



# How States and Counties Can Help Individuals With Opioid Use Disorder Re-Enter Communities

People need access to proven treatment, consistent care post-incarceration

## Overview

At least 95 percent of individuals in state prisons will eventually return to communities. In fact, in a typical year more than half a million people do so, with many more coming from jails. A disproportionate share of these individuals have one or more chronic illnesses, including more than half who met the criteria for a non-alcohol and nicotine-related substance use disorder (SUD) from 2007 to 2009, according to the latest available data. The percentages are likely substantially higher now, however, because of what the Centers for Disease Control and Prevention has described as the current opioid epidemic.

The prospect for a successful re-entry by these individuals is strongly affected by their ability to access health care services post-release, particularly treatment for their SUD.<sup>1</sup> The ability to access care is critical, as the time immediately following release can be particularly dangerous for overdose. Individuals who have been relatively or completely opioid-free behind bars have a reduced tolerance to the drug, and therefore are at high risk of overdose if they resume use at their previous levels.

Policymakers should take the following steps to maximize the chance of successful re-entry for people with SUDs leaving jails and prisons:

- Appropriate sufficient funds for jails and prisons to provide the gold standard of evidence-based care for opioid use disorder (OUD): one of three medications approved by the Food and Drug Administration (FDA)—methadone, buprenorphine, or naltrexone—combined with counseling as necessary. (A companion report from The Pew Charitable Trusts, “Opioid Use Disorder Treatment in Jails and Prisons,” addresses this subject at length.)
- Implement policies that enable people eligible for Medicaid to be enrolled at the time of release.
- Appropriate funds for sufficient jail and prison re-entry staff to ensure that people leaving these facilities will have participated in discharge planning, which should include a needs assessment, connection to care, and self-management training. Such re-entry planning is beneficial whether or not an individual received treatment for OUD while incarcerated.<sup>2</sup>
- Prioritize the funding and development of a statewide data infrastructure that would facilitate the exchange of health information across multiple settings, including between correctional programs, community-based health care, and community-based social services.

Although some re-entry processes are better suited to the longer sentences and more predictable release dates that characterize a prison stay, jail re-entry counselors should begin working with individuals who are incarcerated upon entry and take advantage of their proximity to and knowledge of the resources in the community to which that person will return, often in a short time frame.

### Defining jails and prisons

Jails are typically city- or county-run correctional facilities that house individuals serving sentences generally less than a year long, as well as persons awaiting trial.

Prisons are state- or federally run correctional facilities that house individuals convicted of crimes for which they typically are serving sentences of a year or longer.

## Why connecting released individuals to community care matters

Correctional health care systems and outside communities share a strong interest in facilitating access to community care for individuals at the time of their release. Both systems are motivated by the public health implications of conditions prevalent among the criminal justice population, and also the likelihood that poorly managed chronic diseases will result in avoidable and costly emergency room visits and hospitalizations post-release.<sup>3</sup> For the many individuals with an OUD leaving a correctional setting, a successful connection to treatment can make the difference between life and death.

## Key differences between jails and prisons

Jails differ from prisons in many ways, with implications for what is feasible for both treatment behind bars and re-entry planning. For example, each week in 2017, more than half (54 percent) of the nation's jail population turned over. Many people are released with very little notice—to themselves, their families, or the jail—because of court rulings or other reasons. In contrast, individuals in prisons generally have sentences of at least one year and release dates that are known well in advance.<sup>4</sup> In addition, when people leave state prisons, which are often in remote locations, they tend to fan out across a state, while individuals leaving jails usually return to close-by communities, enabling jail re-entry planners to become familiar with their community resources.

At least four major components can facilitate access to care for individuals about to return to the community:

- Ongoing, consistent, and widely accepted funding for ongoing care, usually via health insurance;
- Comprehensive, person-specific discharge planning within the jail or prison;
- A robust statewide data infrastructure capable of coordinating and exchanging information across criminal justice, community health systems, and health insurers; and
- Physically accessible and high-quality treatment providers who are knowledgeable about and sensitive to the language, culture, and beliefs of the patient.

