JCOIN
Justice Community Overdose Innovation Network

Opioid Use Disorder Best Practices for Corrections

10 Essential Evidence-Based Practices for Jails and Prisons

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Introduction

Individuals with opioid use disorder (OUD) come into frequent contact with the criminal justice system and are at an increased risk of fatal overdose upon their release from incarceration (Winkelman et al., 2018; Binswanger et al., 2007). Consequently, jails and other correctional institutions can play a pivotal role in screening individuals for OUD, providing medications for OUD (MOUD), educating individuals on overdose prevention and treatment options, and facilitating linkages to care.

In response to this urgent need, researchers at Chestnut Health Systems sought to understand the prevalence of OUD best practices in U.S. jails, as well as the jails' resource and training needs. The study targeted jails in the counties most heavily impacted by the opioid epidemic. These counties accounted for 66% of national opioid-related overdose deaths. Researchers completed structured interviews with representatives from 185 jails in those counties, or about 74% of the targeted jails, between December 2019 and February 2021. This study, titled "*Availability of best practices for opioid use disorder in jails and related training and resource needs: findings from a national interview study of jails in heavily impacted counties in the U.S.*", was conducted by Dr. Christy Scott, Dr. Christine Grella, Dr. Michael Dennis, Dr. John Carnevale, and Robin LaVallee (2022) and published in Health and Justice.

While previous studies have examined the availability of MOUD in jails as well as the barriers to its delivery, much less is known about incorporating best practices for addressing OUD in criminal justice settings, and the training, resources, and technical assistance needed to provide them.

The study team identified 10 OUD best practices that were consistently referenced in treatment and practice guidelines recommended by a variety of federal agencies and national organizations, as well as scientific literature. This report offers an explanation of these best practices along with practical tools and information that may be used by corrections facilities to improve their response to OUD. In addition, findings from the Scott et al. (2022) study on the availability of these services in U.S. jails are referenced throughout the report.

10 Core Best Practices

1. Screening for OUD
2. Clinical assessment by a qualified treatment provider
3. Medically managed withdrawal
4. MOUD administration
5. Services for pregnant women
6. Counseling and wrap-around services
7. Collaborative relations with community providers of OUD treatment
8. Assistance with applications for state Medicaid/insurance coverage
9. Reentry services
10. Overdose prevention

BEST PRACTICES 1 & 2

Screening for OUD and Clinical Assessments by a Qualified Treatment Provider

Screening and assessment for individuals with substance use disorders (SUD) upon admission to jail or prison is a critical step in identifying their specific service needs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2005).

A screening involves asking questions carefully designed to determine whether an individual has or is at risk of developing an SUD and whether a full clinical assessment is needed to diagnose their SUD and develop a treatment plan. Many screening instruments require little or no special training to administer.

A comprehensive assessment is conducted by a trained medical professional to evaluate the severity of an individual's SUD and co-occurring physical or mental health disorders. The assessment provides a clinical diagnosis and recommendations for the level of treatment needed and the appropriate setting to receive care (e.g., intensive outpatient, partial hospitalization, residential, etc.).

Many SUD screening and assessment tools are publicly available and can be adopted into admission and discharge protocols. Using validated tools to screen and assess for SUD can reduce bias and stigma and effectively identify individuals who need a clinical assessment.

Study Findings

- 95% of jails utilized a screening protocol for OUD
- 87% of screenings were done by clinical staff (physician, nurse, social worker, counselor)
- 71% of jails provided clinical assessments conducted by a qualified treatment provider
- 22% of jails utilized a standardized screening tool

