Best Treatment Practices in Correctional Settings: From Pre-Diversion to Parole

Lipi Roy, MD, MPH, Clinical Assistant Professor, New York University School of Medicine and Department of Population Health

Kathleen Maurer, MD, MPH, MBA, Medical Director and Director of Health Services, Connecticut Department of Correction

Moderator: J. Kevin Massey, Health Administrator, Correct Care Solutions, and Member, National Rx Drug Abuse & Heroin Summit Advisory Board
Disclosures

- Lipi Roy, MD, MPH; Kathleen Maurer, MD, MPH, MBA; and J. Kevin Massey have disclosed no relevant, real, or apparent personal or professional financial relationships with proprietary entities that produce healthcare goods and services.
Disclosures

- All planners/managers hereby state that they or their spouse/life partner do not have any financial relationships or relationships to products or devices with any commercial interest related to the content of this activity of any amount during the past 12 months.

- The following planners/managers have the following to disclose:
  - Kelly J. Clark, MD, MBA, FASAM, DFAPA – Consulting fees: Braeburn, Indivior
Learning Objectives

- Describe the current treatment landscape of opioid addiction in the correctional system.
- Outline evidence-based practices in correctional settings.
- Identify the challenges and opportunities in implementing best practices in the correctional system.
Battle Behind Bars: Opioid Addiction, Incarceration & Strategies Moving Forward

Lipi Roy, MD, MPH
Clinical Assistant Professor | NYU School of Medicine
Former Chief of Addiction Medicine | NYC Jails (Rikers Island)
@lipiroy | SpicesforLifeMD
lipi.roy@nyumc.org
MEDIA COVERAGE
Celebrities & Overdose

Report: Prince died of an opioid overdose

Whitney Houston's cause of death revealed as an overdose of prescription drugs

Online reports that the singer drowned seem to have been incorrect

Rolling Stone

Tom Petty's Cause of Death: Accidental Overdose

Singer had been taking several pain medications, including Fentanyl and oxycodone, to treat fractured hip and other issues

Heath Ledger's Death: Drug Overdose

Philippa Coan

February 2, 2016

Judy Garland Dies in London

Husband Finds Body in Home
Addiction Doesn’t Just Affect the Rich & the Famous…
Trump declares opioid epidemic a national public health emergency

By Dan Merica, CNN
Updated 5:59 PM ET, Thu October 26, 2017

In a major reversal of policy, President Donald Trump on Thursday declared the opioid crisis a national public health emergency.

The move, which comes as the number of deaths from drug overdoses continues to rise, will allow the federal government to fund efforts to combat the crisis.

"As a nation, we must take action immediately," Trump said in remarks at the White House.

Congress has been working on legislation to address the opioid crisis.

A comprehensive package introduced last month by Sens. Lamar Alexander (R-Tenn.) and Dianne Feinstein (D-Calif.) would, among other things, limit opioid prescriptions and require new prescriber education initiatives.

The legislation has the support of President Trump, who has said he would sign it into law.

"This is a crisis," Trump said. "This is not a crisis that can be addressed by one person."
A Nationwide Epidemic...
Overdose Deaths per 100,000 (1999)

15 years later...

Overdose Deaths per 100,000 (2014)

Ref: Centers for Disease Control and Prevention; National Center for Health Statistics
DRUG OVERDOSES NOW TAKE MORE LIVES EVERY YEAR THAN TRAFFIC ACCIDENTS

PRESIDENT OBAMA'S BUDGET CALLS FOR NEW $1.1 BILLION INVESTMENT TO EXPAND TREATMENT

AND GUN HOMICIDES

Deaths per year

Drug Overdoses

Traffic Accidents

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS). Multiple Cause of Death 1999-2014 on CDC WONDER Online Database, released 2015.
The *TRUE* Causes of Addiction...
“Addiction Tree”

**ROOTS of Addictions**
- TRAUMATIC EVENTS
  - Fire
  - Earthquake
  - Hurricane
  - Divorce
  - Unemployment
- ISOLATION
- STRESS
- FEAR
- SHAME
- GRIEF
- ANGER
- GENETICS
- SEXUAL ABUSE
- PHYSICAL ABUSE
- NEGLECT
- VERBAL/EMOTIONAL ABUSE

**Types of Addictions**
- SEX
- WORK
- PORNOGRAPHY
- EXERCISE
- VIDEO GAMES
- GAMBLING
- SMART PHONES
- CARBS
- SUGAR
- COFFEE
- COCAINE
- CRACK
- ALCOHOL
- TOBACCO
- SUBSTANCES
- Food

---

Diagram showing various types of addictions and their underlying causes.
Addiction is...