## Health insurance coverage

The federal government and others have strongly urged states and localities to incorporate Medicaid enrollment into their correctional discharge planning efforts. The Centers for Medicare & Medicaid Services (CMS) encourages “correctional institutions and other state, local, or tribal agencies to take an active role in preparing individuals who are incarcerated for release by assisting or facilitating the application process prior to release.”<sup>5</sup>

The Affordable Care Act of 2010 created an opportunity for states to broaden their Medicaid eligibility criteria so that for the first time, nearly all people who are imprisoned would be eligible for the program upon release. As of October 2019, 36 states and the District of Columbia have opted to expand (Idaho, Nebraska, and Utah have not yet implemented expansion), but in the remaining states, few people exiting jail or prison qualify for their state's Medicaid program, and instead generally return to their community uninsured.<sup>6</sup>

Beyond setting the threshold for Medicaid eligibility, states can take steps to ensure that people leaving prison and jail are enrolled in Medicaid.

## Suspending or limiting coverage for those entering incarceration as Medicaid enrollees

CMS encourages states not to terminate coverage for enrollees during their time in correctional facilities, but rather to suspend it until release.<sup>7</sup> Suspension can help Medicaid coverage to resume promptly or even immediately upon re-entry to the community, and save the department of corrections (DOC) from helping individuals generate a new application prior to release (and the Medicaid agency from having to process it).

A policy to suspend rather than terminate Medicaid upon incarceration is especially important for brief jail stays. For example, jails in Texas do not suspend enrollment until the person has been incarcerated for at least 30 days, resulting in a far smaller number of change-of-status reports to the state's Medicaid agency.<sup>8</sup>

## Application processes

The Cook County, Illinois, (Chicago) and Philadelphia jails address the unpredictability of release from their facilities by starting a Medicaid application when someone enters jail, per Substance Abuse and Mental Health Services Administration guidelines. They state that “planning for re-entry should begin at jail booking,” while explaining that “periodic screening and assessment should take place over time to ... inform re-entry services.”<sup>9</sup>

States set rules about the necessary application documents—such as a driver’s license or a birth certificate, as well as proof of income—for Medicaid enrollment, which can pose a barrier to individuals who are incarcerated, as they often do not have access to commonly used official sources of identification. Some states take advantage of federal rules allowing alternative documentation, such as a state-issued prison identification instead of a physical form of ID.

States also can allow jails and prison facilities to make use of presumptive eligibility, a policy allowing an individual to be temporarily enrolled in Medicaid based on key information, and prior to an official determination of eligibility. For example, in Connecticut, applicants unexpectedly released from facilities complete a shortened Medicaid application and receive a voucher, which allows them to fill a prescription while their full application is being reviewed.<sup>10</sup> Presumptive eligibility can be a useful tool for expediting post-release coverage, particularly to pay for services during the dangerous first few weeks after release.

## Alternatives to Medicaid coverage

In states that have not expanded Medicaid eligibility, individuals exiting jail or prison generally return to communities uninsured. However, there are some health care providers to whom re-entry counselors can connect individuals, regardless of insurance status. Each state has a lead agency that contracts with providers who offer treatment, to serve people who have an SUD and/or a mental illness. While such programs address a crucial treatment gap, they do not treat other health concerns, such as hepatitis C, HIV, or diabetes.

Another valuable option re-entry counselors can call upon for military veterans in the criminal justice system is the Veterans Health Administration (VA), which operates 1,255 facilities across the country.<sup>11</sup> While VA services are open to all veterans, they are particularly useful to those not eligible for their state’s Medicaid program. The VA’s Veterans Justice Outreach framework provides dedicated clinicians who interface with jails and prisons to identify veterans who are incarcerated, assist with resource access, and coordinate care, including re-entry.<sup>12</sup>

## Prison discharge planning

An assessment of promising release planning practices indicates that trained re-entry counselors should work to develop an individualized re-entry plan that includes:

- an assessment of the person’s ongoing medical needs;
- a mapping, or care plan, of how the person will be able to address those needs;
- confirmation of specific follow-up appointments (with appropriate transportation arrangements also confirmed), with at least a primary care clinician and a provider who can prescribe one of the three FDA-approved medications;
- transfer of the individual’s medical and prescription records to a primary care clinician;
- jail or prison issuance of naloxone, as appropriate, a medication approved by FDA to treat opioid overdoses; and
- self-management training to help the outgoing individual manage, oversee, and advocate for his/her own chronic health conditions.

