MOUD in Jail and Prisons
Anticipated and Unanticipated Barriers

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Disclosure Information

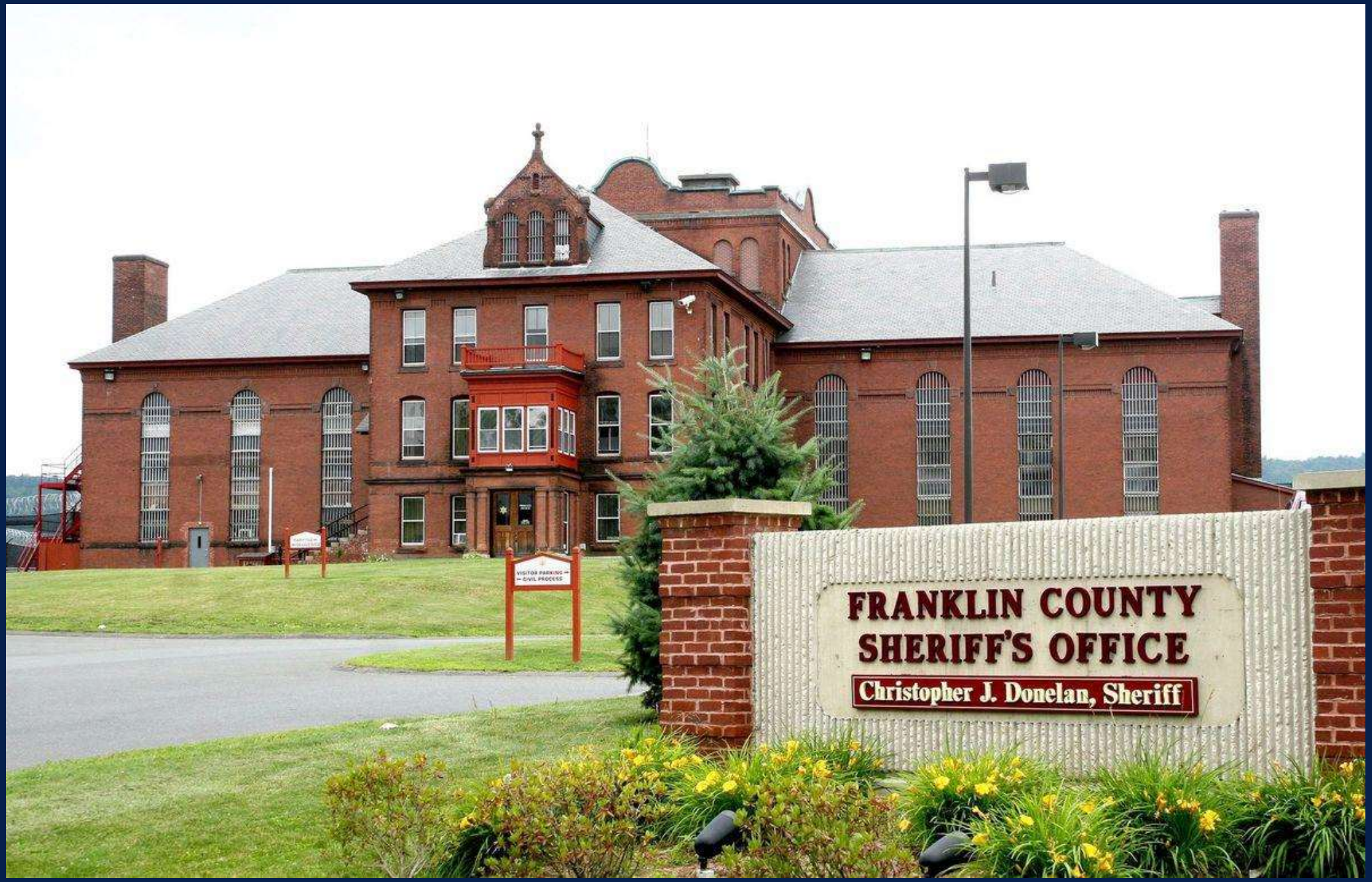
I have no disclosures.

Massachusetts Legislature October 2021

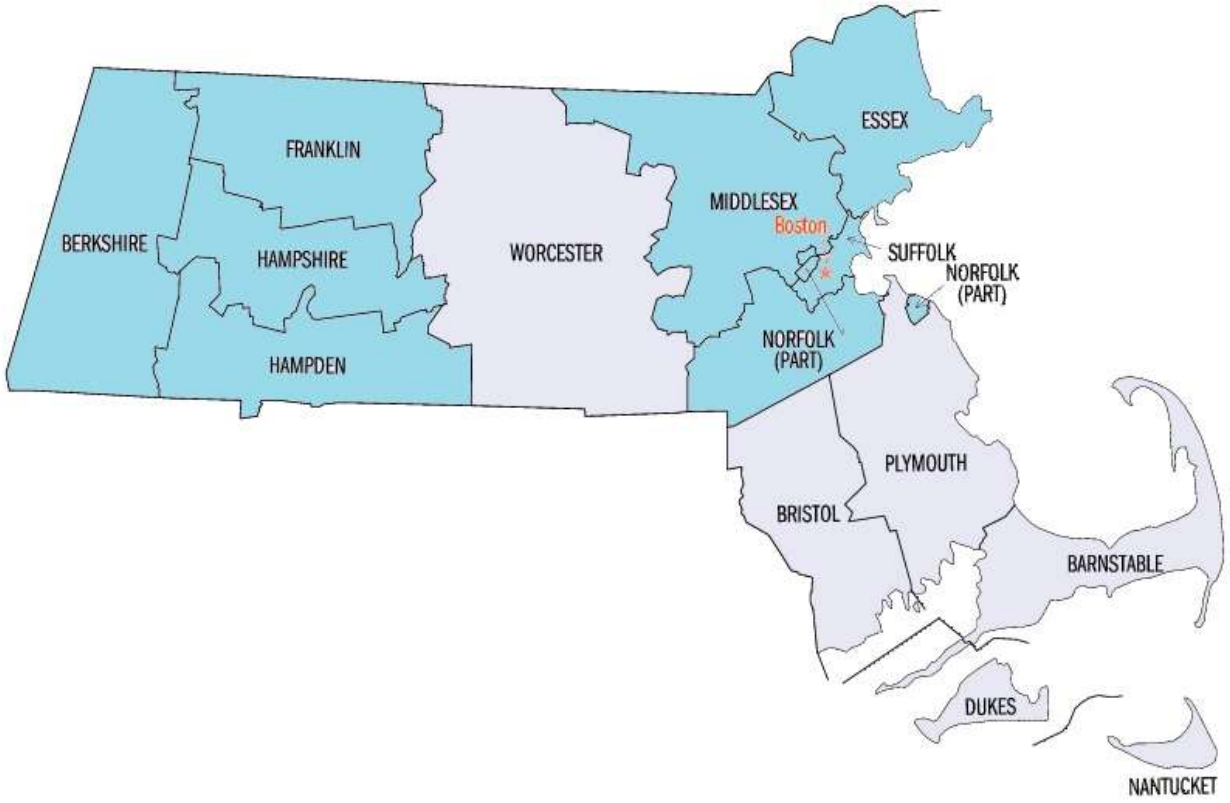
S.1296 An Act regarding consistent care for addiction rooted in evidence Sponsor: John F. Keenan
H.2067 An Act regarding consistent care for addiction rooted in evidence Sponsor: Ruth B Balser

This includes:

- All state and county correctional facilities must offer all three FDA-approved forms of MOUD.
- Every detainee must be assessed for opioid use disorder within 24 hours of incarceration
- If a person was receiving MOUD prior to their incarceration, they must continue to receive MOUD within 24 hours of incarceration.
    - No dosage or medication changes unless a qualified addiction specialist determines such a change is clinically indicated based on an individualized assessment.
- If a person was not receiving MOUD prior to incarceration, they still must be assessed for opioid use disorder within 24 hours of incarceration, and receive MOUD within 24 hours of that assessment where clinically indicated by a qualified addiction specialist.
- Incarcerated people must be allowed to receive MOUD free from incentives, punishments or other pressure to take a particular form of medication
- Correctional institutions must facilitate MassHealth enrollment and continuous MOUD access for patients in advance of their reentry into the community
- To ensure the law functions as intended, facilities will be required to collect and publicly report data about MOUD use on an every 6 month basis.


FRANKLIN COUNTY
SHERIFF'S OFFICE
Christopher J. Donelan, Sheriff

2018 Massachusetts Legislature



Where you get sentenced will determine your access to MOUD in the criminal-legal system.

(Roosevelt Institute, 2019)