...a chronic medical disease, a relapsing and remitting disease of the brain, that causes compulsive drug seeking and use, despite harmful consequences to the individual using drugs and to those around him or her. It is NOT a sign of moral weakness or failure.

Although the initial decision to take drugs is voluntary for most people, the brain changes that occur over time challenge his/her self-control and hamper his/her ability to resist intense impulses to take drugs.

The 4 C’s of Addiction:
1. Impaired **CONTROL** over drug use
2. **COMPULSIVE** use
3. **CONTINUED** use despite harm
4. **CRAVING**
The Incarcerated Population...
Correctional Facilities are Addiction Facilities

Rising SUD in U.S. is having *large* impact on correctional facilities

OUD affects 23% of recent arrestees → risk of dangerous withdrawal symptoms

**PHYSICAL**
- Nausea
- Vomiting
- Diarrhea
- Abdominal Pain
- Sweats

**PSYCHOLOGICAL**
- Agitation
- Irritability
- Anxiety
- Suicidality

[Image of a person in a cage]
Correctional Facilities are Addiction Facilities

~20% of those arrested in NYC test +ve for opioids

>2/3 of individuals entering NYC jails report a history of illicit drug use

**Mortality highest in the first 2 weeks post-release, mostly 2/2 drug overdose**

Substance use affects >50% of individuals entering Rikers

~30,000 individuals with active opioid use disorder

From 2011-16:
Overdose Death Risk: Post-Release

Evidence-based treatment exists! (behavioral therapies & MAT)

Despite efficacy, MAT is underutilized/unavailable in most U.S. jails & prisons

Only 2% of U.S. jails provide access to methadone/bupe for detox

<55% of prisons provide methadone (for pregnant inmates or pain relief)

Opt for “drug-free” detox & treatment, i.e. “cold turkey” \(ightarrow\) LESS effective than MAT (if not more harmful)

Misperception among CJS: MAT “substitutes one addiction for another”

Figure 1. Mortality Rates among Former Inmates of the Washington State Department of Corrections during the Study Follow-up (Overall) and According to 2-Week Periods after Release from Prison.

The dashed line represents the adjusted mortality rate for residents of the State of Washington (223 deaths per 100,000 person-years), and the solid line represents the crude mortality rate among inmates of the state prison system during incarceration (201 deaths per 100,000 inmate person-years).

Binswanger et al. 2007
Treatment of Opioid Addiction
MAT in Corrections: Clinical Rationale

- Mortality Reduction during Incarceration
  - Australian retrospective cohort study showed all-cause mortality decrease by 74%

- Mortality Reduction Post-release
  - Australian retrospective data linkage showed 75% decrease in mortality in 4 weeks post-release

- Recidivism Reduction

- HIV Risk Behavior Reduction
Methadone: Impact on Crime

Crime among 491 patients before and during MMT at 6 programs

Adapted from Ball & Ross - The Effectiveness of Methadone Maintenance Treatment, 1991
Opioid Use Disorder / Addiction

Pharmacotherapy
- Methadone
- Buprenorphine
- Naltrexone

Psychosocial Interventions
- Group Therapy (Group/Individual)
- Case Mgmt (e.g. court liaisons)
- Creative Arts Therapy/Mindfulness (art/music)

SAMHSA; Surgeon General 2016 Report
Pharmacotherapies
(i.e. MAT or Medications for Addiction Treatment)
Methadone: Overview

What is Methadone?

- Medication that is similar to morphine
- Used in maintenance programs to treat people addicted to heroin or other opioids; also used to treat chronic pain

How does it Work?

