

Opioid Use Disorder Education and Treatment ECHO Series

Session 17 – Community Impact: Addiction and Collaboration with Child Services, Social Agencies, and Corrections

August 2, 2022

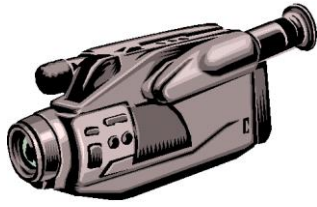
Heather Bell, MD and Kurt DeVine, MD



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STRONG MEDICINE FOR MINNESOTA

Announcements





YES, THERE'S FREE CME

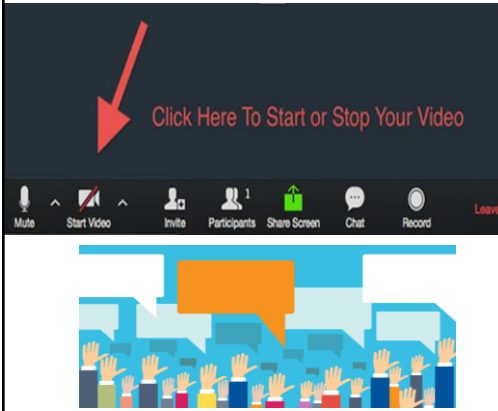
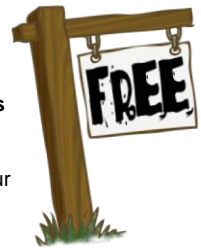
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Minnesota Medical Association (MMA) through the joint providership of Stratis Health and the Minnesota Academy of Family Physicians. **Stratis Health is accredited by the MMA to provide continuing medical education for physicians.**

Stratis Health designates this educational activity for a maximum of **1 AMA PRA Category 1 Credits™**.

Physicians should claim credit commensurate with the extent of their participation in the activity.

Continuing Education Credits and Contact Hours for Other Health Professionals

The OUD Education and Treatment ECHO Series may meet continuing education requirements for your focus. It is the responsibility of the individual to determine if this activity fulfills that requirement.



2



2

Upcoming ECHO Sessions

Tuesday

- **Tuesday, August 16:**
Motivational Interviewing (MI)
Lapse/Relapse
- **Tuesday, September 6:**
Long-Term Management and Surveillance
- **Tuesday, September 20:**
Wrap Up – The Barriers, including:
 - Administration
 - Time
 - Schedule
 - Stigma
 - More!
 - And some fun review too!

Wednesday

- **Wednesday, Aug. 3, 2022**
Damir S. Utrzan, Ph.D., LMFT, DAAETS,
Hazelden Betty Ford Foundation
- **Wednesday, Aug. 10, 2022**
Troy Weber-Brown, MS, LMFT, Sexual and
Gender Medicine, CentraCare
- **Wednesday, Aug. 17, 2022**
Dr Jon Cole, Hennepin Healthcare, ED Physician
and Toxicologist
- **Wednesday, Aug. 24, 2022 – No ECHO**
- **Wednesday, Aug. 31, 2022**
Dr. Sarah Spencer, Alaska- Low-Threshold Bup
in OUD and Co-Occurring Meth Use Disorder

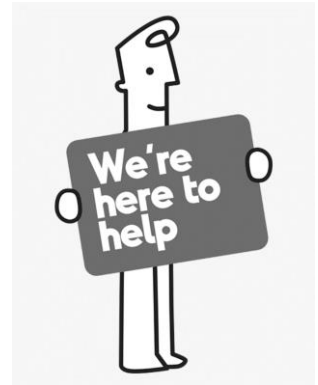
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3

TECHNICAL ASSISTANCE

- **We are ALWAYS here for you!**
 - Program implementation
 - Inductions
 - Difficult cases
 - Trouble-shooting
 - Anything!
- **Call us anytime:**
 - Erin Foss, RN, Program Manager/Nurse Specialist
efoss@stratishealth.org, Cell: 320-282-6553
 - Heather Bell: 320-630-5607
 - Kurt DeVine: 320-630-2507