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PRISONERS ARE AMONG THE SICKEST MEMBERS OF SOCIETY

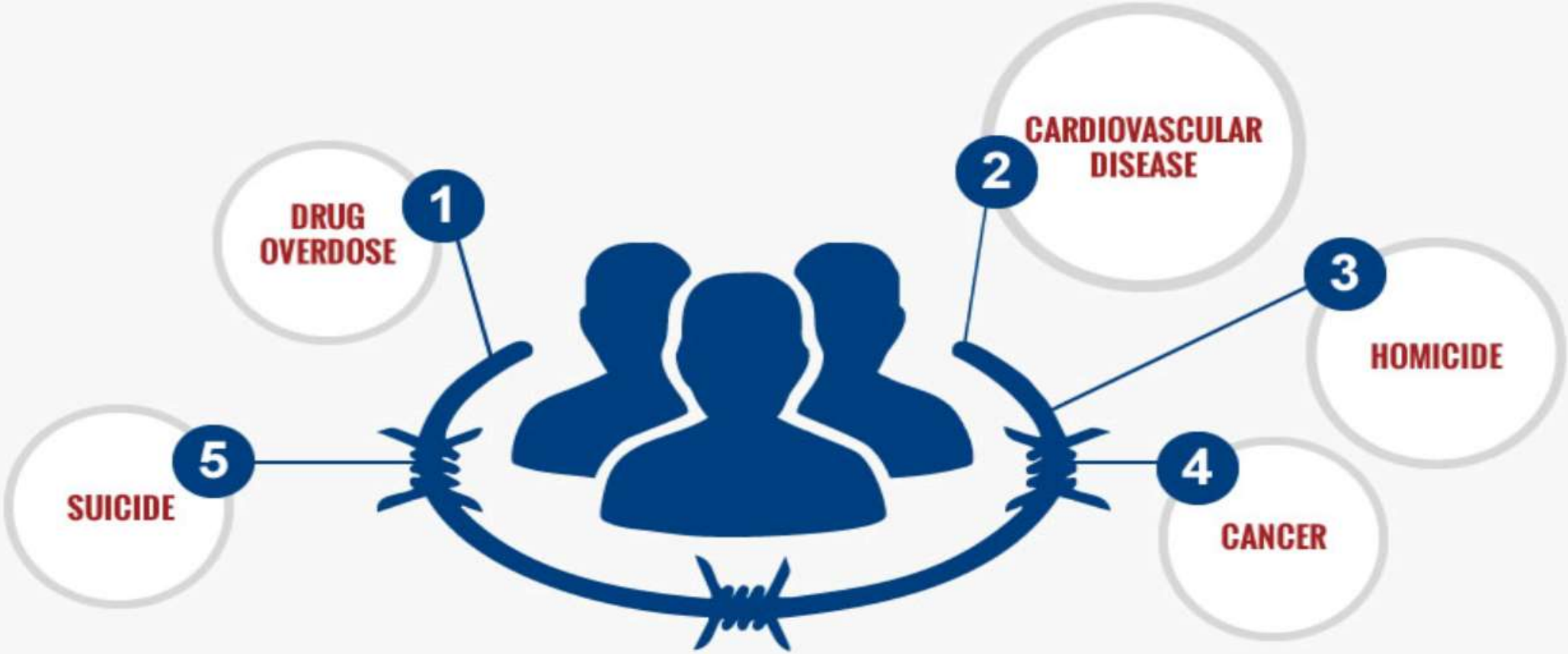
Higher rates of chronic disease: hypertension, asthma, arthritis, cervical cancer

Higher rates of communicable diseases, such as HIV, and Hepatitis C

Up to 50% have symptoms of mental illness

65-80% have a history of substance use and abuse, compared with about 10% in the general population

PEOPLE COMING OUT OF PRISON ARE 12 TIMES MORE LIKELY TO DIE IN THE FIRST 2 WEEKS AFTER THEIR RELEASE



Binswanger, et. al. Release from Prison - A High Risk of Death for Former Inmates. NEJM. Jan. 11, 2007; 356(2): 157-165

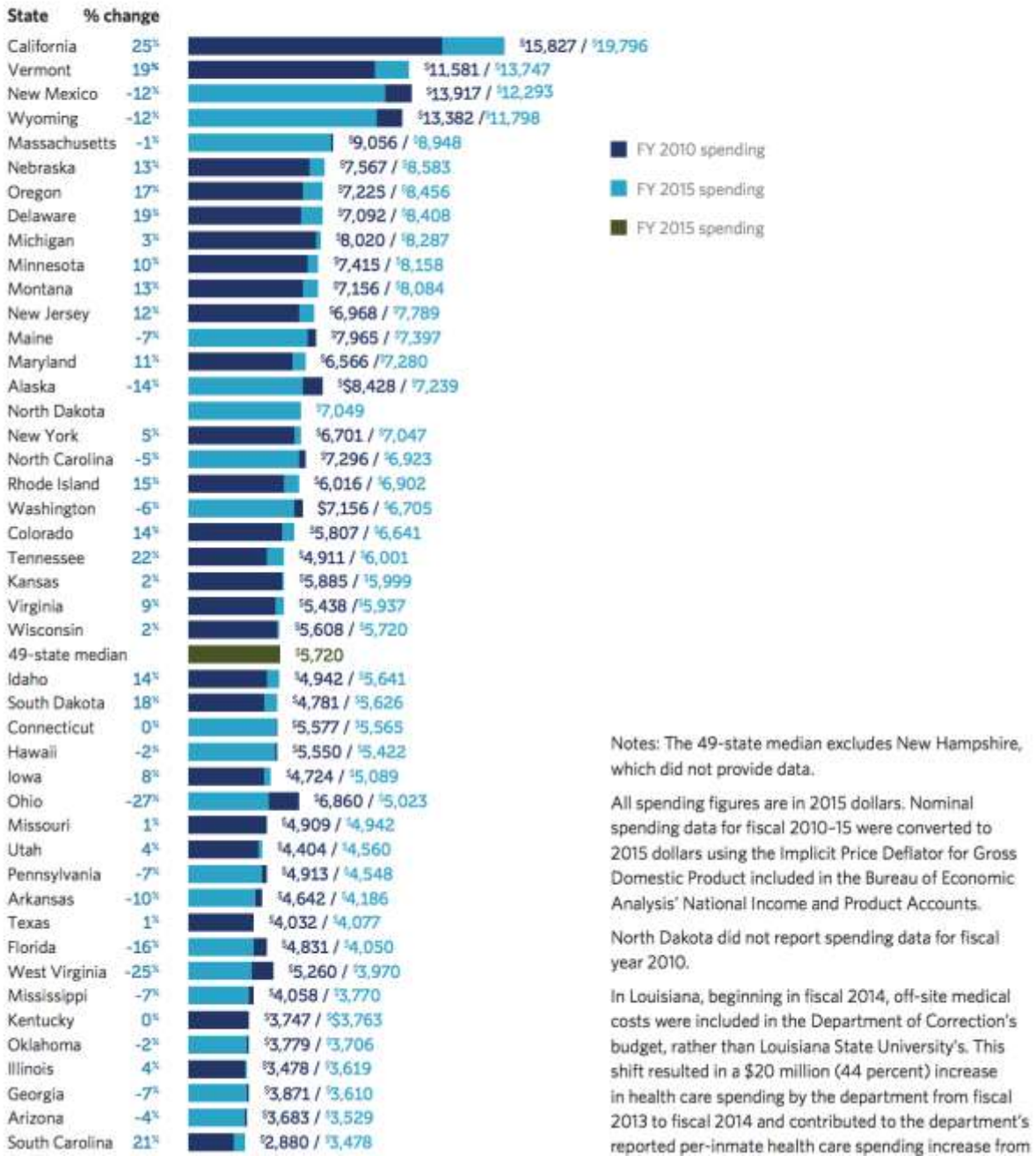
A report from THE PEW CHARITABLE TRUSTS | Oct 2017

Prison Health Care: Costs and Quality

How and why states strive for high-performing systems

Per-Inmate Spending on Prison Health Care Varied Greatly

Magnitude and change by state, FY 2010-15



Notes: The 49-state median excludes New Hampshire, which did not provide data.

All spending figures are in 2015 dollars. Nominal spending data for fiscal 2010–15 were converted to 2015 dollars using the Implicit Price Deflator for Gross Domestic Product included in the Bureau of Economic Analysis' National Income and Product Accounts.

North Dakota did not report spending data for fiscal year 2010.

In Louisiana, beginning in fiscal 2014, off-site medical costs were included in the Department of Correction's budget, rather than Louisiana State University's. This shift resulted in a $20 million (44 percent) increase in health care spending by the department from fiscal 2013 to fiscal 2014 and contributed to the department's reported per-inmate health care spending increase from

Delivery System Organizational Structures Vary

Delivery systems, fiscal 2015

Delivery System	States	Number of States
Direct-provision	AK, CA, HI, IA, NC, ND, NE, NV, NY, OH, OK, OR, SC, SD, UT, WA, WI	17 states
Contracted-provision	AL, AZ, AR, DE, FL, ID, IL, IN, KS, KY, MA, MD, ME, MO, MS, NM, TN, VT, WV, WY	20 states
Hybrid	CO, LA, MI, MN, MT, PA, RI, VA	8 states
State university	CT, GA, NJ, TX	4 states

Note: New Hampshire did not provide data.

Contract Payment Model Decisions Balance Several Factors

Cost-Plus	Factors	Capitation
More state exposure	Financial risk/reward	Less state exposure
Less predictable	Spending predictability	More predictable
More transparent	Spending transparency	Less transparent
Less incentive	Incentivized economizing	More incentive
Necessary	Quality monitoring/oversight	Necessary

The Post's View

It's time to end the callous policy of inmate Medicaid exclusion

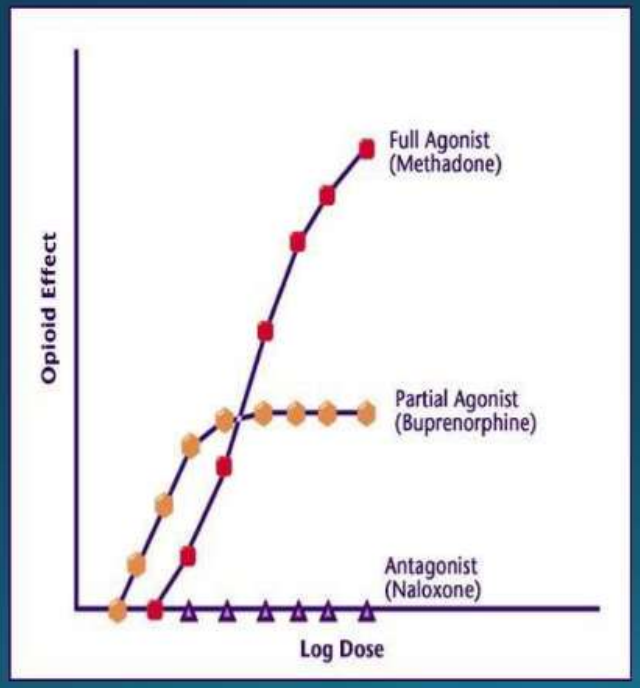
(iStock)