Validated Screening and Assessment Tools

Tool	Substance Type		Patient Age		Administration	
	Alcohol	Drugs	Adults	Adolescents	Self	Clinician
Screening Tools						
Screener for Alcohol Tobacco and Other Drugs (BSTAD) Brief	X	X		X	X	X
Opioid Risk Tool – OUD (ORT-OUD)		X	X		X	
Rapid Opioid Dependence Screen (RODS)		X	X			X
Screening to Brief Intervention (S2BI)	X	X		X	X	X
TCU Drug Screen 5	X	X	X			X
Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS)	X	X	X		X	X
Assessment Tools						
Addiction Severity Index (ASI)	X	X	X		X	
Alcohol Use Disorders Identification Test (AUDIT)	X		X		X	X
CAGE Adapted to Include Drugs (CAGE-AID)	X	X	X		X	
Clinical Opiate Withdrawal Scale (COWS)		X	X	X		X
CRAFFT	X	X		X	X	X
Current Opioid Misuse Measure (COMM)		X	X		X	
Drug Abuse Screening Test (DAST-10)		X	X		X	X
Drug Abuse Screening Test (DAST-20: Adolescent)		X		X	X	X
GAIN Alcohol Other Drug (AOD)	X	X	X			X
Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS)	X	X	X		X	X

BEST PRACTICES 3

Medically Managed Withdrawal

Withdrawal is a combination of physical and mental health symptoms that occur when individuals with an SUD suddenly stop or reduce substance use.

The severity of withdrawal symptoms can vary depending on the type of substance(s), amount, and duration of use. If left unmanaged, withdrawal can pose serious health concerns, such as anxiety, depression, and insomnia, or more severe health consequences like seizures, hallucinations, and even death (American Society of Addiction Medicine [ASAM], 2020). Swift identification and management of withdrawal symptoms are critical in preventing adverse health complications.

Study Findings

- 96% of jails indicated they have a physician-approved protocol to address opioid withdrawal
- 81% of jails used an FDA-approved medication for withdrawal management

Withdrawal management is designed to assess, monitor, and address symptoms in a way that reduces discomfort and pain and prevents the risk of serious injury. The symptoms of withdrawal can often be medically managed by medications that are administered by a clinician. Withdrawal management alone does not constitute treatment, but is part of the continuum of care for SUDs and is often the first step in initiating treatment. Continuation of formal treatment is essential following the completion of withdrawal management services to avert the high risk of relapse to use.

Opioid withdrawal can include flu-like symptoms such as nausea and vomiting, cramps, sweats, diarrhea, and fever. Other symptoms include agitation, depressed mood, and insomnia. Unlike alcohol and benzodiazepine withdrawal, opioid withdrawal is not typically life-threatening. One of the most effective ways to treat opioid withdrawal is to prescribe long-acting oral MOUD, such as methadone and buprenorphine, which relieve withdrawal symptoms and reduce cravings (Schuckit, 2016). Other non-MOUD medicines that are used to address withdrawal symptoms include Clonidine, Lofexidine, Tizanidine, Loperamide, benzodiazepines, and anti-inflammatories (Urits et al., 2020).

BEST PRACTICES 4

MOUD Administration

MOUD are considered the gold standard of treatment and help stabilize brain chemistry, reduce or block the opioid's euphoric effects, relieve cravings, and help patients engage in other aspects of treatment (National Institute on Drug Abuse [NIDA], 2021).

These medications serve as the foundation upon which other treatments, such as behavioral therapies and wrap-around services, can be added. They are also effective in treating withdrawal, decreasing cravings, stabilizing the level of physical dependence, and preventing the risk of non-fatal and fatal overdose (NIDA, 2018).

MOUD also improves social functioning, including the capacity to engage in work and family relationships, retention of and adherence to treatment, and overall quality of life (National Academies of Sciences, Engineering, and Medicine [National Academies], 2019; NIDA, 2021).

There is significant evidence that providing MOUD is essential to reentry and most effective when initiated while individuals are incarcerated.

Study Findings

- 92% of jails provided at least one FDA-approved medication. Of those:
  - 73% provided buprenorphine
  - 73% provided naltrexone
  - 71% provided methadone
- 43% of jails provided all three FDA-approved medications
- 20% of jails provided MOUD to anyone who was assessed with OUD

The Research

- Research shows that initiating MOUD prior to release and continuing during reentry cuts the risk of overdose death by 75% (Degenhardt et al., 2014).
- Individuals who continued MOUD during incarceration were twice as likely to continue MOUD within the first month of release compared to individuals who were in the forced-withdrawal group (Rich et al., 2015).
- Providing MOUD prior to release from jail reduces recidivism by 32% (Evans et al., 2022).