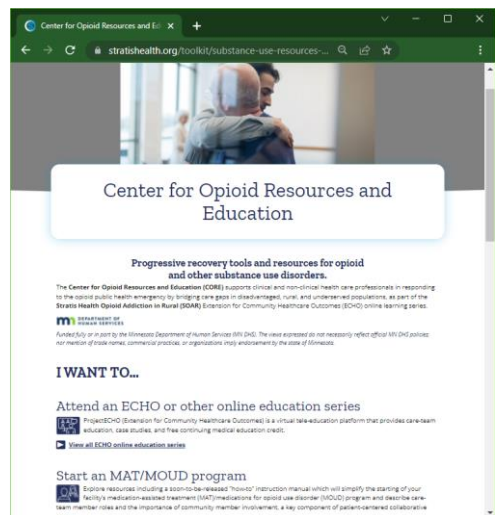


NEW! Center for Opioid Resources and Education (CORE)

Online source for progressive recovery tools and resources for opioid and other substance use disorders includes:

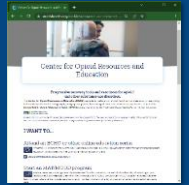
- Links to all current OUD ECHOs
- How-tos to simplify starting an MAT/MOUD program
- SUD clinical resources to use in practice
- Info to connect with other MAT/MOUD practitioners
- And more!
- [Center for Opioid Resources and Education - Stratis Health](https://stratishealth.org/toolkit/substance-use-resources-and-education/)

The **Center for Opioid Resources and Education (CORE)** supports clinical and non-clinical health care professionals in responding to the opioid public health emergency by bridging care gaps in disadvantaged, rural, and underserved populations, as part of the **Stratis Health Opioid Addiction in Rural (SOAR)** Extension for Community Healthcare Outcomes (ECHO) online learning series.
<https://stratishealth.org/toolkit/substance-use-resources-and-education/>



ECHO model = case-based learning!

1. MAFP website (<https://bit.ly/OUDCase>)
2. Announcements email!
3. **Center for Opioid Resources and Education - Stratis Health**
(www.stratishealth.org/toolkit/substance-use-resources-and-education/)



I WANT TO...

Attend an ECHO or other online education



ProjectECHO (Extension for Community Healthcare Outcomes) is a virtual education, case studies, and continuing medical education credit.

[View all ECHO online education series](#)

Stratis Health and MAFP Opioid Use Disorder (OUD) Education and Treatment ECHO Series

First and Third Tuesdays of Each Month through Sep. 2022, 12-1 p.m. CT

Facilitated by Drs. Bell and DeVine, in partnership with Stratis Health and the Minnesota Academy of Family Physicians (MAFP), this series covers the fundamentals of OUD and implementation within primary care.

[More >](#)

Share and Learn – Submit a Case

If you have a case you would like presented to help learn from each others' experiences and expertise, please **fill out, save, and email this form** to the address listed on the last page prior to the session. *(Please note: You must download the form document before completing and submitting it.)*

BUT feel free to present in any de-identified format!



6

“The Addiction Connection Podcast”

Weekly addiction topics- Tuesday release day!

www.buzzsprout.com/954034

(Or anywhere you get your podcasts!)

Email us questions:

theaddictionconnectionpodcast@gmail.com



7

7

Help Us Improve!

Take the Survey:
bit.ly/OUD-ECHO-survey



We want to learn more about you, how our ECHOs influence your day-to-day work, and common barriers to providing opioid use disorder care. Your feedback helps us build timely and relevant education and training to serve your communities!

Objectives

- Describe key stakeholders in a community to “bring to the table” to enhance your clinical care team
- Explain the importance of “meeting patients where they are at” and how each of those locations within not only your facility but also your community have key roles in capturing more patients.
- Understand the roles and responsibilities guiding each community stakeholder and the importance of ongoing communication and shared learning.

Let's Review: It's a Great Place to Start When Getting the Community Involved

(Tend to need great data to 'change the way people think/behave')

Benefits of MOUD

- Improve survival = decrease mortality
- Improve treatment retention
- Decrease in criminal activity
- Improve employment
- Improve birth outcomes
- Decrease HIV/Hep B/C and more
- Enhance social functioning

Benefits of MOUD cont.

- People taking opioids have 10 times the risk of mortality than the general population.

10x

12

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Benefits of MOUD cont.