While jail administrators rarely have the luxury of several months' notice in which to develop a re-entry plan and often don't know when a release will occur because of court rulings, the shorter lengths of stay that characterize jail confinements should also be less disruptive to any community supports and care arrangements in place upon entering. Jail administrators should concentrate on helping individuals keep insurance, prescribed medications, housing, and employment, and begin helping all others to obtain them as early as admission.

## **Promising discharge planning models**

In early 2018, the New Jersey DOC launched a state-funded peer-navigator program to help support individuals with an SUD about to be released from its prisons. People who are incarcerated are referred by a prison-based medical provider to the Intensive Recovery Treatment Support (IRTS) program of Rutgers University Behavioral Health Care (Rutgers University Correctional Health Care is the overall health care provider for NJ DOC), or may apply to the program themselves. Six months prior to release from prison, program participants are paired with a peer who works with them to develop a plan that includes SUD treatment, employment, housing, and other re-entry components. The pair continues to work together for 12 months post-release, with the peer accompanying the client to appointments and providing other recovery support. New Jersey's three teams each have 10 peers (with a caseload capacity of 20 clients each), two counselors who help participants adjust to daily life and expectations in the community, a nurse, a supervisor, and a part-time OUD medication prescriber. Three additional peers have recently been added to meet with individuals who are newly incarcerated at orientation to discuss the DOC's on-site OUD treatment program, which makes all three approved medications available. To qualify for the job, peers must have been in recovery from SUDs for at least five years and must be five years out of jail or prison, including parole. Rutgers has made arrangements for an outside evaluation of the IRTS program.<sup>13</sup>

In August 2019, the Massachusetts Executive Office of Health and Human Services launched a demonstration program through MassHealth, Massachusetts' Medicaid program, that offers intensive re-entry services for some individuals exiting jails in Middlesex and Worcester counties, a state prison releasing people into those counties, and people currently on parole or probation in those counties.<sup>14</sup> Eligible individuals must have a serious behavioral health disorder, an SUD, or co-occurring diseases. The participating justice entities are responsible for identifying and referring individuals to two nonprofit behavioral health providers. Staff from those organizations conduct in-person visits with referred individuals at correctional facilities or meet them at probation and parole offices. The organizations are charged with providing intensive support to this high-needs population, including connecting participants to appointments with medical and behavioral health providers, accessing social services and benefits, and obtaining stable housing after release. The program—which is currently funded with state dollars and no matching federal funding—began in the two jails, with the goal to expand statewide in 2021.