Opinion by the Editorial Board
May 12, 2019 at 7:23 PM ET

OBAMACARE GAVE most low-income people Medicaid cover-

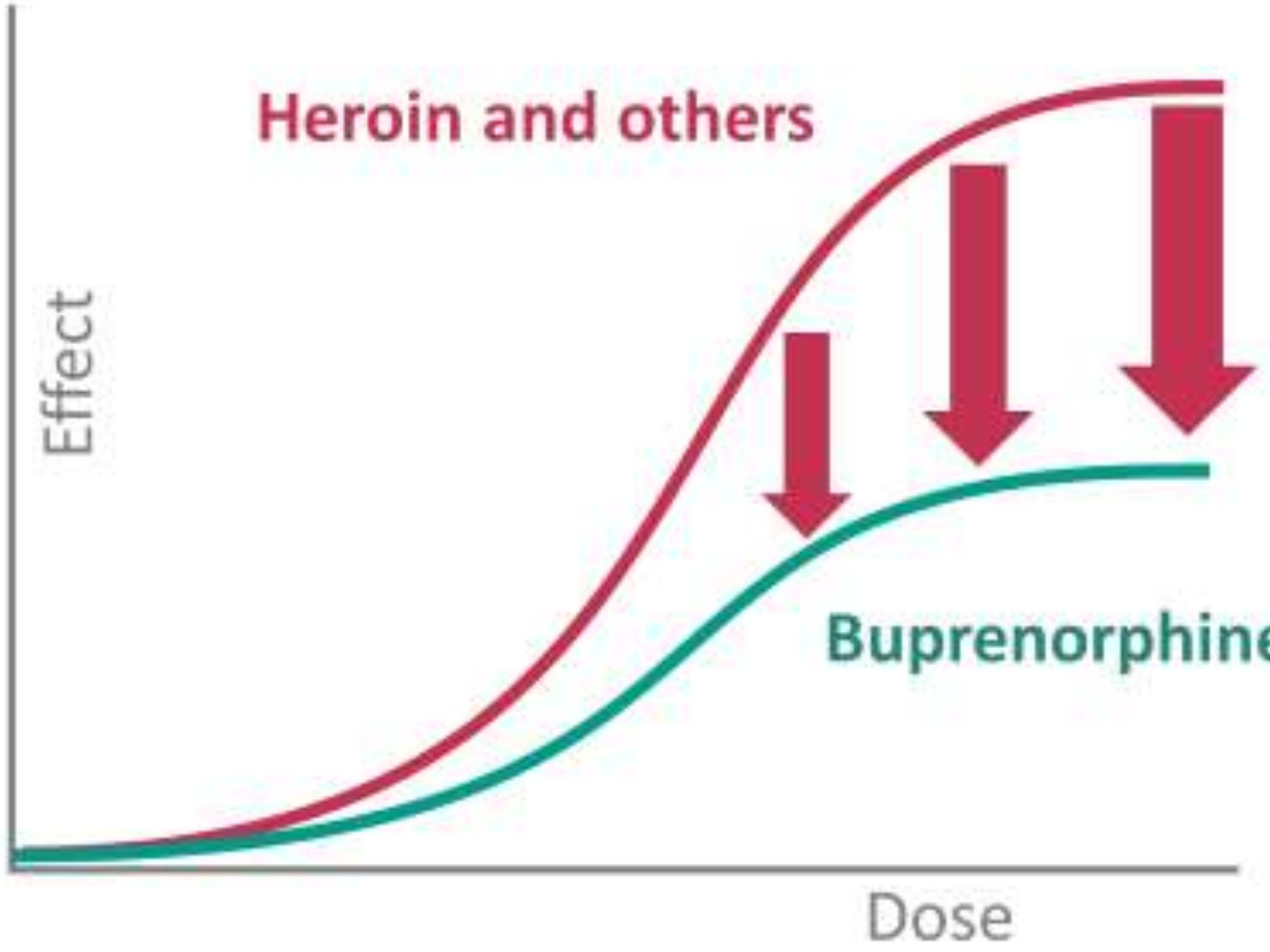
Opioid Agonist Treatment

Methadone



Buprenorphine

Precipitated Withdrawal



Partial activation

- Experienced as withdrawal

Walsh, S. L., & Eissenberg, T. (2003). The clinical pharmacology of buprenorphine: extrapolating from the laboratory to the clinic. Drug and alcohol dependence, 70(2), 513-527.

Which treatment is best?

The One That Works!

	General guidelines
Methadone	Long history of use, high opioid tolerance, unstable life needing lots of structure and support
Buprenorphine	Mild-to-moderate dependence, greater life stability, more potential for abuse
Naltrexone	Mild-to-moderate dependence, greater life stability, greater risk of relapse and overdose


Vermont
DUP USA
SUSPENDED
NOT FOR FEDERAL IDENTIFICATION
4d LICENSE NO 12345678
3 DOB 01/12/1967
4a ISS 01/12/2012
4b EXP 01/12/2016
1 LASTNAME
2 FIRSTNAME MIDDLENAME SUFFIX
ADDRESS LINE 2
CITY, VT 00000-1234
VETERAN
15 Sex F
16 Hgt 5'-03"
17 Wgt 120 lb
18 Eyes BRO
9 Class ABCD
12 Restrictions CEGHJN XZ
9a End ABPTX
Rev MM/DD/CCYY
5 DD WXXUUEXXUUXXYYE DONOR
SUSPENDED
SAMPLE
Janice Sample


iNSURED
NO
YES

Options and Steps to Implement MAT in Pilot Houses of Correction

All 3 Medications: Methadone, Buprenorphine, Naltrexone

OPTION 1
HOC/DOC Acquires OTP Certification

Provision of Methadone

- Obtain SAMHSA Certification (which include counseling, MAT and other required SUD services)
- Requires approvals from:
  - DEA
  - DPH DCP
  - DPH BSAS

Provision of Buprenorphine

- Once OTP Certified, can begin prescribing under OTP

Provision of Naltrexone

- Prescribed by onsite healthcare professional with MCSR

OPTION 2
HOC partners with an existing OTP who provides onsite Meds

- OTP must hold SAMHSA Certification (which include counseling, MAT and other required SUD services)
- OTP obtains additional approvals to operate at corrections location:
  - SAMHSA
  - DEA
  - DPH DCP
  - DPH BSAS
- QSOA Qualified Service Organization Agreement (QSOA) executed by OTP and HOC

OPTION 3
HOC partners with an existing OTP who provides offsite or transports meds daily

- OTP must hold SAMHSA Certification (which include counseling, MAT and other required SUD services)
- Methadone may not be stored at the DOC or a HOC.
- Qualified Service Organization Agreement (QSOA) executed by OTP and HOC

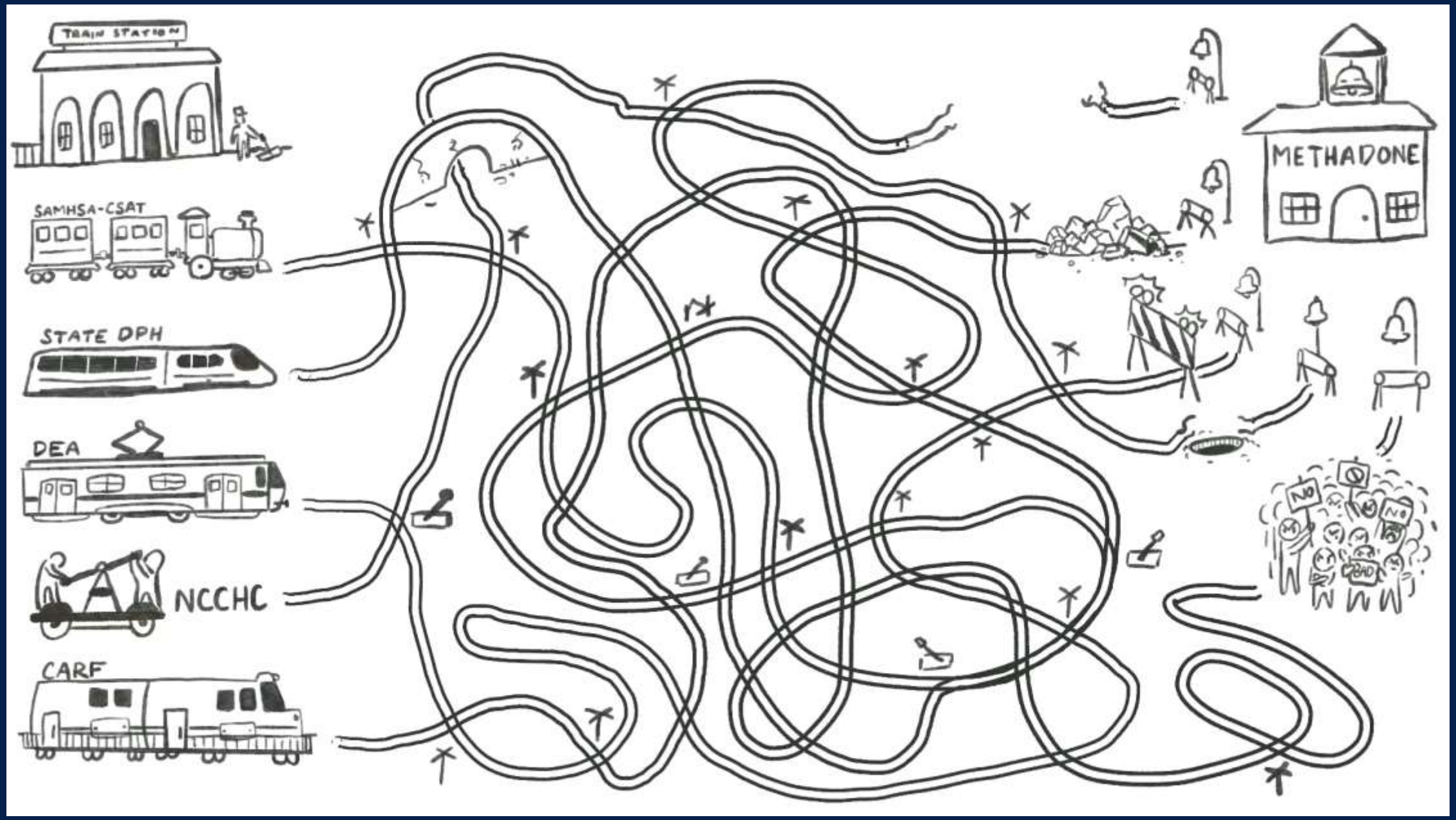
Evaluated by the State for the Appropriateness of your Application

Application to SAMHSA-CSAT

Accreditation by national organization

Apply for DEA Number to be OTP

Apply for state prescribing Authority to be OTP


TRAIN STATION
SAMHSA-CSAT
STATE DPH
DEA
NCCHC
CARF
METHADONE
NO
NO

FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS

INTRODUCTION

The *Federal Guidelines for Opioid Treatment Programs* (Guidelines) describe the Substance Abuse and Mental Health Services Administration's (SAMHSA) expectation of how the federal opioid treatment standards found in Title 42 of the Code of Federal Regulations Part 8 (42 CFR § 8) are to be satisfied by opioid treatment programs (OTPs). Under these federal regulations, OTPs are required to have current valid accreditation status, SAMHSA certification, and Drug Enforcement Administration (DEA) registration before they are able to administer or dispense opioid drugs for the treatment of opioid addiction. As stated in 42 CFR § 8.12(i)(2), these regulations apply to "opioid agonist treatment medications that are approved by the Food and Drug Administration." Currently, these drugs are methadone and pharmaceutical products containing buprenorphine, hereafter referred to as buprenorphine. The regulations apply equally to both of these medications, with the only difference being the time and treatment requirement for unsupervised dosing spelled out in 42 CFR § 8.12(i)(3). Other pharmacotherapies may be provided in a manner consistent with the best medical practices for each drug. For example, the use of naltrexone has a place in OTPs but is not subject to these regulations.