- Swedish study: 16mg buprenorphine daily vs. 6-day detoxification followed by placebo – all patients received psychosocial supports
 - 25% relapse with 16mg buprenorphine
 - 100% relapse with placebo
 - 20% mortality with those who left treatment
 - >2 opioid positive UDAS within 3 months = cessation of treatment

13

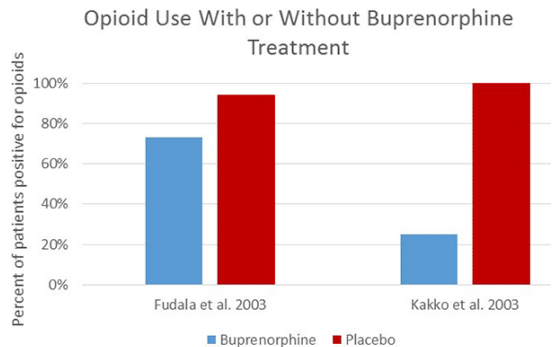
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Benefits of MOUD cont.

- Swedish study: 16mg buprenorphine daily vs. 6-day detoxification followed by placebo – all patients received psychosocial supports
 - $\geq 16\text{mg/day}$ = 1.82 times more likely to stay in treatment
 - Decreased # of opioid-positive drug tests by 14.2%



14

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Community Collaboration

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**“Alone we can do so little;
together we can do so much”**
– Helen Keller

Local Task Force

Community Collaboration

- Clinics/hospitals:
 - Information about the health of patients
- Community representatives:
 - Insight into the severity of local opioid-related trends



18

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Considerations for Task Force

- Hospital Representation
 - Grant funding philanthropy (Hospital Foundation)
 - Expansion of access into inpatient, ED, OB etc.
- Clinic
 - Best-practice recommendations
 - Education on OUD/SUD. neurobiology etc.
 - Promotion of MOUD
 - Quality Improvement



19

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Community Collaboration

- HIPAA laws limit medical->community sharing of information
- Law enforcement can give feedback:
 - Who/what they see
 - Diversion



20

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Considerations for Task Force cont.

- Law Enforcement:
 - Drug trends
 - Drug Take Back days
 - Prescription drop boxes
 - Decriminalization
- School District:
 - Prevention activities
 - Mentorship



21

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Considerations for Task Force cont.

- Pharmacy
 - Patient-facing consultations at prescription fills
 - Naloxone
 - Needles/syringe access
 - Availability of buprenorphine products
 - Prior-authorization assistance
 - Tapering assistance (for opioids, benzos, etc.)



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Considerations for Task Force cont.

- County Attorney's Office
 - Drug court updates
 - Legal explanations on policies
 - Communication with county commissioners
 - Can gain insight into 'non-punitive' supports available in the community



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Considerations for Task Force cont.

- Social Services
 - Can provide social worker for the clinic
 - Chemical use assessments (previously rule 25)
 - Assist in transitions to treatment
 - Update task force on county resources
 - Assisting in services:
 - Insurance
 - Food insecurity
 - Housing instability



24

24

Considerations for Task Force cont.

- Public Health
 - Communication from/to county commissioners
 - Provides community insight via the Community Health Needs Assessment (CHNA) and focus for strategies
 - Identification of resources and funding needs and availability
 - Prevention

PREVENTION

25

25

Considerations for Task Force cont.

- Mental Health Provider(s)
 - Update on trends noted with co-occurring SUD/MH
 - Community partnerships with treatment providers
 - Aid in transition of patients from levels of treatment (in-patient -> out-patient etc.)
 - Update on resources/availability of services in the community



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Considerations for Task Force cont.

- Long-Term Care, Nursing Homes, Home Health
 - Updates on use concerns/diversion in older adult residents
 - Notifications of trends over time
 - Update on trends in home-care
 - Hospice – workflows with disposal of medications after end-of-life care



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Considerations for Task Force cont.

- Child Protection/Guardian Ad Litem
 - Update on trends in placements
 - Update on which substances placements are primarily related to



Considerations for Task Force cont.

- There are MANY more options to add to the task force, all community-dependent
- Others to consider (not an exhaustive list):
 - Local treatment facilities
 - NA/AA etc. member representation
 - Sex trafficking
 - Adjunctive chronic pain (etc.) providers/representatives
 - Minority population representation
 - So many more!

Considerations for Task Force cont.