- Full agonist: binds to opioid receptor
  → reduces withdrawal symptoms & cravings
  → allows patients to engage in treatment & recovery

*Methadone is a life-saving medication*
Detox vs. Maintenance

**Detoxification**
- Patient is weaned off their dependence on opioids slowly by taking methadone
- Relapse rates post-d detox alone are >90%

**Maintenance**
- Indefinite therapy
- 3 aims:
  1. Prevents withdrawal
  2. Keeps patient comfortable by reducing cravings
  3. “Blocks” effects of illicit opioids

Path to Recovery

**NOT TREATMENT**
Public Health Impact of Methadone Maintenance

- Reduces risk of HIV by ~6x
- Reduces Hepatitis C & B transmission
- Increases rates of employment
- Reduces criminal activity after 6 months or more of treatment
- Reduces illicit opioid use by 40-70%
- Increases length of life for patients with opioid addiction
- Reduces opioid overdose death rates by 40-80%
Myths about Methadone

MYTH: “Methadone substitutes one addiction for another.”

REALITY: Methadone is a medication used to treat individuals with opioid use disorder. It reduces cravings and withdrawal, and restores balance to the brain circuits affected by addiction. Methadone allows a person to return to a normal life, return to work or school, and/or care for their family. It allows recovery.

MYTH: “Methadone will get you high.”

REALITY: When an individual first starts treatment, he/she may feel lightheaded or sleepy for a few days but tolerance soon develops, and they will begin to feel “normal.”
Methadone at Rikers Island

“KEEP” Program (Key Extended Entry Process)

- Started in 1987
- Nation’s 1st jail-based opioid treatment program
- Funded by NYC Dept of Health & Mental Hygiene (DOHMH)
- Accredited by the National Commission on Correctional Healthcare (NCCHC)
- ~11,000 detoxes/year with methadone
- ~4000 patients maintained/year
Buprenorphine ("Suboxone")

What is Buprenorphine-Naloxone (Bupe)?
- Medication that binds the same receptor as methadone, morphine
- Also used to treat opioid addiction

How does it Work?
- Partial agonist: strong enough to reduce withdrawal symptoms & cravings but NOT enough to cause euphoria → allows patients to engage in treatment & recovery 😊
- Low risk of overdose

*Buprenorphine is a life-saving medication*
Psychosocial Therapies
Behavioral Therapies

- Help engage people in treatment
- Provide incentives to remain abstinent
- Modify attitudes and behaviors related to drug use
- Increase life skills to handle stressful circumstances that may trigger intense cravings

**TYPES**

1. Cognitive-Behavioral
2. Motivational Enhancement
3. Adolescent and Family
4. 12-Step Facilitation

**Rikers Island: “A Road Not Taken”**

- Started in 2008
- Evidence-based modified therapeutic community
- Structured program:
  - Individual & Group therapy
  - Creative arts
  - Mindful practice
- Teach KEY skills: problem solving, conflict navigation, moral reasoning, tolerating anxiety

Ref: National Institute of Drug Abuse; Selling D, J Correct Health Care, 2015
**Stigma**

*Stigma*: attribute, behavior or condition that is socially discrediting

Of the 23 million Americans with SUD, only 10% access treatment

**STIGMA is a major barrier to seeking help**

Drug addiction is the #1 most stigmatized social problem (more than mental illness; alcohol #4)
WORDS MATTER: Changing our Language

Stigmatizing - Punitive - Tough

“Substance/drug abuse”
“Substance/drug abuser”
“War on Drugs”
“Dirty urine”
“Junkie,” “Addict,” “Cokehead,”
“Lush”

Less regard for patients
with addiction
“Less motivated”,
“violent”, “manipulative”
Shorter visits

Health care professionals

Less likely to seek help
Perceive ↑ discrimination

SUBOPTIMAL CARE

Less Stigmatizing

“Substance use disorder”
“Person with substance use issues/disorder”
Urine positive for opioids

Patients feel less judged,
more respected
Improves therapeutic relationship
More likely to seek care

Racial Disparities + Incarceration

Lifetime Likelihood of Imprisonment of U.S. Residents Born in 2001

- **White Men**: 1 in 17
- **Latino Men**: 1 in 6
- **Black Men**: 1 in 3
- **White Women**: 1 in 111
- **Latina Women**: 1 in 45
- **Black Women**: 1 in 18

BLACK AMERICANS
ARE
13% OF THE US POPULATION
14% OF DRUG USERS
56% OF THOSE INCARCERATED FOR DRUG RELATED CRIMES
So, What Happened to Brian*?