Substance Abuse and Mental Health Services Administration. Federal Guidelines for Opioid Treatment Programs. HHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015

March 1973 Regulations
Unprecedented Departure from Allowing Licensed Physicians to Use Judgement

- Age (18)
- Length of Use (at least one year)
- Maximum initial doses (30 mg)
- Minimum amount of counselling
- Specifics limitations on take home doses
- Closed system: approved clinics and hospital pharmacies

Jaffe, Jerome H., and Charles O'Keeffe. "From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States." *Drug and alcohol dependence* 70.2 (2003): S3-S11

(3) Maintenance treatment admission exceptions. If clinically appropriate, the program physician may waive the requirement of a 1-year history of addiction under paragraph (e)(1) of this section, for patients released from penal institutions with a documented history of opioid use disorder (within 6 months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated patients (up to 2 years after discharge).

(4) Detoxification (medical withdrawal) treatment. An OTP shall maintain current procedures that are designed to ensure that patients are admitted to short- or long-term detoxification treatment by qualified personnel, such as a program physician, who determines that such treatment is appropriate for the specific patient by applying established diagnostic criteria. Patients with two or more unsuccessful detoxification episodes within a 12-month period must be assessed by the OTP physician for other forms of treatment. A program shall not admit a patient for more than two detoxification treatment episodes in one year.

FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS

medication units. The program sponsor need not be a licensed physician but shall employ a licensed physician for the position of medical director."

The program sponsor is the person ultimately responsible for the operation of the program, and most importantly, ensuring the program is in continuous compliance with all federal, state, and local laws and regulations. If there is a change of program sponsor, SAMHSA requires formal notification within 3 weeks of the change.

While the program sponsor retains the ultimate responsibility for an OTP's operations, the day-to-day management of the program often is assigned to the program director or manager who assumes the duties assigned by the program sponsor. It is important to note that the regulations do not require OTPs to have program directors or managers on staff nor define the role of a program director; therefore, the program sponsor in some OTPs also serves as the program director.

The medical director is responsible for monitoring and supervising all medical and nursing services provided by the OTP. The medical director should have completed an accredited residency training program and have at least 1 year of experience in addiction medicine or addiction psychiatry. Board certification in his or her primary medical specialty and in addiction psychiatry or addiction medicine is preferred. All OTP physicians are urged to complete the training in the use of buprenorphine required by the Drug Addiction Treatment Act 2000 (DATA 2000), even if they do not plan to provide buprenorphine under office-based opioid treatment (OBOT) rules. In some cases, the one individual may be both medical director and program sponsor but only a physician may serve as the medical director of an OTP. (See 42 CFR § 8.2.) If there is a change of medical director, SAMHSA requires formal notification within 3 weeks of the change.

Narcotic Addict Treatment Act of 1974
DEA Jurisdiction Over Methadone

- Specific licenses for clinics and providers
- Restrictive storage rules
- Specific safes size, weight, alarming to police stations or 24 hour security system alarming to central authority.
- Specifics of who can distribute methadone and all of their personal data (social security numbers, home addresses, etc)
- Clearly delineated “reverse distribution”
- Strong preference for using computerized dispensing through expensive software programs

J.H. Jaffe, C. O’Keeffe / Drug and Alcohol Dependence 70 (2003) S3/S11

Massachusetts Dept of Public Health
105 CMR 164.000 = 156 pages

Licensing Procedures and Requirements

164.007: Applications Required

(A) Application for a license, approval, substance abuse treatment license for a Department of Mental Health licensed facility [hereinafter reference to license shall include substance abuse treatment license for a Department of Mental Health licensed facility where referenced in 105 CMR 164.012(D)(3)], or for renewal of a license or approval shall be filed on forms provided by the Department and accompanied by all supporting documents required by 105 CMR 164.000.

(B) No entity, except a general hospital or clinic licensed by the Department, or a department, agency or institution of the federal government or of the Commonwealth, or any subdivision of those listed above, shall operate a substance abuse treatment program without a substance abuse treatment license from the Department.

105 CMR 164.00: Licensure of substance abuse treatment programs 6/3/2016

https://www.mass.gov/regulations/105-CMR-16400-licensure-of-substance-abuse-treatment-programs

State Regulations Can Be More Onerous

Statutory Limits on Numbers of Methadone Clinics

- Ohio
- Wyoming
- Indiana
- Georgia
- West Virginia
- Louisiana

Some states don't allow any take-homes

Some states don't allow any private companies to open OTPs

No Medicaid Reimbursement for Methadone Treatment

- Alabama
- Arkansas
- Idaho
- Louisiana
- Illinois
- Wyoming
- Texas
- North Dakota
- Kentucky
- Tennessee
- South Carolina
- Nebraska
- Iowa

Long Stigmatized, Methadone Clinics Multiply in Some States

STATELINE ARTICLE October 31, 2018 Christine Vestal

REQUIRED SERVICES

42 CFR 8.12(f) *Required services*. (1) General. OTPs shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. These services must be available at the primary facility, except where the program sponsor has entered into a formal, documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to patients.

OTPs must provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. Any assessments or treatments not directly provided at the facility must be assured via a formal documented agreement with the appropriate community providers.

Adequacy of services is manifest by a plan to manage and follow up each problem identified in the patient's history, physical exam, psychiatric evaluation, health risk assessments, and social support evaluations within 30 days of admission. An OTP should have appropriate information-sharing agreements with other providers, in accordance with federal regulations, in order for these services to be considered fully available to patients.

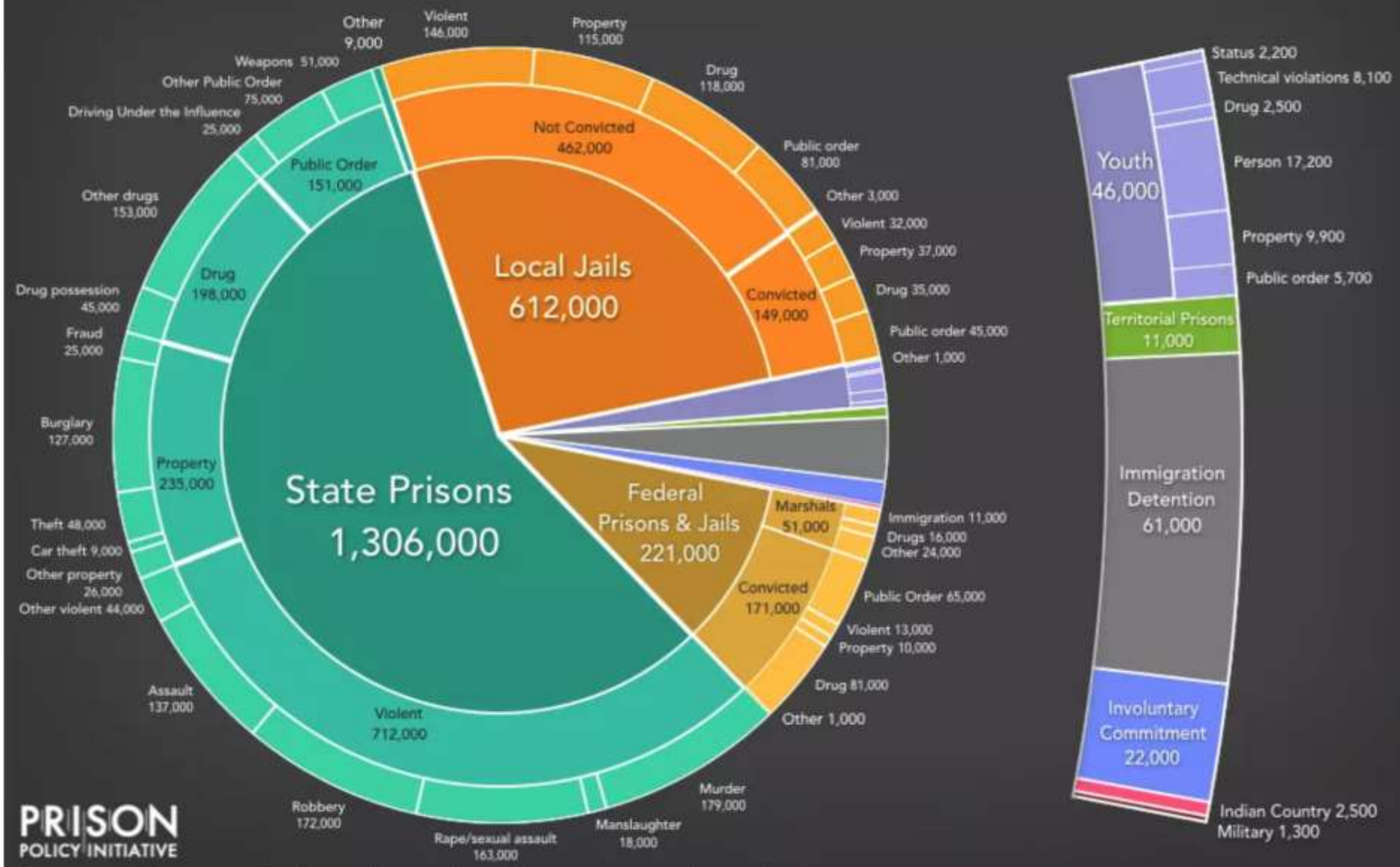
FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS

An individual patient record should contain:

- Documentation of compliance with the approved central registry system (if applicable) or an alternative mechanism to avoid dual registration.
- The initial assessment report.
- Narrative bio-psycho-social history prepared within approximately 30 days of the patient's admission or as required by state regulation.
- Medical reports, including results of the physical examination; past and family medical history; nursing notes; laboratory reports, including results of regular toxicology screens, a problem list, and list of medications updated as clinically indicated; and progress notes, including documentation of all medications and dosages. Information in the medical record is entered by physicians and authorized healthcare professionals, as appropriate.
- Dated case entries of all significant contacts with patients, including a record of each counseling session, in chronological order.
- Dates and results of patient case conferences.
- The treatment plan and any amendments to it; quarterly reviews; and updates of the assessment and treatment plan for the first year of continuous treatment; and in subsequent years, semiannual assessments; treatment plan updates; and counselor summaries, which include an evaluation of the existing treatment plan and the patient's response to treatment.
- Documentation that all services listed in the treatment plan are available and actually were provided or that the patient was referred to such services.
- A written report on the process used to make patient treatment decisions, such as privileges or changes in counseling sessions, frequency of drug tests, or any other significant treatment changes, either positive or negative, and the factors considered in the decisions.
- A record of correspondence with patient, family members, and other individuals.