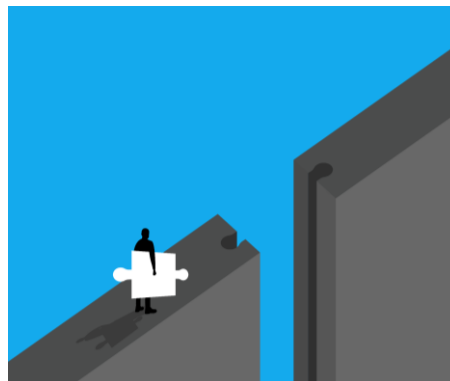
- No one member of the task force is more important than another
- While all add their insight the biggest thing gained is learning and sharing of information



Capturing Patients

Where are the Gaps?

- Emergency Departments
- Pharmacy
- Social services/Child protection
- Jails/Law enforcement



The Emergency Department

Emergency Department

- Stigma of “these/those” people
- Taking time and beds
- Received naloxone but nothing further
- Un- or mis- identified withdrawal symptoms



34

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Emergency Department cont.

- Lack of recognition of co-occurrence of SUD with mental health disorders
- No follow-up protocols
- No treatment protocols
- Un-waivered providers*
- “Overlooked” (accidentally +/- intentionally)



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Emergency Department cont.

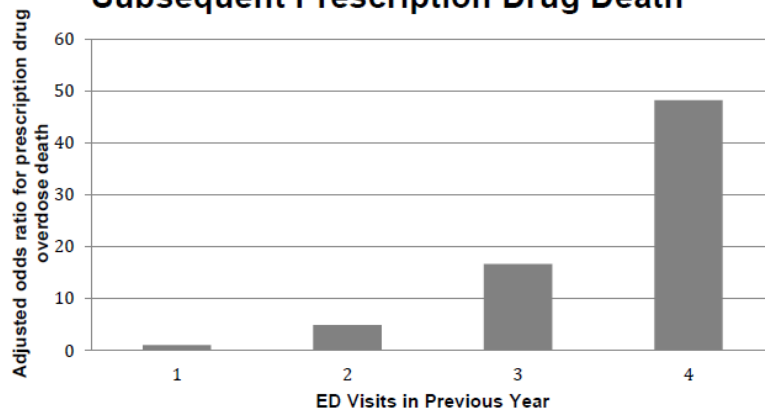
- Setting where patients with OUD commonly present:
 - Seeking more opioids
 - Seeing help with opioid withdrawal
 - Post-overdose
- ED physician uniquely positioned to intervene at a critical moment in the cycle

36

36

Emergency Department cont.

**Association of Frequent ED Visits and
Subsequent Prescription Drug Death**



37

37

Emergency Department cont.

Yale Study- Gail D'Onofrio

- 329 patients screened
 - 1/3 referral to treatment
 - 1/3 referral to treatment with brief intervention
 - 1/3 prescribed buprenorphine with close follow-up
- 30-day retention rates
 - Referral only: 37%
 - Referral with brief intervention: 45%
 - Buprenorphine: 78%

Pharmacy

Pharmacy

- Many barriers:
 - Prior authorization issues
 - Formulary changes
 - Refill policies
 - Insurance – or lack thereof
 - Stigma



Child Protection

Child Protection

- Patients fear CPS so they avoid, rather than getting help from, their services
- Chemical Use Assessments:
 - Often no assistance getting into treatment
 - Limited treatment facilities for women with kids
- Insurance barriers
- Cannot get housing assistance due to past issues

42



42

Child Protection cont.

- Article from Drug and Alcohol Review:
 - 171 mothers with 302 children under age 16:
 - 99 in out-of-home care
 - 42 removed at birth
 - 49 removed while mother was in an opioid treatment program
 - 32 had child removed at birth then had a subsequent birth
 - NONE retained care of new baby
 - Women chose treatment for child-related reasons
 - Few services were provided to them outside of their treatment program

43



43

Criminal Justice System

Barriers

1. Stigma:

- Against:
 - Mental health
 - Substance use disorder
- By:
 - Medical staff
 - Correctional staff
 - Jail administrators
 - County boards
 - Society
 -



Barriers cont.

2. Medical decision-making by:

- Medical
- Jail admin
- Agencies (discussed more in a later slide)
- Example:
 - Provider wishes to start a patient on medications for opioid use disorder (MOUD)... admin won't allow... in jail
 - “That med”
 - “Not a necessary med”
 - “They need to be ‘clean’”



46

46

Barriers cont.