## **Using Medicaid MCOs in discharge planning**

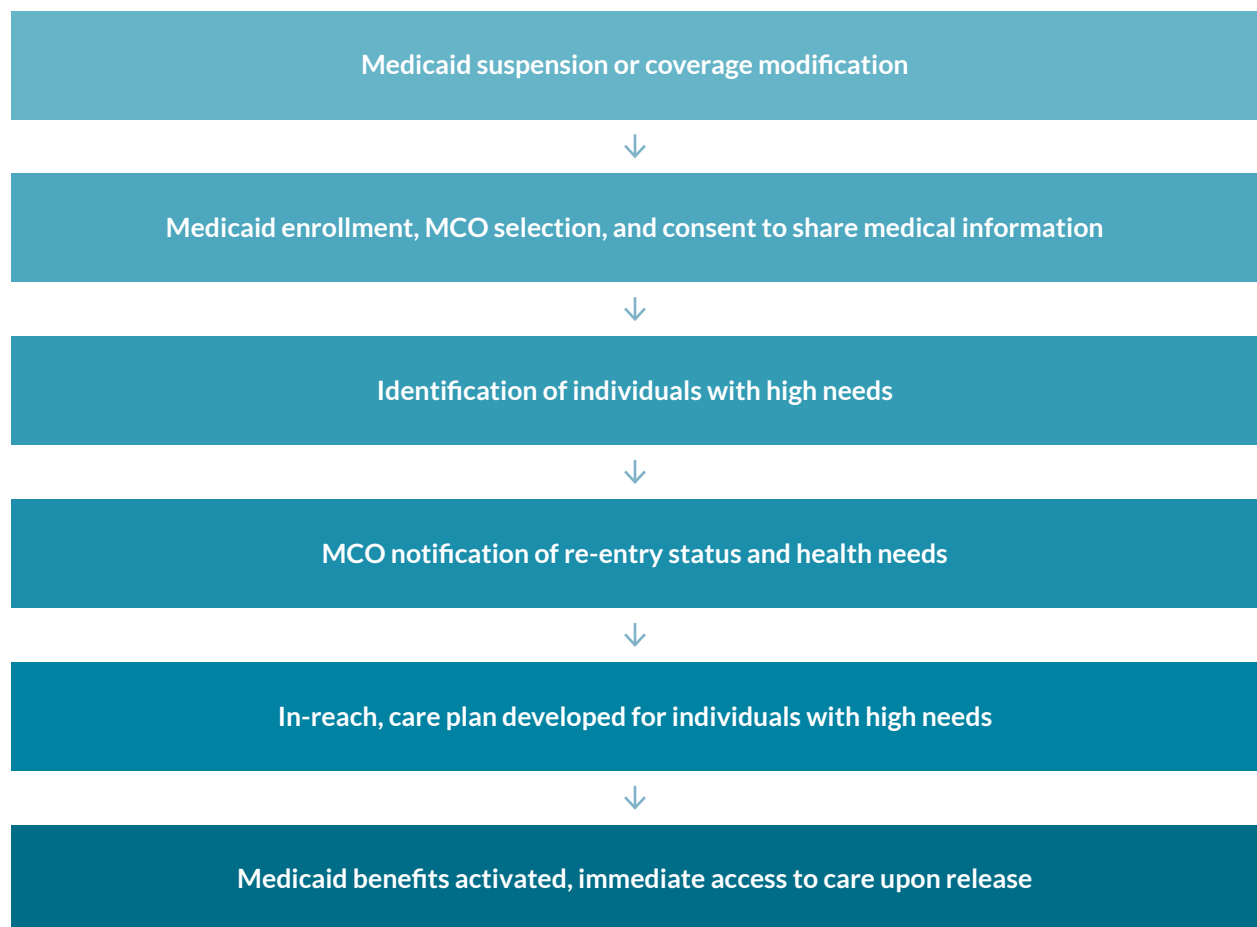
States that use Medicaid managed care organizations (MCOs) to deliver benefits and additional services to enrollees (and most do) should actively include MCOs in the discharge process.<sup>15</sup> The Ohio Department of Rehabilitation and Correction (ODRC) partners with the state's Medicaid agency to initiate enrollment for those about to be released from prison and facilitates an individual's selection of an MCO. The MCO must provide various care management services to all enrollees with "high acuity of needs," which includes people with an SUD and a second chronic condition.<sup>16</sup> The medical histories of individuals in the ODRC who meet these criteria are shared with staff from the selected MCO who use the data to develop pre-release transition plans, contact (via phone or video conference) the person about to be released to review and refine them, and follow up with the individual within five days of release.<sup>17</sup> Louisiana Medicaid launched a similar re-entry program in January 2017 for people with severe or moderate SUD, serious mental illness, cancer, HIV, or disabilities.<sup>18</sup>

Complementing Ohio Medicaid's set of covered services, Ohio's Department of Mental Health and Addiction Services since 2016 has offered a specialized re-entry program, the Community Transition Program, for people who identified as having a history of substance use and who participated in substance use-related programming while incarcerated. This program is offered statewide through the network of alcohol, drug addiction, and mental health services boards and provides recovery services, including pre-release contact by a care coordinator from the person's selected MCO, a scheduled post-release appointment with a community-based behavioral health provider, peer recovery services, housing subsidy and support, employment support, transportation assistance, ongoing relapse prevention, and care management services. It also provides access to funds to secure critical state and federal identification including birth certificates and Social Security cards.