Types of Medications for Opioid Use Disorder

There are three FDA-approved MOUD: methadone, buprenorphine, and naltrexone.

- **Methadone** is a long-acting agonist medication that binds to the same opioid receptors in the brain and body as other opioids. It blocks the effect of opioids, reduces cravings, and prevents withdrawal. Methadone is dispensed only through federally regulated opioid treatment programs (OTP). Methadone is taken daily and is available in tablet and liquid forms. Brand names include Diskets®, Dolophine®, Methadone Hydrochloride Intensol™, and Methadose™.

- **Buprenorphine** is a partial agonist medication that binds to the same receptors as methadone and other opioids, but produces a less intense effect. It can be dispensed by an OTP or prescribed by physicians, nurse practitioners, or physician assistants in an office-based opioid treatment (OBOT) program. Buprenorphine is available in two forms: by itself and in combination with naloxone (an overdose reversal medication); and can be administered through oral tablets, dissolvable films, extended-release injectable, or a long-acting implant. Brand names include Subutex®, Suboxone®, Zubsolv®, Bunavail™, Sublocade® (extended-release injectable), and Probuphine® (long-acting implant).

- **Naltrexone** is an antagonist medication, which prevents opioids from binding to opioid receptors in the brain. Patients do not develop a dependence on naltrexone, and it cannot be misused as it does not activate the opioid receptors. Physicians, nurse practitioners, and physician assistants can prescribe and administer naltrexone without an additional license. Naltrexone does not reduce withdrawal symptoms and should only be administered after at least seven days of abstinence from short-acting opioids and 10-14 days from long-acting opioids (SAMHSA, 2023). An extended-release monthly injectable naltrexone formulation is available under the brand name Vivitrol®. Other brand names include ReVia® and Depade®.

BEST PRACTICES 5

Services for Pregnant Women

SUDs present substantial risks during and after pregnancy. Pregnant women with SUD are up to six times more likely than those without SUD to have maternal complications (National Academies, 2019). Approximately 58,000 pregnant women are incarcerated every year, and an estimated 14% of pregnant women admitted to jail have OUD (Wang, 2021; Sufrin et al., 2020).

Research shows that there is a lack of comprehensive prenatal and birthing care services and policies to support pregnant and postpartum women (PPW) who are incarcerated (Daniel, 2019). Incarceration can expose pregnant people to heightened risks that impact the well-being of the individual and their infants, such as high levels of stress, violence, poor nutrition, and substandard health care (Wang, 2021; Daniel, 2019; Wolfrey, 2021).

The overwhelming majority of children born to incarcerated mothers are separated immediately after birth and placed with relatives or into foster care. This separation disrupts opportunities for mothers and children to develop emotional bonds, with the likely result that the children will have emotional and behavioral problems (Martin, 2017).

Study Findings

(limited to 174 jails)

- 85% of jails that house women have some type of MOUD available for pregnant women
- 72% of jails made methadone available to pregnant women
- 66% of jails made buprenorphine available to pregnant women
- 53% of jails had both methadone and buprenorphine available for pregnant women

For PPW who are admitted to jail, it is critical to screen and assess for SUD and provide rapid referrals to evidence-based treatments, such as MOUD. Both methadone and buprenorphine are recommended for treating OUD during pregnancy and are effective in improving outcomes for the mothers and their newborns (National Academies, 2019). It is also critical to provide comprehensive support services and training programs to help mothers cope with parenting challenges that arise while in treatment and to offer children the healthiest possible foundations while preventing them from adverse risks associated with parental SUD.

The Research

- Methadone and buprenorphine are recommended for treating OUD during pregnancy and improving outcomes for women and their newborns (National Academies, 2019).

- Research shows that a longer duration of MOUD during pregnancy can decrease the risk of preterm birth and lower birth weight (Krans et al., 2021).