3. Medication selection:

- Effective medications use in community settings “Not *allowed*” in corrections
 - Abuse potential
 - Cost of medication
- Examples:
 - Bupropion (Wellbutrin)
 - Gabapentin
 - Quetiapine (Seroquel)
 - Trazodone
 -



47

47

Barriers cont.

4. Medication judgement:

- Patients punished:
 - Medications with abuse ‘potential’ discontinued
 - If urine has unexpected results (‘dirty’)



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Barriers cont.

- Medication judgement example:
 - Patient has a urine + for methamphetamine or cannabis.... Bupropion is discontinued



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Barriers cont.

5. Mental Health:

- Inadequate
 - Disproportionately high levels of severe mental health diagnosis +/- severe SUD
 - No or limited access to higher levels of care
 - Mental health providers:
 - Advanced practice providers (CNP/PA) are prescribers
 - Social workers are the mental health providers
- Not timely
 - Contract for a set number of hours per month
 - Rationing
 - Prioritizing



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Barriers cont.

6. Different Agencies:

- Types of agencies:
 - ICE (Immigration)
 - US Marshalls
 - DOC (Department of Corrections – convicted inmates awaiting prison placement or serving [often shorter] prison terms in county jails)
 - County
- Services ‘allowed’
 - Many above agencies require permission for treatment/images/labs/services
 - Refusal or delay of treatments



U.S. Immigration and
Customs Enforcement



51

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Barriers cont.

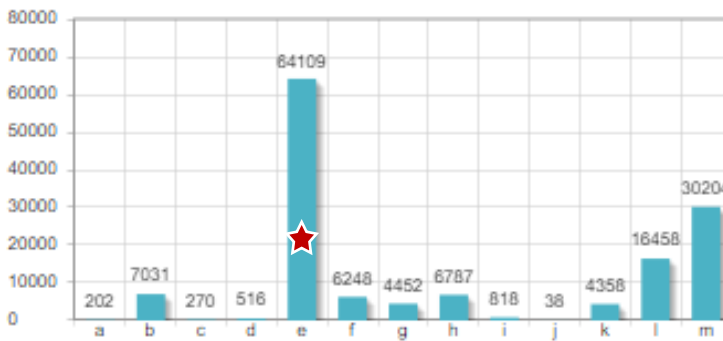
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- Insurance may be discontinued (especially with state programs)
- County now responsible for all cost:
 - ‘Cut corners’ to save county money
 - ‘Cheapest’ options for medications and treatments
 - Many ‘not necessary’ medications



National Statistics - Prison

- Data from January 2022



Federal Bureau of Prisons. 2/12/2022

Chart Label	Offense	# of inmates	% of inmates
a	Banking and Insurance, Counterfeit, Embezzlement	202	0.1%
b	Burglary, Larceny, Property Offenses	7,031	5.0%
c	Continuing Criminal Enterprise	270	0.2%
d	Courts or Corrections	516	0.4%
e	Drug Offenses	64,109	45.3%
f	Extortion, Fraud, Bribery	6,248	4.4%
g	Homicide, Aggravated Assault, and Kidnapping Offenses	4,452	3.1%
h	Immigration	6,787	4.8%
i	Miscellaneous	818	0.6%
j	National Security	38	0.0%
k	Robbery	4,358	3.1%
l	Sex Offenses	16,458	11.6%
m	Weapons, Explosives, Arson	30,204	21.3%

Minnesota Statistics - Prison

• Data (last reported: 6/29/2017)

• Averages:

- 27% active drug offense
- Length of sentence: 39-97 months
- Native American: 7-22% (1.3% pop.)
- African American: 15-46% (6.2% pop.)

• Shakopee:

- Female-only
- ~1.4 inmates Native American
- Almost half have active drug charge

• Willow River and Togo:

