Report to
The Vermont Legislature

Medication-Assisted Treatment for Inmates: Work Group Report and Recommendations

In Accordance with Act 67, 2013
An Act Relating to Court Administration and Procedures

Submitted to: House Committee on Corrections and Institutions
House Committee on Human Services
House Committee on Judiciary
Senate Committee on Health and Welfare
Senate Committee on Judiciary

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Executive Summary

Act 67 (2013), *an act relating to court administration and procedure,* directs the Vermont Department of Corrections (DOC) to collaborate with the Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP) to convene a Work Group for the purpose of examining medication assisted treatment (MAT) for inmates, including persons who were receiving treatment in the community immediately prior to incarceration. The Work Group was convened to examine and respond to the specific questions posed in Act 67, Section 11. This report discusses the Work Group's findings, recommendations and plan for continued work. The group did not identify any issues that require legislative action at this time.

Vermont had the second highest per capita rate of all states for admissions to treatment for prescription opiates abuse in 2011. And, although no data exist on the percentage of DOC detainees and inmates who have opioid dependence, it is widely recognized that the incidence of opioid dependence among the corrections population is significantly higher than in the general population.

The report describes Vermont's current system for opioid addiction treatment, including the new Hub and Spoke structure for managing medication assisted treatment. Current state and federal laws and regulations related to MAT are discussed, as is the current DOC policy of limiting MAT duration to 30 days for inmates. This policy is contained in Facilities Directive 363.01.

As a result of its research and discussions, the Work Group identified three key action steps to improve access to MAT for individuals involved in the corrections system who are addicted to opioids. They are as follows:

1. Implement a one-year demonstration project to pilot the use of MAT for longer than 30 days if necessary to treat inmate opioid dependence
2. Revise the Department of Corrections Facilities Directive 363.01 to enable the demonstration project
3. Continue the MAT Work Group to inform and monitor the demonstration project discussed below

The report concludes with a list of related clinical, policy or operational issues that will need to be considered as part of the ongoing enhancement of MAT for inmates.

Introduction

In 2013, the Vermont Legislature passed Act 67, *an act relating to court administration and procedure.* Section 11 of this act directed the Vermont Department of Corrections (DOC) to collaborate with the Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP) to convene a Work Group for the purpose of examining medication assisted treatment for inmates, including for persons who were receiving treatment in the community immediately prior to incarceration. The Work Group was convened and, in addition to representatives of the Vermont Department of Health (VDH) and DOC, participants included representatives from: The Department of Vermont Health Access (DVHA), The Howard Center, and The Defender General's Office. (See Appendix A) This group held four meetings in addition to numerous communications outside of the formal meetings.

Act 67, Section 11 asked the Work Group to examine and respond to five specific questions. In preparation, the Work Group reviewed best practice literature, federal and state laws and regulations, current Vermont DOC directives, policies, procedures and prevailing community practice to develop its recommendations. The following report responds to questions in Act 67, presents an overview of Vermont's current opioid treatment system, presents findings and recommendations, and describes an action plan to continue the work of the group to improve access to treatment for opioid use and abuse. The group did not identify any issues that require legislative action at this time.

Opioid Abuse in Vermont

Vermont had the second highest per capita rate of all states for admissions to treatment for prescription opiates abuse in 2011, with only Maine's rate being higher[i]. The majority (57%) of these admissions were young people 20 to 29 years old.[ii] In 2006, opioids other than heroin overtook heroin as the primary source of opioid addiction for people receiving treatment at publicly funded programs. In 2012, heroin use increased by more than 35%. Furthermore, the number of people seeking treatment for addiction to other opiates has continued to increase each year.

While current data on the number of opioid dependent individuals who are incarcerated do not exist, it is recognized that criminal behaviors resulting in involvement with the criminal justice system is highly correlated with opioid dependence. According to DOC data, 1560 individuals were placed on detoxification protocols in 2012 at the time of intake. Although the data do not identify the specific substance from which the inmates were detoxed, it is known that the majority of detoxification episodes were for alcohol. It is widely recognized that the use of illegal opioids often leads to individuals committing criminal acts in order to support their addictions. As a result, the incidence of opioid dependence in the corrections population is significantly higher than in the general population.

According to data from the Legal Action Center in 2011, within state prisons, rates of opioid dependency range from as low as 8% to as high as 27% in urban areas. For this reason, it is important that effective treatment be available for this population. Research has demonstrated that addiction treatment programs involving the use of Medication Assisted Treatment (MAT) can be an effective intervention to treat addiction. In addition, use of MAT is anticipated to have a positive effect on participants' overall criminal activities within the community. This report examines issues related to expanding the use of MAT in Vermont's corrections system.

