healthcare system and societal perspectives.	Guided by the Consolidated Framework for Implementation Research, we will examine facilitators and barriers of MISSION-CJ implementation with participants (n=30) and staff (N=12)

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