- MOUD, in combination with behavioral therapies, has shown to reduce opioid use, prevent withdrawal symptoms, and decrease the risk of overdose, and is associated with overall improved maternal and infant outcomes (SAMHSA, 2018).

BEST PRACTICES 6

Counseling and Wrap-around Services

In addition to MOUD, evidence-based treatment approaches for criminal-legal system-involved individuals with SUDs include a variety of individualized wrap-around services, such as behavioral therapies, treatment of co-occurring disorders, self-help groups like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), peer recovery support services, and counseling (NIDA, 2018; Oser et al., 2009).

Comprehensive wrap-around services help ensure individuals receive the care that is most appropriate to their needs during transitions between different levels of supervision and treatment, whether incarcerated or in the community (SAMHSA, 2000). Wrap-around services have been shown to improve engagement in treatment, health outcomes, and family reunification, and to reduce crime and recidivism (Shaffer et al., 2021; Oser et al., 2009).

Study Findings

- 93% of jails provided some type of counseling or wrap-around services along with MOUD
- 85% of jails provided other substance use services/treatment as part of MOUD treatment
- 85% of jails provided self-help or other recovery support services
- 59% of jails provided services for co-occurring disorders

Behavioral Therapies

Behavioral therapies help people engage in treatment, modify cognitive patterns and behaviors related to substance use, and improve life skills to handle stress and potential triggers of recurrence of use (NIDA, 2018). These therapies are a key component of addiction treatments. Evidence-based behavioral therapies include cognitive behavioral therapy, contingency management, 12-step facilitation, motivational enhancement therapy, individual and group counseling, and therapeutic communities.

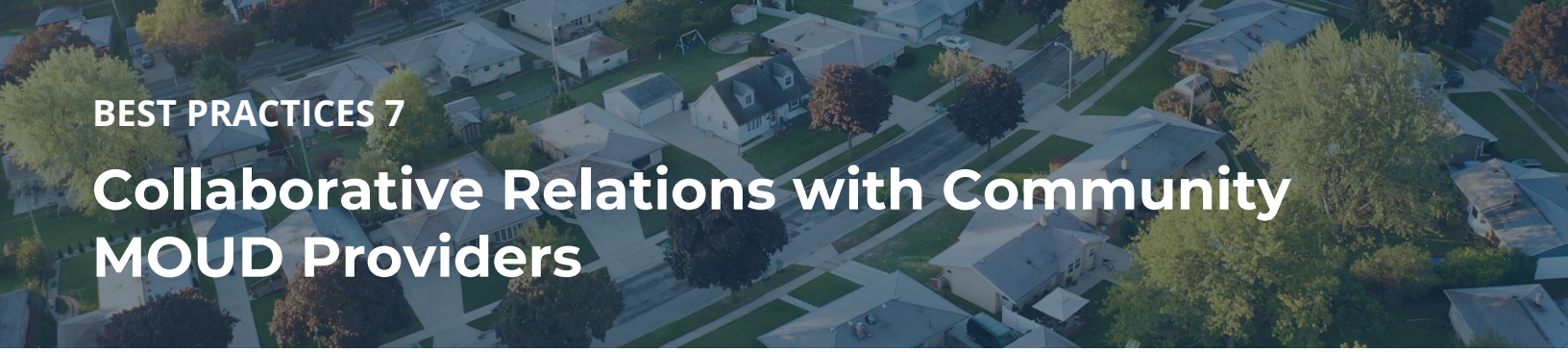
- **Cognitive behavioral therapy (CBT)** helps patients develop effective coping strategies to identify and change destructive thought patterns that negatively affect behavior and emotions. The maladaptive thought patterns CBT addresses often include automatic thoughts, cognitive distortions, and underlying core beliefs. The ultimate goal of CBT is to address these negative thinking patterns and the subsequent behaviors. Research shows that CBT is effective in treating various SUDs, including alcohol, opioids, marijuana, cocaine, methamphetamine, and nicotine (McHugh et al., 2010; NIDA, 2018), and produces better outcomes for patients with OUD when combined with MOUD (Morre et al., 2016) and other behavioral therapies (Zamboni et al., 2021).