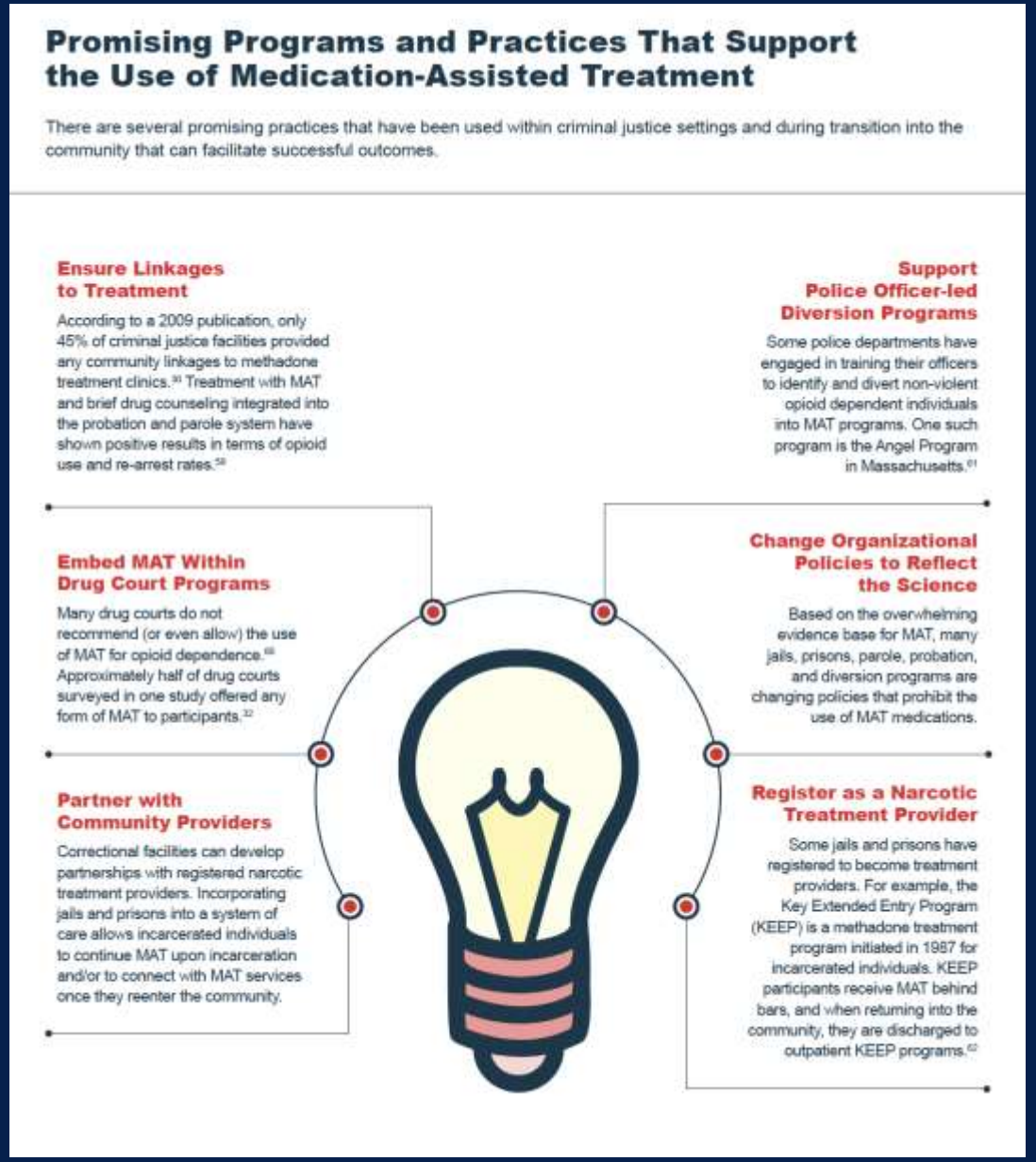
How many people are locked up in the United States?

The U.S. locks up more people per capita than any other nation, at the staggering rate of 698 per 100,000 residents.
But to end mass incarceration, we must first consider *where* and *why* 2.3 million people are confined nationwide.



PRISON POLICY INITIATIVE

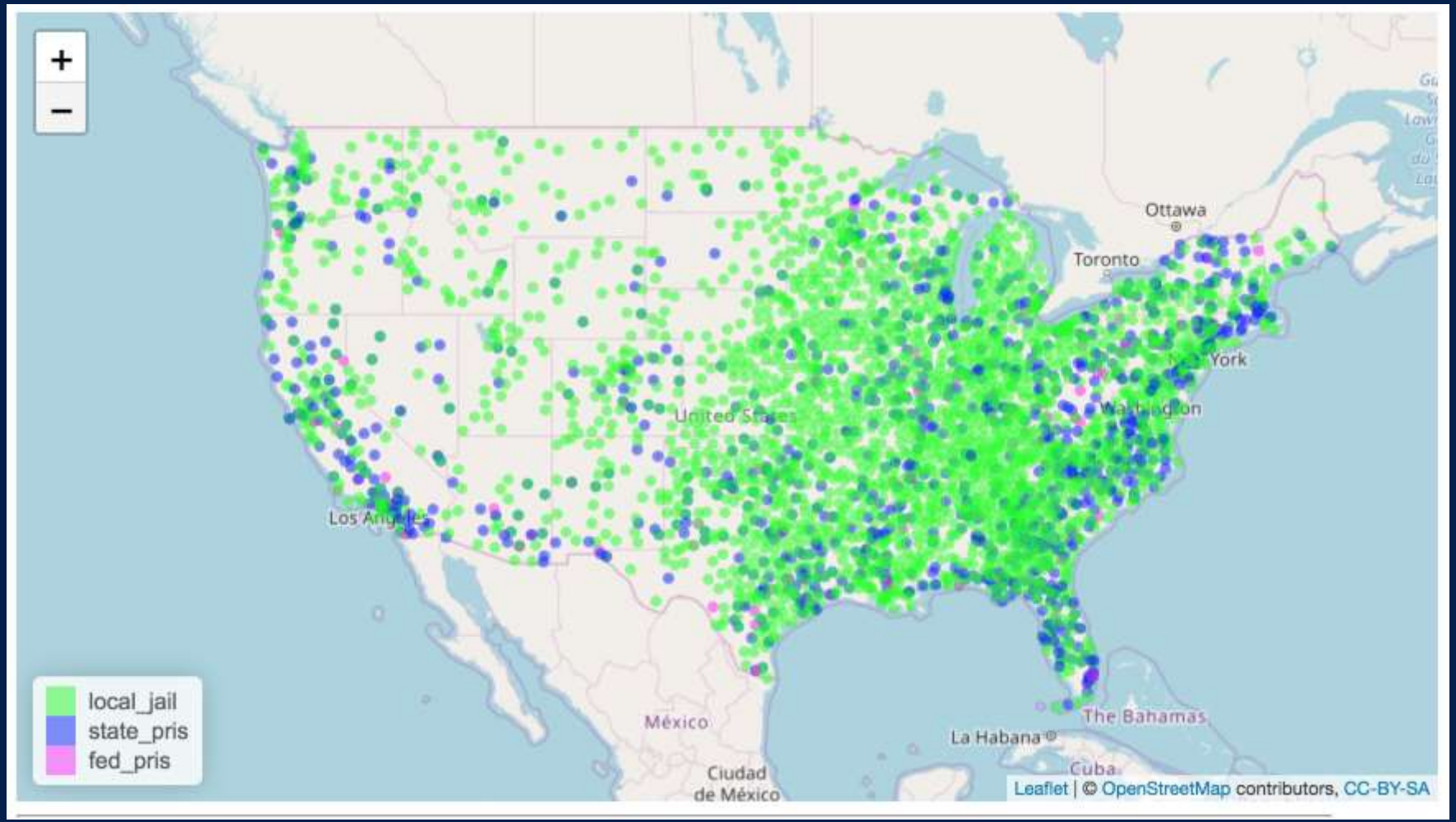
Sources and data notes: See https://www.prisonpolicy.org/reports/pie2019.html



Substance Abuse and Mental Health Services Administration: Use of Medication-Assisted Treatment in the Criminal Justice Settings. HHS Publication No. PEP19-MATUSECJS Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2019.