The Kentucky Department of Medicaid Services has also implemented a pilot re-entry effort specifically targeting people with SUD or mental illness returning from prison. MCOs under contract with the state's Medicaid program collaborate with the Kentucky DOC, Medicaid, and community-based behavioral health providers to identify re-entering individuals who have been assigned to MCOs prior to release and provide care coordination and referrals to community-based behavioral health services.<sup>19</sup>

Figure 1

## **A process of obtaining or reactivating health insurance coverage and managed care enrollment from some states' prisons**



## **The role of a robust statewide data system**

Many people incarcerated in jails and prisons are low-income and have chronic illnesses, including SUDs, and interact with a multitude of county, state, federal, and nongovernmental agencies during their lifetimes. For both historical and confidentiality reasons, these agencies all tend to have stand-alone data systems unable to exchange information in a user-friendly and confidential manner; however, such a system may be the most important factor in achieving the goal of seamless re-entry. For example, when a released person's recent medical history is not conveyed to his or her MCO and community-based providers, the person will be forced to repeat the screenings, tests, and assessments that were likely already done to determine the diagnosis and treatment plan. In addition, counties and states cannot determine the effectiveness of health care re-entry processes for people with OUD if MCOs and Medicaid administrators are unable to identify new enrollees who came from the criminal justice system.

Although neither jails nor prisons can launch a statewide data system on their own, officials can advocate for the establishment of one and point to the benefits it would bring to the people who enter the criminal justice system and the agencies from which they often receive services. In the meantime, jails and prisons can establish a process for securely transmitting a person's important health information and medications to follow-on providers and insurers.

## **Treatment**

### **Synergies between community providers and jail/prison health providers**

One approach to facilitating continuity of care is to use a community-based provider—such as a public health department or a health care provider that serves a high proportion of publicly insured and uninsured patients—as the entity that provides care within the prisons and jails. This arrangement offers significant advantages because individuals in jails usually obtain their community-based health care from such providers, so efficiencies can occur through a shared medical record, similar sets of preferred pharmaceuticals, or the use of the same clinicians across sites.

Examples of jails that use their cities' safety net health care providers include the Cook County, Illinois, jail (Cook County Health); the Dallas County, Texas, jail (Parkland Health and Hospital System); Denver city and county jails (Denver Health); and the jail on Rikers Island in New York City (New York City Health and Hospitals Corporation). The Los Angeles County Department of Health Services and Multnomah County's (Portland, Oregon) health department do the same for their county jails. But jails don't have to be big-city facilities to utilize this type of arrangement; one of the earliest examples was in Hampden County, Massachusetts (Springfield), which contracted its in-jail health care from nearby Baystate Brightwood community health center. The center's clinicians already cared for many of the individuals who cycled through the county jail.

DOCs in Rhode Island and Delaware contract for part or all of their prison health care with the state's largest SUD care provider. Rhode Island found that exiting individuals' mortality rate from drug overdose dropped by 60.5 percent after it introduced the use of all three FDA-approved medications inside its prisons. It is likely that Rhode Island's contract with a provider that straddled the prison/community divide contributed to achieving that significant reduction in overdose mortality, since one of the most vexing challenges of re-entry planning is identifying an available, convenient treatment provider able to seamlessly continue treatment started during incarceration.<sup>20</sup>

## **Dedicated providers for those exiting jail or prison**

Arizona's Medicaid agency has addressed incarceration-specific health and re-entry needs by establishing 12 health care clinics in probation/parole offices around the state that offer integrated physical and behavioral care, including all three types of medications, screening for employment, housing, and food assistance.<sup>21</sup> The rationale for co-locating health care services in probation/parole offices is that keeping a scheduled medical appointment is more convenient for a person at a place he or she is already obliged to visit. Arizona Medicaid also requires each contracted MCO to designate a justice liaison who coordinates all matters pertaining to enrollees who were recently incarcerated.

Transitions Clinics are an emerging set of private not-for-profit health care providers established specifically to address the many health and other challenges faced by individuals newly returning to urban locations. These clinics are a national network of medical homes for individuals with chronic diseases who have been recently released from incarceration. They are founded on the idea that the people closest to the problem are also closest to the solution, and clinics that adopt this model employ a community health worker with a history of incarceration as part of the clinical team.<sup>22</sup> The network has 25 clinics in 11 states and Puerto Rico, located in the under-resourced communities to which released individuals tend to return.