- **Contingency management (CM)** involves delivering positive reinforcement to support key behavioral changes, such as abstinence, counseling attendance, and medication compliance. Incentives can be tangible (e.g., gift cards, vouchers, or money) or intangible in the form of social recognition (e.g., verbal or written praise). CM operates on the principle that such incentives stimulate the parts of the brain damaged by addiction while replacing the reward previously provided by alcohol and other substances with a new reward for treatment adherence. Research on the effectiveness of CM dates back more than 30 years. It consistently shows that CM improves patient outcomes, including reducing substance use and increasing continuous abstinence, engagement and retention in treatment, medication adherence, and attendance in other behavioral therapies (Higgins & Petry, 1999; Bolívar et al., 2021; Prendergast et al., 2006). A review of 74 studies involving 10,444 participants receiving MOUD found that 77% of those who also received CM as part of their treatment regimen reported significantly higher medication adherence and had better outcomes than the average control group participant (Bolívar et al., 2021). CM is highly effective in treating SUD, particularly for stimulant use disorder (e.g., methamphetamine, cocaine), which has no FDA-approved medication treatments (Petry et al., 2017; Farrell et al., 2019). Another 2018 meta-analysis reviewed 50 clinical trials with 6,943 participants to compare outcomes of 12 different behavioral interventions against treatment as usual for cocaine and/or methamphetamine addiction. This analysis found that CM combined with a community reinforcement approach (CRA) was the most effective treatment both in the short and long term (De Crescenzo et al., 2018).

- **12-step facilitation therapy** involves helping individuals with SUD engage in 12-step mutual support groups such as AA and NA and participate in a community of peers, while promoting abstinence. The key elements of 12-step facilitation include accepting and recognizing that addiction is a disease and abstinence is the only solution, surrendering to a higher power, accepting the community and support structure of other individuals in the program, and being active and engaged in the program's activities (NIDA, 2018; Donovan et al., 2013). Research shows individuals who participate more frequently in mutual support groups are more likely to sustain abstinence for prolonged periods, demonstrate higher levels of self-efficacy, and have higher social functioning (Moos & Moos, 2006).

- **Motivational enhancement therapy (MET)** focuses on increasing individuals' motivation and commitment to engaging in SUD treatment and stopping substance use. MET combines assessments, goal setting, and motivational interviewing to help build a patient's internal plan for change. The therapy consists of an initial battery assessment session that includes a series of psychological tests and lasts seven to eight hours, followed by two to four treatment sessions that focus on moving the patient toward a plan for change. Research shows that MET increases treatment engagement and adherence, and is most effective in combination with other behavioral therapies (NIDA, 2018).

- **Therapeutic communities (TC)** are traditionally in residential treatment settings and focus on changing an individual's overall lifestyle by promoting abstinence, prosocial engagement, and personal and social responsibility. TCs emphasize active participation in group living and activities within a community made up of peers, treatment staff, and individuals in recovery (NIDA, 2015). The goals of TCs are to help patients sustain recovery and to prepare them for employment, school, or training following treatment. Multiple studies have found that there is a correlation between the length of treatment in TCs and sustained recovery (NIDA, 2015). Findings also suggest that incorporating TCs in correctional facilities and facilitating participation in community-based TCs during reentry are effective in preventing relapse and increasing social connections (NIDA, 2015).



BEST PRACTICES 7

Collaborative Relations with Community MOUD Providers

Connecting incarcerated individuals with SUDs to care in the community is paramount to achieving and sustaining recovery. These connections prevent disruptions in accessing needed services as an individual transitions back into the community.