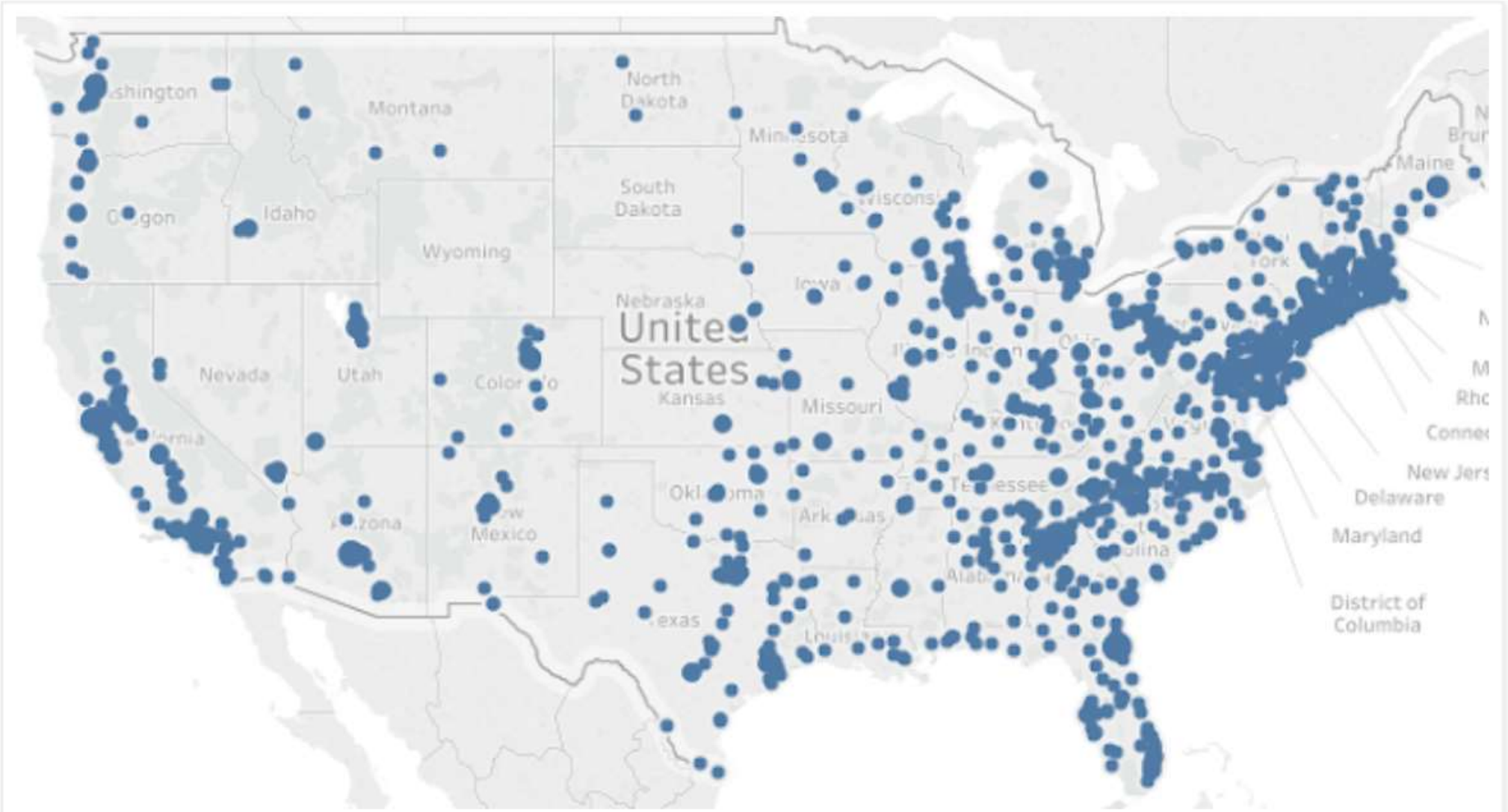
https://www.prisonpolicy.org/reports/pie2019.html#slideshows/slideshow1/2

Jails and Prisons in the United States

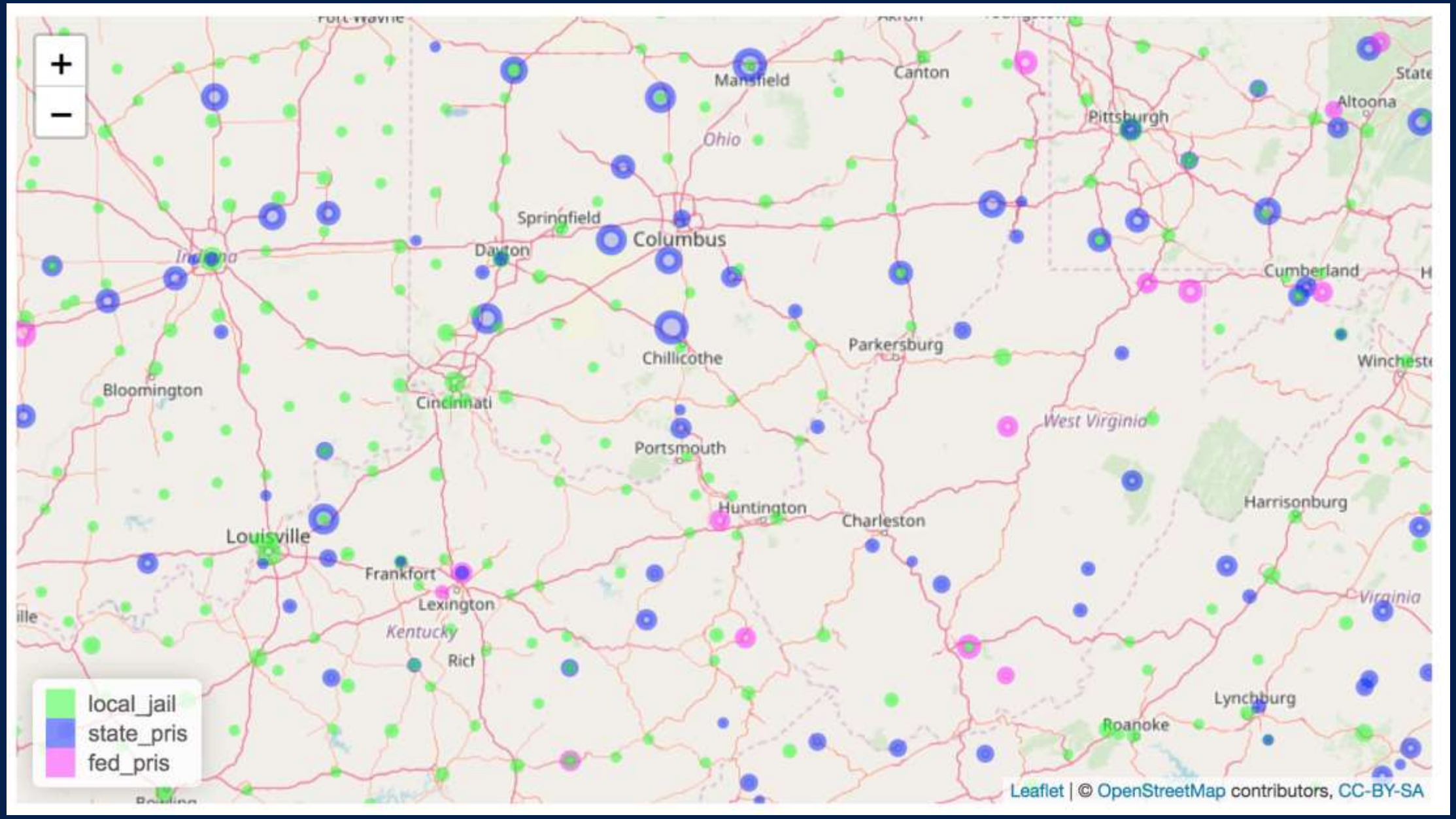


https://www.gl-li.com/2018/02/05/map-prisons-in-the-united-states/

Medication-assisted treatment expands as stigma decreases and more states cover treatment under Medicaid



Methadone clinics in the U.S. *(Stateline map; click here for the interactive version)*



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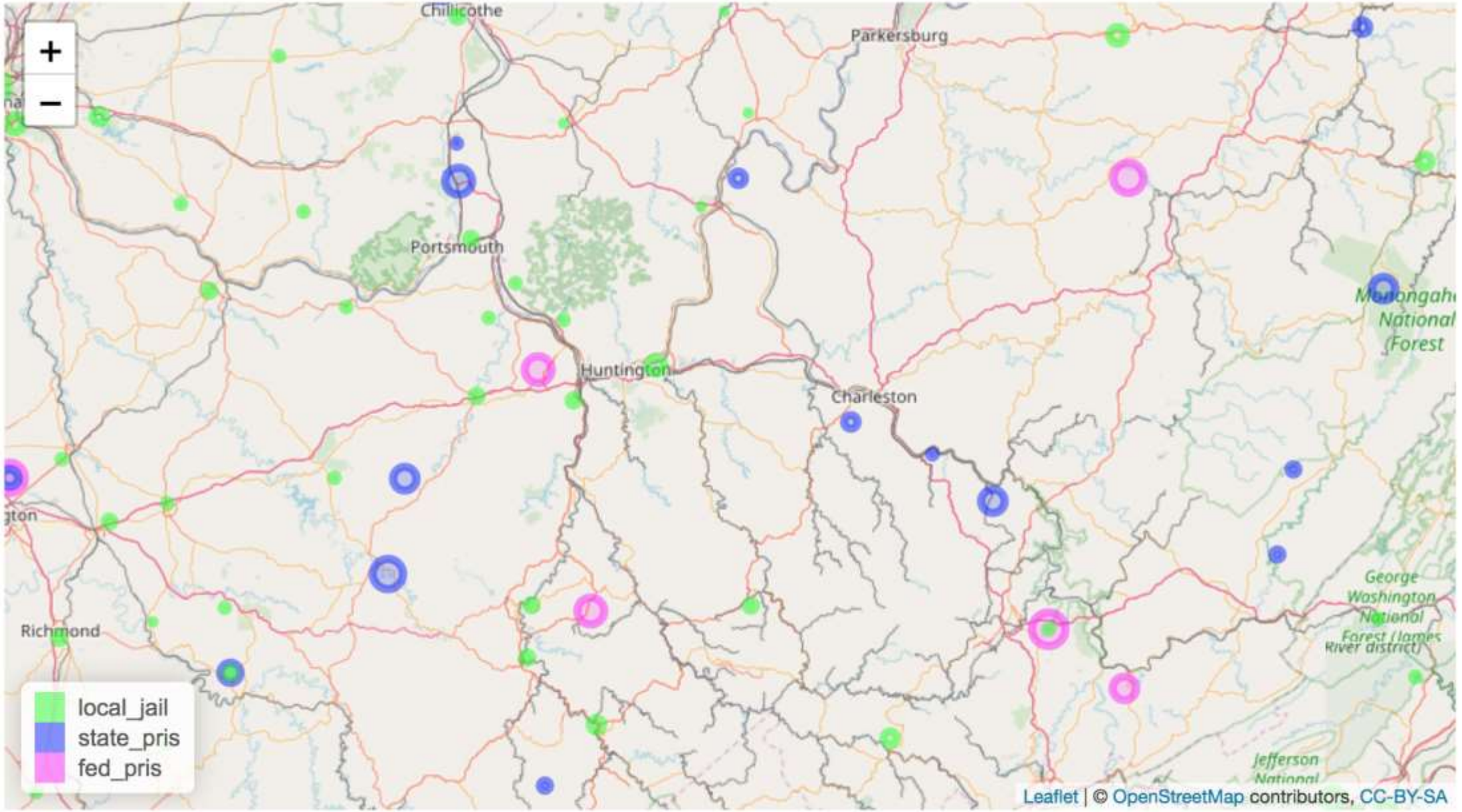