- Over half have active drug offense

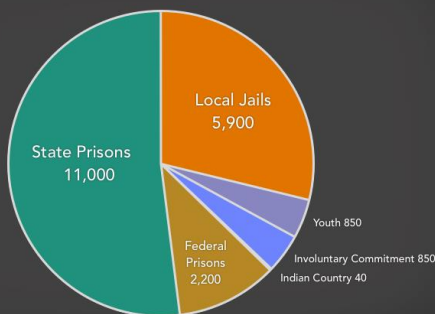
	% of Native	% of Black	# of adults with an active sentence	Drug Offense Active Sentence/Total # of Sentences	Percentage of Drug Offenses compared to Total	Months of Average Length of Drug Offense Sentence
Faribault	7%	35%	1986	703/3037	23%	58 mo
Lino Lakes	10%	28%	1654	556/2588	21%	62 mo
Oak Park Heights	16%	44%	424	29/705	4%	97 mo
Red Wing	7%	44%	45	25/59	42%	79 mo
Rush City	10%	45%	946	100/1529	7%	60 mo
St. Cloud	9%	28%	1070	392/1772	22%	39 mo
Shakopee	22%	15%	639	407/971	42%	39 mo
Stillwater	10%	46%	1526	213/2572	8%	63 mo
Willow River	8%	27%	169	154/304	51%	63 mo
Moose Lake	7%	29%	1045	394/1625	24%	64 mo
Togo	8%	33%	76	59/110	54%	66 mo
2016 US Census Bureau	1.3%	6.2%				

Source: Minnesota Department of Corrections (DOC)
Data Pulled: 6/29/17

Minnesota Statistics - cont.

How many Minnesota residents are locked up and where?

21,000 of Minnesota's residents are locked up in various kinds of facilities



Minnesota's prison and jail incarceration rates

Number of people incarcerated in state prisons and local jails per 100,000 people, 1978-2015

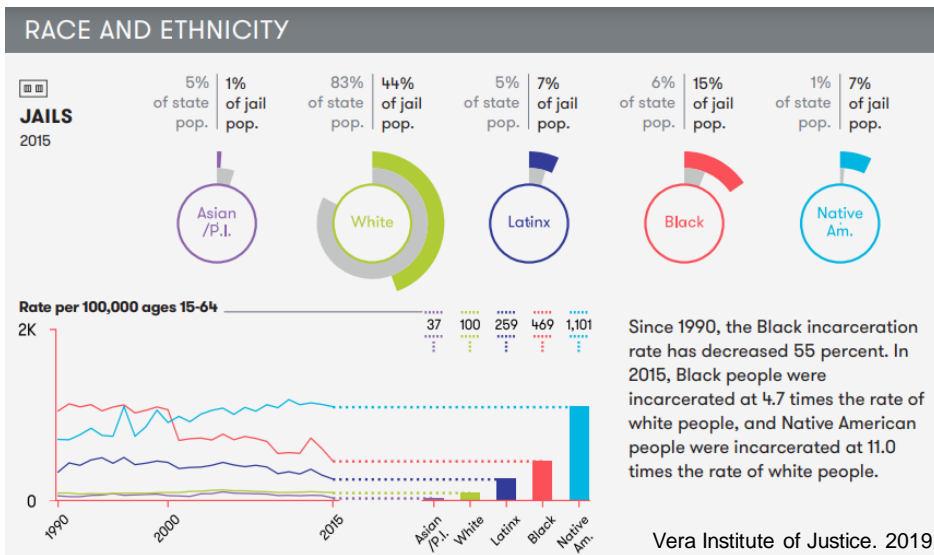


Jail populations were adjusted to remove people being held for federal and state authorities. For jail sourcing, see: www.prisonspolicy.org/reports/jailsonvertime.html#methodology

Minnesota Statistics - cont.



Minnesota Statistics - Jail



Co-Occurring SUD and MH Disorders

- 2.1 million people incarcerated in U.S. in 2016
 - 655 per 100,000
- Mental health: More people in jails and prisons than hospitals
 - Schizophrenia
 - Bipolar disorder
 - Major depression
- Clinically significant symptoms while incarcerated:
 - 1:7 state and federal inmates (14%)
 - 1:4 jail inmates (26%)



58

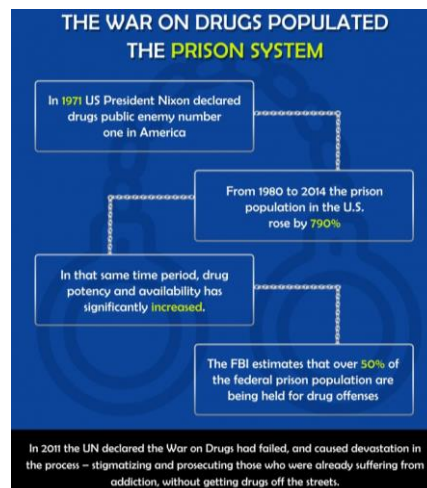
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Co-Occurring SUD and MH Disorders