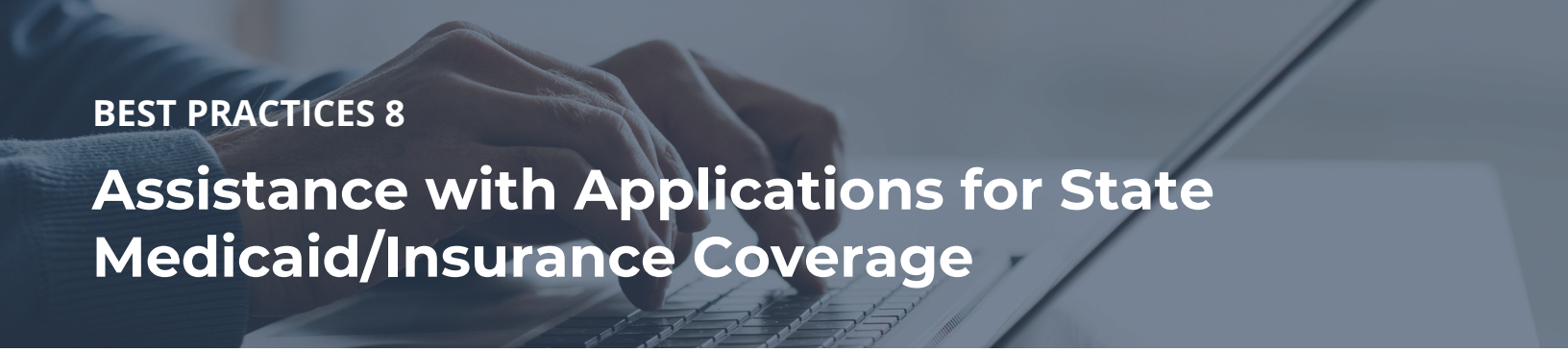
Jail program staff can connect individuals to community-based treatment services, set up physician and other treatment appointments, and ensure a seamless transition to needed SUD services.

Linking individuals to a broad spectrum of services can begin before release by facilitating in-reach approaches from community-based behavioral health treatment providers to ensure continuity of care in the community following release. In-reach program staff can build rapport with people leaving incarceration and help ensure that treatment continues seamlessly as they move from the facility to the community. Staff can also make sure that individuals have an adequate supply of medication upon release to bridge any gap in scheduled treatment appointments, and are enrolled in health care.

Peer support specialists (also known as peer navigators or mentors) can play a critical role for people with SUDs by connecting them to community-based services, transporting them to appointments, helping build social support and relationships within the community, and serving as role models for recovery. Research on peer support specialists within reentry programs has shown promising results in reducing recidivism, increasing treatment engagement, and enhancing the utilization of community-based health and social services such as housing, employment, and support groups (Lee, 2021; Russ et al., 2021).

Study Findings

- 72% of jails engaged in some collaborative activities with community MOUD providers or parole/probation officers to facilitate continuity of care. Of those:
  - 68% scheduled appointments with MOUD providers in the community
  - 66% facilitated the exchange of key information with MOUD providers in the community
  - 60% provided assistance completing intake paperwork for MOUD providers in the community
  - 50% coordinated MOUD services with parole or probation officers



BEST PRACTICES 8

Assistance with Applications for State Medicaid/Insurance Coverage

Individuals returning to the community following incarceration face challenges in obtaining health care coverage, which impacts their ability to afford and access medical care and is one of the core social determinants of health (Russ et al., 2021; Office of the Assistant Secretary for Planning and Evaluation [ASPE], 2023).