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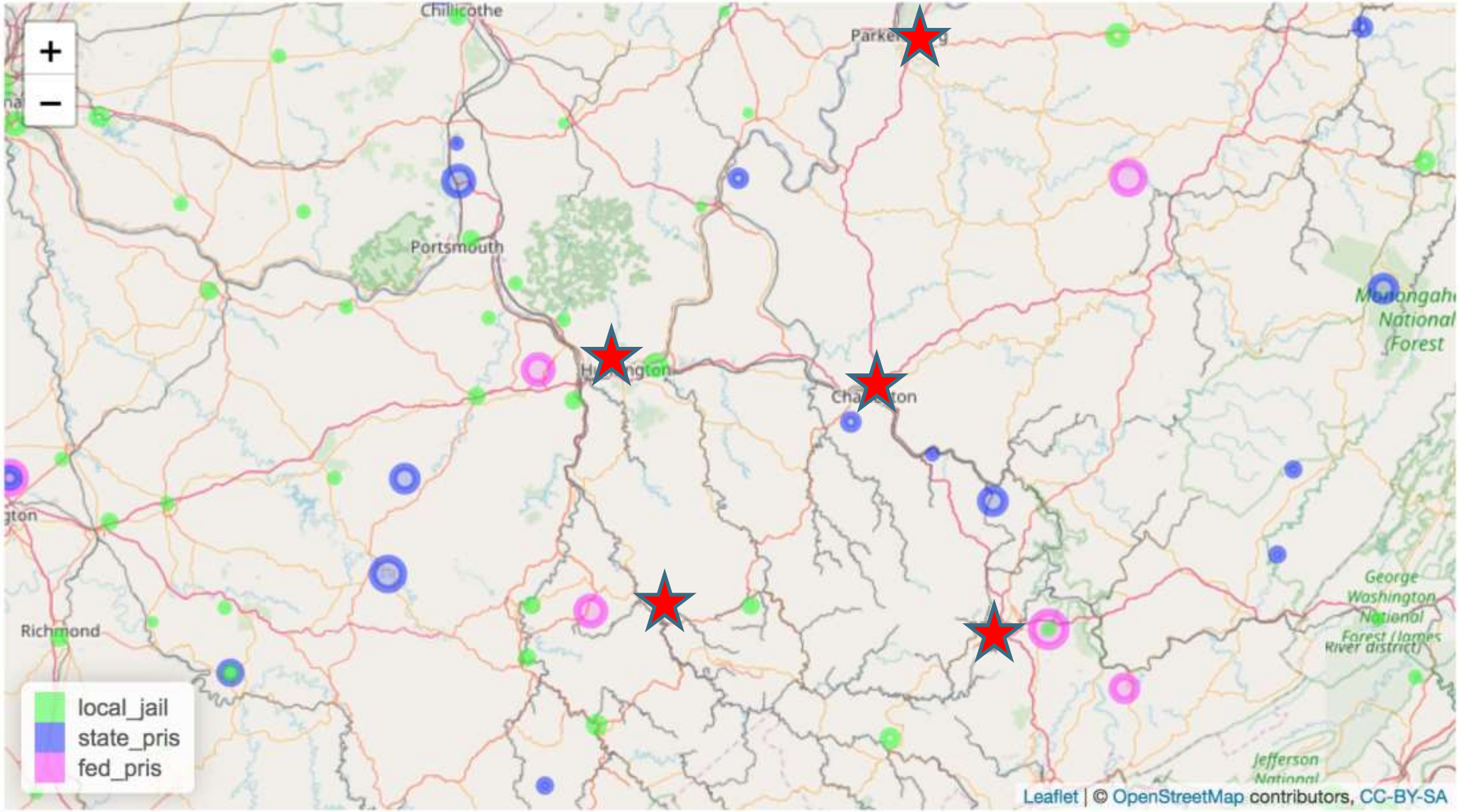
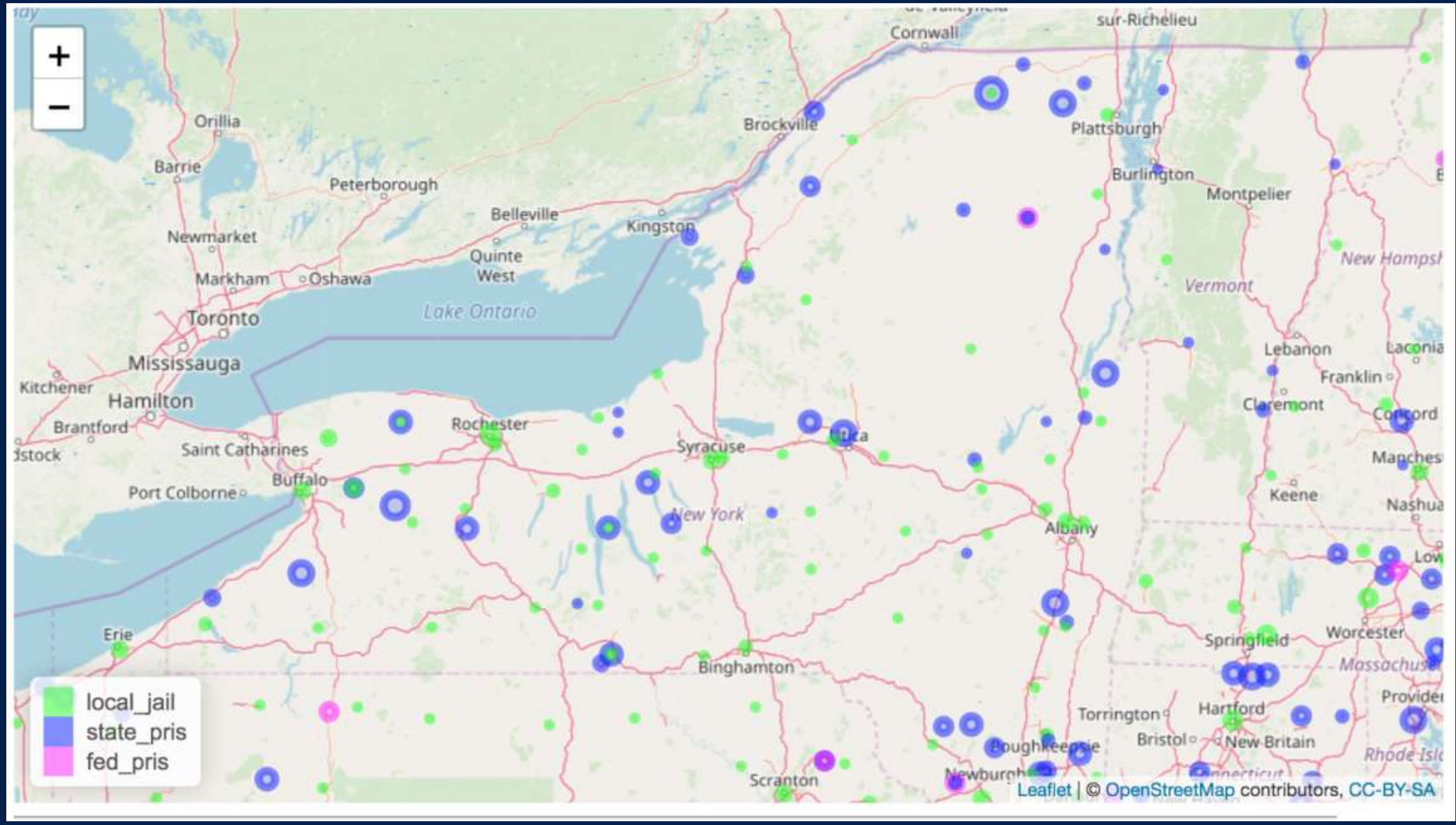
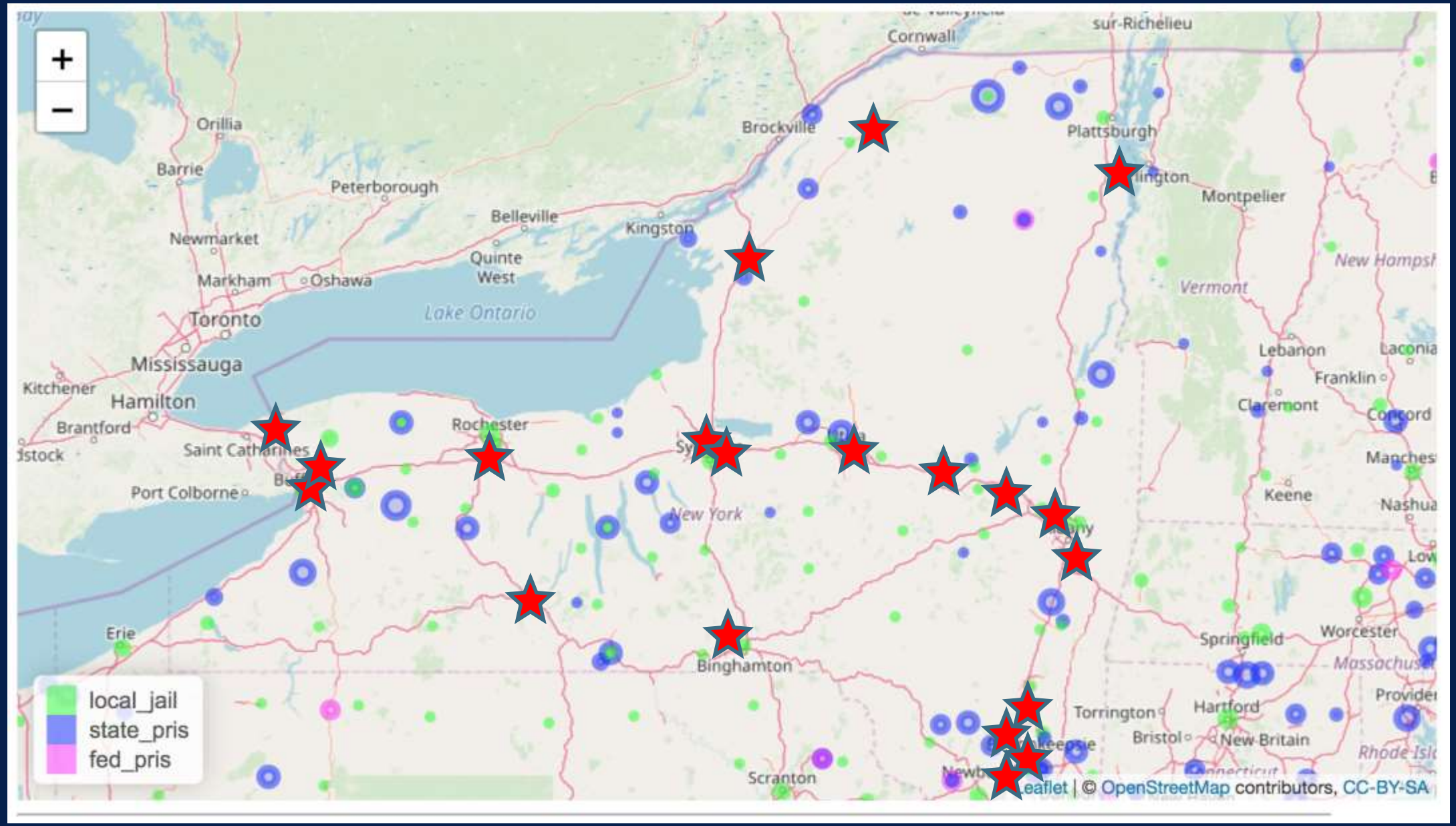