Current System for Treating Opioid Dependence

The four key state partners working collaboratively to develop an effective treatment system in Vermont are:

- **The Department of Corrections** manages the health needs of incarcerated individuals which includes detainees and sentenced persons, many of whom have addiction problems, some with opioids
- **The VDH's Division of Alcohol and Drug Abuse Programs (ADAP)** has a mission of helping Vermonters prevent and eliminate the problems caused by alcohol and other drug use, and works in partnership with state, national public and private organizations to plan, support, and evaluate a comprehensive system of services statewide.
- **The Department of Vermont Health Access (DVHA)** is responsible for the administration and expenditures related to Medicaid and state oversight and coordination of Vermont's health care reform initiatives designed to increase access, improve quality, and contain the cost of health care for all Vermonters.
- **The Blueprint for Health,** within DVHA, oversees the statewide multi-insurer program designed to integrate a system of health care for patients, improve the health of the overall population, and improve control over health care costs by promoting health maintenance, prevention, care coordination and management at the provider level.

Overview of Medication Assisted Treatment

Medication-Assisted Treatment (MAT) is established as an evidenced based treatment approach to opioid addiction.[iii] It involves prescribing medication – methadone or buprenorphine – in combination with ancillary support services to opioid dependent individuals. In Vermont, MAT is delivered through an integrated treatment model, called the Care Alliance for Opioid Treatment, a collaboration of the VDH/ADAP, the Blueprint, and the Department of Vermont Health Access. The Care Alliance for Opioid Addiction uses a *Hub & Spoke* Model to monitor

progress and provide coordinated care for patients within the community who are receiving MAT.

> **A Hub** is a regional opioid treatment program responsible for coordinating the care and support services for patients who have complex addictions and co-occurring substance abuse and mental health conditions. Patients who need methadone must be treated here. Patients who need buprenorphine may or may not be treated here. Hubs serve as the regional consultants and subject matter experts on opioid dependence and treatment.
>
> **A Spoke is a "medical home"** responsible for coordinating the care and support services for patients with opioid addictions who have less complex medical needs, such as in a primary care practice or health center. Only patients who are treated with buprenorphine receive treatment in the spokes. *Spokes* are supported in providing individuals with substance abuse issues with Health Home services through the Blueprint Community Health Teams.

Each patient treated at a Hub or a Spoke is overseen by a physician and supported by nurses and counselors who work to connect the patient with community-based support services. Depending on the patient's needs, Support Services may include mental health and substance abuse treatment, pain management, family supports, life skills, job development, and recovery supports. This initiative relies on the strengths of the specialty opioid treatment programs, the physicians who prescribe buprenorphine in office-based settings, and the local Blueprint Community Health Teams and Medical Home infrastructure.

Medication Assisted Treatment within the DOC

While MAT is established as an evidenced-based practice to treat opioid dependence in a general community based population, there is limited research in the United States to demonstrate similar benefits of MAT within correctional facilities. DOC has an internal policy, the DOC Facilitation Directive 363.01, which allows individuals entering custody to remain on MAT for up to 30 days.

The exceptions to this directive are for pregnant women, a priority population determined by Federal Regulation 45 CFR Part 96: Pregnant women are maintained on their established treatment regimen/plan in collaboration with Fletcher Allen Health Care Comprehensive Obstetrics and Gynecology unit (FAHC COGs). The historical rationale for the 30 day MAT limit was multifactorial and included the use of limited and expensive DOC staff resources for transporting inmates to treatment sites which were not consistently and conveniently located near correctional facilities, a limited outpatient infrastructure with which to coordinate treatment, limited physician expertise in prescribing MAT and inadequate funding for the medication. Because some of these factors have changed, it may be timely to consider if this limit should be extended.

A significant challenge recognized by the workgroup, and particularly relevant to MAT within the DOC, is the regulatory oversight for use of MAT. Methadone treatment for opioid dependence and buprenorphine dispensed from the Hubs, are among the most highly regulated medical treatments available. As will be discussed below, there are federal and state regulations related to treatment protocols, medication dispensing, storage, accreditations, payment, etc. These must be complied with when developing strategies for improving treatment options for addicted individuals in the corrections system.

Responses to Questions in Act 67, Section 11

The Work Group has examined the questions posed in Act 67, Section 11, and offers the findings and recommendations set out below. The report concludes with a list of planned action steps to continue the work identified in this report.

1. **What are the federal and state legal parameters that apply to medication-assisted treatment for persons who are incarcerated?**

   Findings: The MAT Work Group identified the following federal and state legal parameters related to MAT for individuals with opioid dependence involved with Vermont's criminal justice system:

1. *Federal Regulation 42 CFR, Part 8: Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction; Final Rule.*

   This SAMHSA regulation broadly covers the treatment of opioid treatment programs, (Hubs) it regulates buprenorphine as well. Additional regulations in this same chapter relate to certification, accreditation and compliance issues and can be found in the Federal Register.[iv] Of particular importance to MAT within DOC are:

   - Take-home dosing exemptions (needed to administer within DOC facilities);
   - Frequency of drug abuse testing, namely urine toxicology, and continued testing over long term treatment regimens.

2. *The Drug Addiction Treatment Act of 2000(DATA)*

   For office-based opioid treatment (OBOT) with buprenorphine, Data 2000 dictates the requirements for certification of the prescribing physician. The certification is mandatory, and is not facility or locale based.