## **Enlisting the assistance of community supervision staff**

In some states, health care has become an increasingly important element of parole and probation officers' portfolios. Officers are assigned specific caseloads of individuals, such as those with mental illness, or domestic violence or sex offenders. States might find it practical to assign certain officers to individuals with SUDs so that they can familiarize themselves with local providers, sober housing, and other supports that encourage adherence to treatment or that they should train all staff to become familiar with such services. Parole officers can also be tasked with assisting re-entry counselors based in prisons around the state to identify local practitioners and make appointments with them for specific people who are re-entering.

Missouri parole officers are responsible for urging individuals who received a naltrexone injection before exiting a state prison to obtain subsequent ones.<sup>23</sup> Louisiana uses parole officers to check that all issued prescriptions have been filled and medical appointments kept.<sup>24</sup> And Arizona has co-located a number of clinics in parole offices around the state to facilitate the keeping of appointments and to underscore the association between successful re-entry and management of chronic health conditions.



## Conclusion

Correctional facilities and jurisdictions can help individuals with an SUD address challenges to a successful re-entry. To facilitate these efforts, policymakers can:

- appropriate budget dollars to help the criminal justice system offer evidence-based medication and counseling treatment for OUD from admission to release;
- fund re-entry counselors in the correctional institutions within their jurisdiction and require that funding be used to develop effective and comprehensive re-entry plans;
- ensure immediate Medicaid coverage upon leaving a jail or prison, or encourage jail and prison re-entry staff to consistently make a referral to a state-funded or VA's OUD treatment provider when appropriate; and
- fund the development of an integrated data system across jurisdictional and departmental boundaries.

While counties and states pursue these core activities, research needs to test which set of components is most effective to a successful re-entry for those with SUD.

## Endnotes

- 1 K. Kim, M. Becker-Cohen, and M. Serakos, "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System" (The Urban Institute, 2015), <https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system>; J. Baillargeon et al., "Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door," *American Journal of Psychiatry* 116, no. 1 (2009): 103-109, <http://doi.org/10.1176/appi.ajp.2008.08030416>.
- 2 The Pew Charitable Trusts, "Prison Health Care: Costs and Quality" (2017), <https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>; National Sheriffs' Association, "Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field" (2018), <https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf>; Federal Bureau of Prisons, "Substance Abuse Treatment," accessed Oct. 28, 2019, [https://www.bop.gov/inmates/custody\\_and\\_care/substance\\_abuse\\_treatment.jsp](https://www.bop.gov/inmates/custody_and_care/substance_abuse_treatment.jsp); J. Allen, medical director, Federal Bureau of Prisons, meeting, Feb. 7, 2019.
- 3 J.W. Frank et al., "Increased Hospital and Emergency Department Utilization by Individuals With Recent Criminal Justice Involvement: Results of a National Survey," *Journal of General Internal Medicine* 29, no. 9 (2014): 1226-33, <https://www.ncbi.nlm.nih.gov/pubmed/24817280>; E.A. Wang, Y. Wang, and H.M. Krumholz, "A High Risk of Hospitalization Following Release From Correctional Facilities in Medicare Beneficiaries: A Retrospective Matched Cohort Study, 2002 to 2010," *JAMA Internal Medicine* 173, no. 17 (2013): 1621-28, <https://www.ncbi.nlm.nih.gov/pubmed/23877707>; Frank et al., "Increased Hospital and Emergency Department Utilization."
- 4 Z. Zeng, "Jail Inmates in 2017" (U.S. Department of Justice, Bureau of Justice Statistics, 2019), <https://www.bjs.gov/content/pub/pdf/ji17.pdf>.
- 5 V. Wachino, director, Centers for Medicare & Medicaid Services, letter to state health officials, "To Facilitate Successful Re-Entry for Individuals Transitioning From Incarceration to Their Communities," April 28, 2016, <https://www.medicare.gov/federal-policy-guidance/downloads/sho16007.pdf>.
- 6 Kaiser Family Foundation, "Status of State Medicaid Expansion Decisions," last modified Sept. 20, 2019, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map>.
- 7 Wachino, letter.
- 8 G. Carter, deputy associate commissioner, access and eligibility services program policy, Texas Health and Human Services Commission, letter to eligibility services regional directors and supervisors, program managers, regional attorneys, and hearings officers, "Suspension, Termination and Reinstatement of Health Care Coverage for Persons Confined to a County Jail," Dec. 14, 2018.
- 9 Substance Abuse and Mental Health Services Administration, "Screening and Assessment of Co-Occurring Disorders in the Justice System" (2015), [https://store.samhsa.gov/system/files/pep19-screen-codjs\\_1.pdf](https://store.samhsa.gov/system/files/pep19-screen-codjs_1.pdf).
- 10 S.N. Bandara et al., "Leveraging the Affordable Care Act to Enroll Justice-Involved Populations in Medicaid: State and Local Efforts," *Health Affairs* 34, no. 12 (2015): 2044-51, <https://www.ncbi.nlm.nih.gov/pubmed/26643624>.
- 11 U.S. Department of Veterans Affairs, "Veterans Health Administration Providing Health Care for Veterans," accessed Oct. 29, 2019, <https://www.va.gov/health>.
- 12 Veterans Health Administration, "Veterans Justice Programs" (2017), [https://www.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=5473](https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5473).
- 13 M.C. Bohan, vice president of outpatient and ambulatory services, Rutgers University Behavioral Health Care, meeting, July 24, 2019.
- 14 Massachusetts Executive Office of Health and Human Services, "Behavioral Health Initiative Enhances Connection to Community-Based Supports for Individuals Involved With the Criminal Justice System," news release, July 15, 2019, <https://www.mass.gov/news/behavioral-health-initiative-enhances-connection-to-community-based-supports-for-individuals>.
- 15 Kaiser Family Foundation, "State Health Facts: Share of Medicaid Population Covered Under Different Delivery Systems," July 1, 2019, <https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- 16 K. Miller, chief of care management and quality improvement section, "Ohio Medicaid Pre-Release Enrollment Program" (presentation, Atlantic States Fiscal Leaders Meeting, Boston, Feb. 25, 2017).
- 17 Ibid.
- 18 K. Page, justice-involved pre-release enrollment project manager, Louisiana Department of Health, meeting, Nov. 29, 2018.
- 19 K. Hurley, director of criminal justice services, CareSource, email, Aug. 13, 2019.
- 20 T.C. Green et al., "Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System," *JAMA Psychiatry* 75, no. 4 (2018): 405-407, <https://www.ncbi.nlm.nih.gov/pubmed/29450443>.