https://www.gl-li.com/2018/02/05/map-prisons-in-the-united-states/

https://dpt2.samhsa.gov/treatment/Home/map.aspx


Cornwall
sur-Richelieu
Brockville
Plattsburgh
Orillia
Barrie
Peterborough
Belleville
Kingston
Burlington
Montpelier
Newmarket
Quinte West
Markham
Oshawa
Lake Ontario
Vermont
Toronto
Mississauga
Kitchener
Hamilton
Brantford
Rochester
Syracuse
Saint Catharines
Buffalo
Port Colborne
Lebanon
Franklin
Claremont
Keene
New York
Albany
Erie
Binghamton
Springfield
Worcester
Torrington
Hartford
Bristol
New Britain
Scranton
local_jail
state_pris
fed_pris
Leaflet | © OpenStreetMap contributors, CC-BY-SA



https://www.gl-li.com/2018/02/05/map-prisons-in-the-united-states/

Canada – 6 Settings

- Addiction Clinic
- Primary Care Office
- Correctional facilities
- Pharmacies
- Home
- Hospitals

UK

- Pt stabilized in specialty methadone clinic and then prescribing is taken over by a GP
- Pharmacies can do daily and direct-observed administration

Keen, Jenny, et al. "Does methadone maintenance treatment based on the new national guidelines work in a primary care setting?." *Br J Gen Pract* 53.491 (2003): 461-467.

Calcaterra, S. L., et al. "Methadone matters: what the United States can learn from the global effort to treat opioid addiction." *Journal of general internal medicine* 34.6 (2019): 1039-1042.

Primary care clinic prescribing of methadone for opioid use disorder could reduce drive times to methadone in rural counties

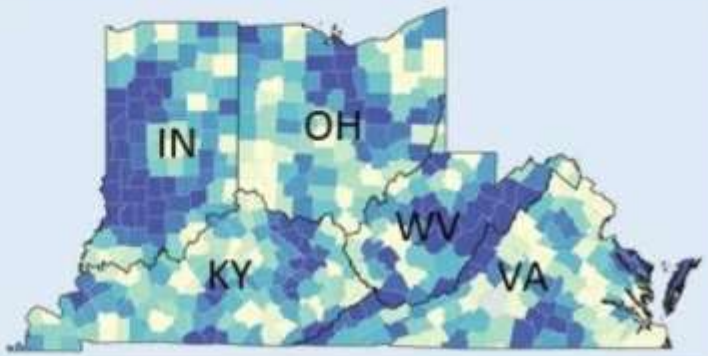
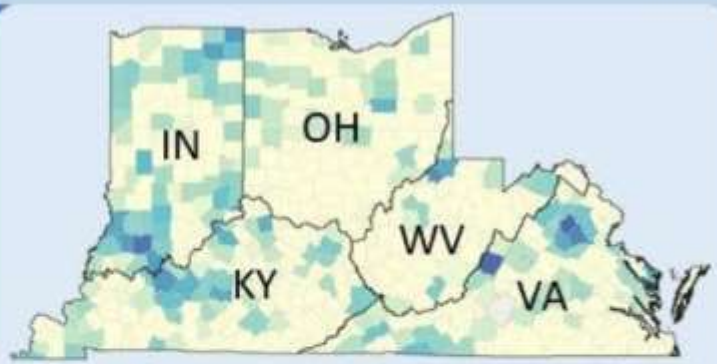
Question: How would prescribing methadone in Federally Qualified Health Centers impact drive time to methadone in rural counties?

Design: Cross-sectional geospatial Analysis

Sample: 487 counties (55% rural) in five states heavily impacted by the opioid epidemic

Outcome: drive time from county population center to nearest facility

Data sources: SAMHSA and Health Resources Services Administration data warehouse 2017

	All counties	Very rural counties	Five state map of all counties
Average To nearest methadone clinic	37 minutes	49 minutes	
VS	VS		
To nearest Federally Qualified Health Center	16 minutes	17 minutes	

Yale SCHOOL OF MEDICINE

Joudrey, P. J. et al. JAMA 2019
doi:10.1001/jama.2019.12562

@PaulJoudreyMD

JAMA The Journal of the American Medical Association

It takes 50 years to get a wrong idea out of medicine, and 100 years a right one into medicine.

~ John Hughlings Jackson

AZ QUOTES

Hall, John C., and Cameron Platell. "Half-life of truth in surgical literature." *The Lancet* 350.9093 (1997): 1752.

COVID-19 Risk Mitigation in Franklin County

- Immediate lock down of facility to decrease exposure
- No admittance of non-violent detainees
- Regular testing and quarantine of inmates and staff
- Rapid release of non-violent pre-trial inmates (25% reduction)
- Telehealth behavioral health treatment
- Provided take home doses for released inmates when needed
- No internal spread of COVID-19 within facility. Fewer than 5 inmates COVID-19 positive at intake

Donelan CJ, Hayes E, Potee RA, Schwartz L, Evans EA. COVID-19 and treating incarcerated populations for opioid use disorder [published online ahead of print, 2020 Dec 2]. *J Subst Abuse Treat*. 2020;108216. doi:10.1016/j.jsat.2020.108216

Trauma Informed Jail

- Previous and continuing trauma is highly present for individuals involved in the criminal justice system
- Jail/Prison puts them in an environment where they have little control over; they are surrounded by individuals who have either victimized, or have been victims themselves, there is little expectation of privacy and emotional safety while incarcerated
- The impact of trauma can be experienced throughout life and affect various aspects of functioning and behavior
- Trauma frequently results in problematic behavior, poor relationships, and justice involvement
- When people are in a fight/flight/freeze response, their executive functioning decreases, and people make choices in order to survive (they do what they have done in the past to survive)

It is important that systems

- Ensure interpersonal interactions with officers and staff be grounded in respect, providing information, ensuring safety, and offering choice
- Make reasonable accommodations to keep the nervous system grounded
  - Informed consent to treatment with full disclosure of what the patient should expect
  - Approach people from the front (don't walk up behind people)
  - Explore triggers and make accommodations (e.g., keys jiggling, racking the doors, separating people who have victimized people from people who have been victimized)
  - Offer embodied practices that treat the whole body: yoga, gardening, exercise, music/art, sleep hygiene, healthy eating, other mindfulness based practices
- Seeing people as more than their worst moments and seek to clarify values and who/what is MOST important to the patient
- Create opportunities for community and positive peer connection
  - milieu based treatment
  - rituals and memorials
  - social empowerment model of treatment

COVID-19 Vaccination Rates

References

1. Jaffe, Jerome H., and Charles O'Keeffe. "From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States." *Drug and alcohol dependence* 70.2 (2003): S3-S11.
2. Calcaterra, S. L., et al. "Methadone matters: what the United States can learn from the global effort to treat opioid addiction." *Journal of general internal medicine* 34.6 (2019): 1039-1042.
3. Priest, Kelsey C., et al. "Comparing Canadian and United States opioid agonist therapy policies." *International Journal of Drug Policy* 74 (2019): 257-265.
4. “Medication-Assisted Treatment (MAT) for Opioid Use Disorder in Jails and Prisons.” *National Council*, www.thenationalcouncil.org/medication-assisted-treatment-for-opioid-use-disorder-in-jails-and-prisons/.
5. Brezel, Emma R., Tia Powell, and Aaron D. Fox. "An ethical analysis of medication treatment for opioid use disorder (MOUD) for persons who are incarcerated." *Substance Abuse* (2019): 1-5.

References

1. Ferguson, Warren J., et al. "Advancing the implementation and sustainment of medication assisted treatment for opioid use disorders in prisons and jails." *Health & Justice* 7.1 (2019): 19.
2. “105 CMR 164.00: Licensure of Substance Abuse Treatment Programs.” *Mass.gov*, Department of Public Health, 2016, www.mass.gov/regulations/105-CMR-16400-licensure-of-substance-abuse-treatment-programs.
3. Substance Abuse and Mental Health Services Administration. Federal Guidelines for Opioid Treatment Programs. HHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
4. Alderks, C.E., Trends in the Use of Methadone, Buprenorphine, and Extended-release Naltrexone at Substance Abuse Treatment Facilities: 2003-2015 (Update). The CBHSQ Report: August 22, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.
5. Helena Hansen, , Samuel K. Roberts, "Two Tiers of Biomedicalization: Methadone, Buprenorphine, and the Racial Politics of Addiction Treatment" In Critical Perspectives on Addiction. Published online: 08 Mar 2015; 79-102.