“Work together”

Connected to care (psych, ortho, case mgmt)

Buprenorphine for OUD

Apartment, Relationship w/ Son, Recovery

Purpose

*Brian’s story is featured in a documentary short, The Faces of Addiction (Refinery 29) ©

Photo credit Jacki Huntington, Refinery 29
References in TV, Film & Books

CNN: The Black & White of Heroin

HBO Heroin: Cape Cod,

13TH

RIKERS

The New Jim Crow by Michelle Alexander

Chasing the Scream by Johann Hari

Dreamland by Sam Quinones
References

- American Society of Addiction Medicine (ASAM)
- Centers for Disease Control and Prevention (CDC)
- Center for Mindfulness, UMass Medical School
- Harm Reduction Coalition (HRC)
- National Institute of Drug Abuse (NIDA)
- New York City Department of Health and Mental Hygiene (DOHMH)
- Providers’ Clinical Support System for MAT (PCSS-MAT)*
- Substance Abuse and Mental Health Service Administration (SAMSHA)
THANK YOU!!

Lipi.Roy@nyumc.org
SpicesforLifeMD
@lipiroy
Treating Opioid Use Disorder In the Justice System: The Connecticut Experience

Kathleen F. Maurer, MD, MPH, MBA
Connecticut Department of Correction
Session Learning Objectives

Upon completion of this course, participants will be able to:

- Describe the current treatment landscape of opioid addiction in the correctional system
- Outline evidence-based practices in correctional settings
- Identify the challenges and opportunities in implementing best practices in the correctional system
1. Disease of Addiction Over-Represented in Justice System

- 85-90% of population has substance use disorder
- Prevalence similar in male and female populations

Data courtesy of CT DOC Addiction Services and MIS. February 2018.
2. MAT Represents Community Standard of Care
3. Current Practice Places Releasing Offenders at Risk for Overdose and Death

- Cravings generally not extinguished by time spent in jail or prison
- After a short period of time, addicted persons lose tolerance
- Patients addicted to opioids frequently seek the drug soon after release
- Same dose without tolerance increases risk for overdose and death
CT Former Inmate Overdose Deaths by Month After Release--2015

Accidental Drug Overdose Deaths

CT Accidental Drug Intoxication Deaths

4. Current Practice Complicates Return to Treatment

- Typical practice is to “detox” (medically managed withdrawal) patients from methadone or other MAT pharmaceuticals.
- Upon release, when methadone or other MAT pharmaceutical is not offered, patients may have difficulty returning to MAT provider—delay in getting seen and other barriers may exist.
- Likelihood of returning to MAT provider is markedly reduced when patients are not inducted or treated with MAT during incarceration or upon release.
Sequential Intercept Model

Treatment Pathway Program

MAT

Living Free

Treatment Pathway Program

April 2015 – December 2017
Screened – 825
Admitted to Treatment--289

Slide courtesy of RNP, Inc.
TPP Screenings and Admissions--2017

2017 TPP Screenings and Admissions

Data Reflects 2017 Treatment Cohort = 107 Persons

Slide courtesy of RNP, Inc.
Time to Admission to Treatment Relative to TPP Decision 2017

- Admitted into program within 1 day: 77%
- Admitted into program in over 1 day: 23%

Slide courtesy of RNP, Inc.
Outcomes—2017

N = 107

Non-Pending TPP Clients

- Nollied: 8%
- Incarceration Sentence: 23%
- Non-Incarceration Sentence: 69%

TPP Dispositions—Clinical

- Not Completed: 41%
- Completed: 59%

Slide courtesy of RNP, Inc.
Use of MAT in TPP Patients with Opioid Use Disorder

- No Medication Assisted Treatment:
  - Unsuccessful Completion: 57%
  - Successful Completion: 43%

- Medication Assisted Treatment:
  - Successful Completion: 75%
  - Unsuccessful Completion: 25%

Slide courtesy of RNP, Inc.
Facility-based Medication for Addiction (MAT) Treatment
5-Year MAT Treatment—NHCC & BCC