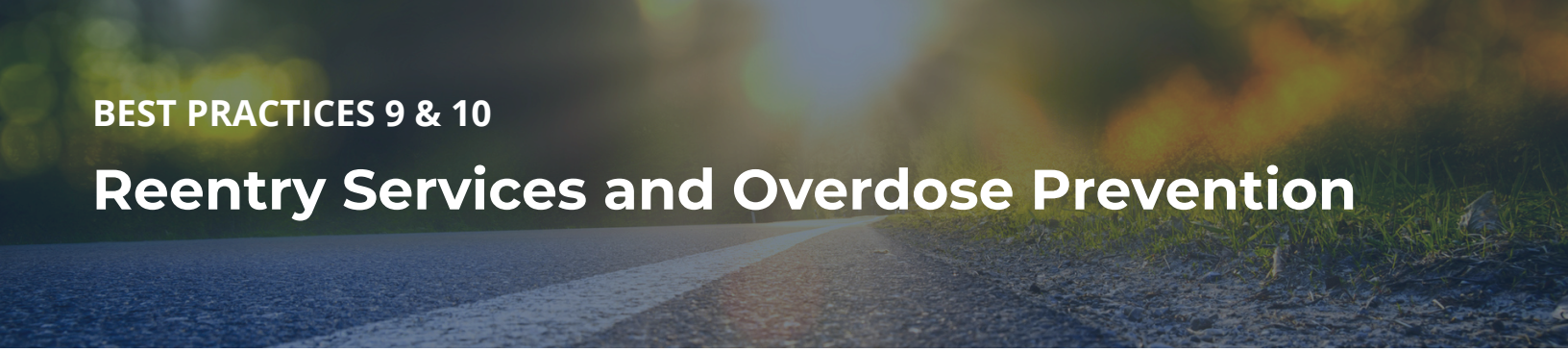
For individuals with SUD, this gap in health care coverage can increase the risk of rearrest, re-incarceration, relapse, and death (Russ et al., 2021; Gordon et al., 2014). Access to Medicaid or private insurance coverage is essential for many individuals to receive addiction treatment, including MOUD and support services, and has been shown to increase treatment utilization among criminal-legal system-involved individuals (Khatri et al., 2021).

Federal law requires Medicaid benefits to be suspended or terminated while an individual is incarcerated in jail or prison. The way this is done varies by state. In "suspension states," coverage may be suspended upon incarceration and reactivated during release, or it may be maintained, but with limited allowable services. In states that terminate Medicaid entirely, individuals must reapply once they are released, which can lead to extended lapses in healthcare coverage and create additional barriers to care during reentry, such as access to treatment medications.

Currently, 42 states, including the District of Columbia, suspend or maintain Medicaid benefits in jail, and 43 states, including the District of Columbia, suspend or maintain Medicaid in prisons (ASPE, 2023). Several states suspend Medicaid for a specific time period, such as two to three years, and other states allow enrollment to continue for the first 60 days of incarceration before being suspended; New York is the only state that indefinitely suspends Medicaid (de la Guéronnière & Reid, 2022).

Study Findings

- 73% of jails provided some assistance with applications for healthcare coverage. Of those:
  - 61% of jail staff assisted with reactivating or applying for state Medicaid or other types of insurance
  - 58% of jail staff helped complete paperwork/application for Medicaid prior to release
  - 36% of jails provided access to the technology necessary to submit Medicaid applications



BEST PRACTICES 9 & 10

Reentry Services and Overdose Prevention

During the transition from prison or jail to the community, individuals with SUD are at a significantly higher risk of relapse, rearrest, reincarceration, overdose, and death.

Successful reentry includes an individualized release plan that accounts for the provision of basic needs, including transportation and employment opportunities, a customized relapse prevention plan, linkage to care in the community, and an adequate supply of medications.

Core Components of an Individualized Release Plan

1. Basic needs prior to release.
Ensuring basic needs are met for individuals leaving incarceration is a vital part of a comprehensive reentry plan. Key needs include access to health care, housing, food, clothing, transportation, employment opportunities, and personal identification, which are the building blocks of a successful transition.

2. Relapse prevention plan.
A relapse prevention plan is a CBT tool that identifies individualized recovery goals, potential triggers and early warning signs of relapse and indicates coping strategies and action steps to take if an individual is close to relapsing or has relapsed.

Study Findings

- 75% of jails provided some reentry services at discharge
- 47% of jails provided transportation
- 39% of jails provided or arranged transportation to MOUD providers in the community
- 50% of jails connected individuals to peer support specialists
- 21% of jails provided other services to facilitate linkage to MOUD
- 22% of jails provided a bridge supply of multiple doses/days of MOUD

Action steps may include: immediately meeting with the individual's treatment provider to reassess their treatment regimen and reinforce recovery goals, connecting with their lead case planner, encouraging engagement with support networks, and calling medical or mental health professionals should additional services be needed.