- 21 Arizona Health Care Cost Containment System, "AHCCCS Initiatives and Processes to Support Reentry for Individuals Released From Incarceration," accessed Oct. 1, 2019, [https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/AHCCCS\\_Initiatives\\_for\\_CJ.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/AHCCCS_Initiatives_for_CJ.pdf); M. Rudnick, project manager, Office of the Director, Arizona Health Care Cost Containment System, email, July 28, 2019.
- 22 Transitions Clinic, "Transitions Clinic Network," accessed Oct. 28, 2019, <http://transitionsclinic.org/transitions-clinic-network>.
- 23 D. Williams, assistant division director for health services, Missouri Department of Corrections, telephone call, Sept. 16, 2016.
- 24 J. Lipinski, "State Prisons to Enroll Ex-Inmates in Medicaid Starting Jan. 1," *The Times-Picayune*, Dec. 9, 2016, [https://www.nola.com/entertainment\\_life/health\\_fitness/article\\_d61128a8-60a4-52aa-b199-fa805012413c.html](https://www.nola.com/entertainment_life/health_fitness/article_d61128a8-60a4-52aa-b199-fa805012413c.html); R. Singh, medical director, Louisiana Department of Corrections, telephone call, Sept. 16, 2016.

---

**For further information, please visit:**  
**[pewtrusts.org](http://pewtrusts.org)**

---

**Contact:** Erin Davis, associate manager, communications  
**Email:** [edavis@pewtrusts.org](mailto:edavis@pewtrusts.org)  
**Project website:** [pewtrusts.org/substancemisuse](http://pewtrusts.org/substancemisuse)

---

**The Pew Charitable Trusts** is driven by the power of knowledge to solve today's most challenging problems. Pew applies a rigorous, analytical approach to improve public policy, inform the public, and invigorate civic life.