Facility-Based Methadone Treatment: BCC and NHCC

2013 - 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Referrals</th>
<th>Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>65</td>
<td>43</td>
</tr>
<tr>
<td>2014</td>
<td>350</td>
<td>161</td>
</tr>
<tr>
<td>2015</td>
<td>649</td>
<td>271</td>
</tr>
<tr>
<td>2016</td>
<td>699</td>
<td>235</td>
</tr>
<tr>
<td>2017</td>
<td>663</td>
<td>237</td>
</tr>
<tr>
<td>Total</td>
<td>2426</td>
<td>947</td>
</tr>
</tbody>
</table>
Outcomes

- Compared inmates in the MMT group to the control group on outcomes:
  - During Incarceration
    - Disciplinary tickets
    - Other program attendance
  - Post-release
    - Re-engagement in MMT within 1 day, 30 days, 6 months
    - Recidivism
- Qualitative interviews

Disciplinary Tickets

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>MMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Tickets</td>
<td>88.9%</td>
<td>96.2%</td>
</tr>
<tr>
<td>One or More</td>
<td>11.1%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

MMT Group had significantly fewer disciplinary tickets during incarceration
Odds Ratio = 0.32, p<.05
Post-release Re-engagement in Community Based MMT

MMT Group was more likely to re-engage in community-based MMT within 1 and 30 days post-release.

1 day Odds Ratio = 32.04, p<.001; 30 day Odds Ratio = 6.08, p<.001

**Effect of Re-engagement in MMT on Recidivism in APT Subsample**

<table>
<thead>
<tr>
<th>Did not Re-engage</th>
<th>Re-engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.70*</td>
<td>Ref</td>
</tr>
<tr>
<td>3.27*</td>
<td>Ref</td>
</tr>
<tr>
<td>10.22*</td>
<td>Ref</td>
</tr>
<tr>
<td>7.26*</td>
<td>Ref</td>
</tr>
<tr>
<td>5.50*</td>
<td>Ref</td>
</tr>
<tr>
<td>3.08*</td>
<td>Ref</td>
</tr>
<tr>
<td>13.53*</td>
<td>Ref</td>
</tr>
</tbody>
</table>

APT subsample participants who *failed to re-engage* in MMT post-release were more likely to get arrested, have new charges, and be re-incarcerated.
Recidivism among APT Subsample who Re-engaged vs. Did Not Re-engage in MMT

APT subsample participants had lower rates of arrest, new charges, and reincarceration.
Inmate Feedback about how MMT Improved their Lives

- “I’m not sticking needles in my arm or breaking any laws”
- “It has saved my life”
- “A chance to stay off street drugs”
- “It has helped me stay alive, I have not done opiates since being in the program”
- “It kept me from losing my job”
Living-Free Program

Collaborative Care Model

Based on best evidence practices

Dr. Sherry McKee
Dr. Lindsay Oberleitner

Yale-DOC-DMHAS partnership

Slide courtesy of Living Free, New Haven, CT
Client Flow Through Treatment

- IDENTIFICATION: <6 months prior to release
- IN-REACH: <2 months prior to release
- ESCORTED VISIT: <1 month prior to release
- COMMUNITY BASED SERVICES: Immediately upon release

Slide courtesy of Living Free, New Haven, CT
Preliminary Outcomes

- n=211 enrolled
  - 48% women
  - 52% men
- Community supervision
  - 64% on parole
  - 22% on probation
  - 14% end of sentence

Slide courtesy of Living Free, New Haven, CT
### Sentence histories by Crime type