3. Connection to community-based treatment services.
Program staff can facilitate the connection of individuals to community-based treatment and recovery support services to ensure a smooth transition to health and treatment services. Recovery services, which include working with peer support specialists, can support transition and help build positive social support.

4. Adequate supply of medication upon release.
Health authorities recommend that individuals receive at least a four-week supply of medications upon release from prison and jail (SAMHSA, 2019).

5. Naloxone access.
Another key step in release planning for individuals with OUD is the provision of naloxone to prevent overdose, which also involves training program staff and justice-involved individuals on what it is and how to use it. For more than 40 years, naloxone, a safe and effective medication, has been used to reverse the effects of opioid overdose and save lives. Program staff can provide take-home naloxone at release and connect individuals with community naloxone distribution providers. Educating and training incarcerated individuals on naloxone and how to use it has also been shown to be an effective practice.

Study Findings

- 18% of jails provided written prescriptions for MOUD
- 30% of jails provided individuals with Naloxone kits at release
- 33% of jails provided education and training to incarcerated individuals on how to use naloxone
- 93% of jails provided staff training on how to use naloxone
- 96% of jails provided staff with naloxone kits to reverse overdose in jail

The Research

- Multiple studies have found that corrections-initiated naloxone distribution and education programs are effective in reducing overdose death during reentry (Carroll et al., 2018; Anthony-North et al., 2018).
- One study found that one in three people who participated in a jail-based naloxone distribution and education program reported reversing an overdose, and 44% received naloxone refills after reentry (Wenger et al., 2019).
- Another study saw a 50% reduction in overdose deaths after four weeks following the implementation of naloxone distribution and education programs (The Lancet, 2019).

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Scott, C. K., Grella, C. E., Dennis, M. L., Carnevale, J., & LaVallee, R. (2022). Availability of best practices for opioid use disorder in jails and related training and resource needs: findings from a national interview study of jails in heavily impacted counties in the U.S. *Health & Justice*, *10*(1), 36. https://doi.org/10.1186/s40352-022-00197-3

About JCOIN

The Justice Community Overdose Innovation Network (JCOIN) is funded by the National Institute on Drug Abuse (NIDA) through the Helping to End Addiction Long-term® Initiative, or NIH HEAL Initiative®, an aggressive, trans-NIH effort to speed scientific solutions to the national opioid health crisis. Launched in April 2018, the HEAL Initiative improves prevention and treatment strategies for opioid misuse and addiction and enhances pain management.

JCOIN is a groundbreaking initiative designed to advance scientific knowledge on effective policies, practices, and interventions and expand their use in daily practice within health and justice settings. NIDA awarded JCOIN grants to 13 clinical research centers (“Research Hubs”) and two large resource centers: the Coordination and Translation Center (CTC) and the Methodology and Advanced Analytics Resource Center (MAARC). Together, these centers will engage justice settings and treatment providers in research studies to address the opioid crisis and disseminate findings to stakeholders across the country.

Learn more at www.jcoinctc.org.

About Chestnut Health Systems

Chestnut offers a comprehensive scope of behavioral health and human services in Illinois and Missouri. Our professional and experienced staff is committed to providing high-quality care and services to the communities we serve. From residential and outpatient drug and alcohol addiction treatment facilities to primary care medical homes to a research institute, Chestnut continuously works to achieve its mission to make a difference and improve quality of life through excellence in service.

Chestnut is comprised of the following four core service areas:

- Substance use treatment and prevention
- Mental health treatment and housing for persons with mental illness
- Applied behavioral research, training, and publications
- Primary care treatment and preventative services

Learn more at www.chestnut.org.

About APF

The Addiction Policy Forum (APF) is a nationwide nonprofit organization dedicated to eliminating addiction as a major health problem. Our national headquarters are located in Bethesda, MD, with resources and services in every state. Our vision is to eliminate addiction as a major health problem.

Founded in 2015, our strategic priorities include helping patients and families in crisis, ending the stigma around addiction, expanding prevention and early intervention, increasing the uptake of evidence-based practice, and advancing patient-led research.

Learn more at www.addictionpolicy.org.

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