- Previous mental health diagnosis:
 - 37% prison
 - 44% jail
- SUD diagnosis within a year of incarceration
 - 53% prisons
 - 45% jails
- Co-occurring (COD)
 - 42% prison
 - 37% jails
 - Female rates higher: 74%



59

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Co-Occurring SUD and MH Disorders

- Cost: 2007 data
 - SUD:
 - \$193 billion in 2007
 - \$113 billion linked to costs of drug-related crime and criminal justice system expenditures
 - Treating SUD:
 - \$14.6 million
 - Medication assisted treatment in community \$5000/year
 - Diabetes:
 - \$174 billion in 2007
 - Incarcerating a person:
 - \$24,000/year



60

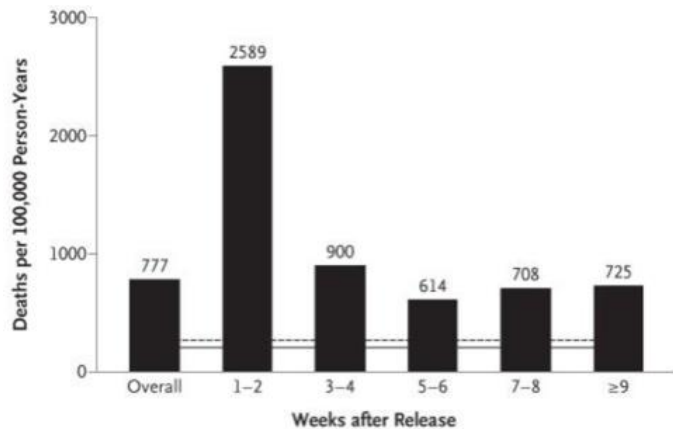
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Criminal Justice System

- Risk of death from OD is >12x's higher in the first 2 weeks after release from incarceration



61

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Criminal Justice System

- Research based on randomized controlled studies with greater than 3 month follow up show buprenorphine/naloxone is as effective as methadone in:
 - Decreasing opioid use and re-arrest
 - Increased treatment retention
 - Inmates were more likely to report to continued community treatment upon release

Criminal Justice System

- In correctional settings, heroin dependent men were randomized to methadone or buprenorphine after 10-90-day sentences.
 - Buprenorphine patients reported to community treatment centers 48% of the time, while methadone patients only followed up 14% of the time.

Criminal Justice System

Memorandum from Massachusetts- 11/26/18

- District court
- 8th Amendment violation: cruel and unusual punishment
- “Deliberate indifference to a medical condition”
- Violates American Disability Act



Decriminalization 101

- Vicknasingam et al. Study 2018 Curr Opin Psychiatry
“Decriminalization of drug use”
 - Review of 7 articles on decriminalization vs. 57 articles of legalization
 - Decriminalization:
 - No effect on age of onset of use
 - Price of drugs did not decrease or increase
 - Summary: more studies needed

Decriminalization 101 cont.

- Pros:

- Reduce prison population
- Increased treatment
- Reduced criminal justice costs
- Reduced arrests
- Encourages maintaining position in society
- Helps reduce stigma
- Criminal justice to focus on criminal justice
- Not the same as legalization
- Reduced societal violence
- Better MH treatment



66

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Decriminalization 101

- Cons:

- May encourage experimentation
- ? Drug price reduction
- Treatment infrastructures still lacking
- Decriminalization a lead into legalization?
- Safety worse rather than better?



67

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67

Variation in State Naloxone and Good Samaritan Laws

As of October 24, 2017



Prescription by Standing Order Authorized

43 states have a standing order to authorize non-medical personnel to issue naloxone (as of 7/2017)

Prescribers Immune from Liability

34 States have laws to protect naloxone prescribers from civil and criminal liability (as of 7/2017)



Good Samaritan Law Protects Against Arrest

10 states have Good Samaritan Laws that prevents a person who calls 911 from arrest for drug possession, drug paraphernalia possession, and probation/parole violation (as of 12/2016)

Source: Prescription Drug Abuse Policy System

68

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68

Summary

- “It takes a village.”
- Patients with OUD/SUD intersect many places in a community and each ‘touch point’ is an OPPORTUNITY to make a difference.
- Understanding the disease of addiction and working together can create a not only patient-centered approach to patient care, but also a community approach.

69

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Podcast:
The Addiction
Connection



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70

Sources

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71



71