<table>
<thead>
<tr>
<th>Ofense types</th>
<th>121 Living Free Clients</th>
<th>Cum Percent of 121</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOP</td>
<td>81</td>
<td>67%</td>
</tr>
<tr>
<td>Public Order</td>
<td>63</td>
<td>52%</td>
</tr>
<tr>
<td>FTA</td>
<td>58</td>
<td>48%</td>
</tr>
<tr>
<td>Theft/Larceny</td>
<td>58</td>
<td>48%</td>
</tr>
<tr>
<td>Drug related</td>
<td>56</td>
<td>46%</td>
</tr>
<tr>
<td>Conspiracy- Crim attempt YO</td>
<td>40</td>
<td>33%</td>
</tr>
<tr>
<td>Burglary related</td>
<td>35</td>
<td>29%</td>
</tr>
<tr>
<td>Felony assault</td>
<td>26</td>
<td>21%</td>
</tr>
<tr>
<td>DUI related</td>
<td>24</td>
<td>20%</td>
</tr>
<tr>
<td>Robbery related</td>
<td>23</td>
<td>19%</td>
</tr>
<tr>
<td>Weapon</td>
<td>23</td>
<td>19%</td>
</tr>
<tr>
<td>Threat/stalk/strangle</td>
<td>19</td>
<td>16%</td>
</tr>
<tr>
<td>MV related MISD</td>
<td>16</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>13%</td>
</tr>
<tr>
<td>Risk Injury/Reck_Endangerment</td>
<td>12</td>
<td>10%</td>
</tr>
<tr>
<td>Car theft</td>
<td>9</td>
<td>7%</td>
</tr>
<tr>
<td>Viol Prot Order</td>
<td>9</td>
<td>7%</td>
</tr>
<tr>
<td>Prost - related</td>
<td>7</td>
<td>6%</td>
</tr>
<tr>
<td>Homicide</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Arson</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Admission histories

<table>
<thead>
<tr>
<th>DOC admits</th>
<th>Clients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once</td>
<td>13</td>
<td>11%</td>
</tr>
<tr>
<td>Twice</td>
<td>18</td>
<td>15%</td>
</tr>
<tr>
<td>3 through 5</td>
<td>23</td>
<td>19%</td>
</tr>
<tr>
<td>6 though 10</td>
<td>23</td>
<td>19%</td>
</tr>
<tr>
<td>Over 10</td>
<td>45</td>
<td>37%</td>
</tr>
</tbody>
</table>

89% of our clients have been incarcerated multiple times.  
20% have been incarcerated more than 15x.  
The top 6 reasons for incarceration are non-violent.
Preliminary Outcomes

- 94% addiction treatment engagement
- 79% successfully complete treatment
- 58% with psychiatric co-morbidity (depression, PTSD, anxiety)
- 47% of those with psychiatric co-morbidity receiving medication

96%
48%
Preliminary Outcomes

Opioid overdose prevention plan

- 29% identify opioids as drug of choice
- 80% recommended to MAT are taking medication
  - 74% on buprenorphine
  - 22% on methadone
  - 4% on naltrexone/vivitrol

- Opioid overdose risks discussed with all clients (recruitment, in-reach, escorted visit)

- Kits are prescribed or provided at first outpatient visit (train client, family, etc.)
Preliminary Outcomes

• 6-month recidivism of new arrest
  • 2% men
  • 8% women

• 6-month recidivism of new incarceration
  • 0% men
  • 0% women
What’s Next?

- Expand MAT treatment across the justice system landscape
- American Society of Addiction Medicine and American Correctional Association joining forces
- Resolution supporting MAT passed by ACA in August 2017
- January 2018 policy approved by ACA
- Joint ACA-ASAM policy supporting MAT treatment for opioid use disorders now in place
Thank you to . . .

- Community OTP Providers
  - Recovery Network of Programs, Inc., Bridgeport, CT
  - APT Foundation, Inc., New Haven, CT
  - CHR, Windsor, CT
- CT DOC Staff
  - Wardens, Deputy Wardens, Counselor Supervisors, Counselors, Addiction Counselors and Supervisors, custody officers, lieutenants, and captains, CT DOC Health & Addiction Services Staff and Grant staff
- FORDD (Forensic Drug Diversion Clinic), Yale University School of Medicine Law and Psychiatry Program & Connecticut Department of Mental Health and Addiction Services (DMHAS)
  - Dr. Sherry McKee and Dr. Lindsay Oberleitner
- Department of Mental Health and Addiction Services and Office of Policy and Management
- American Correctional Association leadership and staff
Law Enforcement & Corrections Track

Best Treatment Practices in Correctional Settings: From Pre-Diversion to Parole

Lipi Roy, MD, MPH, Clinical Assistant Professor, New York University School of Medicine and Department of Population Health

Kathleen Maurer, MD, MPH, MBA, Medical Director and Director of Health Services, Connecticut Department of Correction

Moderator: J. Kevin Massey, Health Administrator, Correct Care Solutions, and Member, National Rx Drug Abuse & Heroin Summit Advisory Board
THANK YOU

#RxSummit

www.NationalRxDrugAbuseSummit.org