3. *Federal Regulation 42 CFR, Part 2: Confidentiality of Records of alcohol and substance abuse clients.*

   This regulation protects the confidentiality of persons who receive substance abuse treatment within a designated substance abuse treatment facility.

4. *Federal Regulation 42 CFR Part 164, HIPAA Privacy*

   This regulation requires confidentiality of any protected health information.

5. *Federal Regulation 45 CFR, Part 96: Priority Populations.*

   a. Pregnant intravenous (IV) drug users
   b. Pregnant women
   c. Tuberculosis (active cases)
   d. IV drug users

   These are federal priority populations for treatment funded with federal block grant dollars.

6. *Vermont's Department of Corrections Facilities Directive 363.01*

   Internal DOC policy that has guided the treatment duration for MAT.

7. *Vermont MAT Treatment Rules for Opioid Dependence*

Rules adopted in 2011; standards for Vermont physicians prescribing MAT to more than 30 individuals and to Opioid Treatment Programs (Hubs).

8. *Vermont State Law on Medical care of inmates, 28 V.S.A. § 801(a)*

   States that the Department must provide health care for inmates in accordance with the prevailing medical standards.

In addition to the above, there are other federal and state legal parameters relating to all opioid treatment programs. Examples include Drug Enforcement Agency (DEA) regulations around the transport, storage space and dosing of medication and state protocols to ensure public and inmate safety. Other complicated issues include rules related to: transportation and storage of medications, Public Safety and the transport of inmates in and out of facilities. Additionally, rules exist about medication chain of custody, smooth transfers and releases, and continuity in treatment services. Barriers to the delivery of paired substance abuse counseling also exist.

The federal laws and regulations identified above pose barriers nationally to the expansion of MAT services for incarcerated individuals. The challenge in Vermont will be to comply with these regulations while improving access to appropriate treatment for addicted individuals.

2. **What are the existing time limits on medication-assisted treatment for persons who are incarcerated, specifically with regard to health outcomes and recidivism rates?**

   Inmates incarcerated within the Department of Corrections (DOC) to whom this report applies are generally of two categories: those who have been detained by the court pending adjudication or those who have been sentenced to serve a specified duration of time.

   Findings:

   - Inmates who are expected to be incarcerated 30 days or less remain on MAT throughout their period of incarceration;
   - Inmates with incarceration/length of stay durations greater than 30 days, have their MAT discontinued or tapered;
   - Inmates without a known duration of incarceration on intake are maintained on MAT up to the point of 30 days, at which point they are tapered and discontinued.

Health Outcomes:

Tapering: From an evidence-based perspective, an optimal duration of a scheduled prescribed taper from MAT is a point of discussion by experts. While, the evidence is contradictory, more recent findings suggest a longer taper may be more beneficial in community based patients. In general, the majority of inmates on MAT taper using the current two week process do well without any negative health outcomes. The process is overseen by medical staff in the facility but is under the direction of the methadone treatment provider, or for buprenorphine, the facility physician certified in use of buprenorphine.

Recommendation: The Work Group determined that the length of treatment for detainees and sentenced inmates should be extended. When necessary or desirable, the tapering of medication should be done in collaboration between the facility medical provider and the community based physician.

Recidivism:

No DOC or ADAP data exist for recidivism related to this topic. The Work Group determined that they will attempt to gather data related to *episodes of re-incarceration* related to substance use.

3. **What is known about the effectiveness of directing medication-assisted treatment to persons who are incarcerated by offense category?**

The Work Group reviewed literature and data to determine if there is any indication that by prioritizing populations by offenses, the state might be able to reduce social risks and/or costs. For example, the Work Group considered if inmates with burglary offenses or violent offender histories were to respond positively to the best practice treatment regimen of MAT, would they also be less likely to engage in the high social cost criminal activity of burglary and violent offenses often associated with the substance abuse.

Finding: There is no known correlation between MAT and individual success or need by offense category. While several offense categories might correlate positively with overall

use of substances, neither the suitability nor success of utilizing MAT has been established based on offense categories. Furthermore, other than the federally mandated criteria, there may be negative implications for prioritizing individuals for treatment based on offense over an average citizen also trying to access treatment services.

Recommendation: Offense category should not be used as a determining criterion for directing MAT to certain individuals.

Recommendation: ADAP and community partners will continue to support efforts to increase capacity and effectiveness to intervene earlier through Screening, Brief Intervention and Referral to Treatment (SBIRT), Rapid Arraignment, etc. in an attempt to provide earlier legal and substance misuse/abuse interventions.

4. **What is the prioritization of medication assisted treatment by**:

   i. **Providers of the Hub and Spoke Opioid Integrated Treatment Initiative to persons ordered to receive treatment by a drug court**

   Finding: Hubs must adhere to criteria of admission preference for treatment services as specified by the Federal Regulation 45 CFR, Part 96: Priority Populations. These criteria are stated in ADAP standards and provider protocols for the following types of individuals in order of priority: Pregnant IV users, Pregnant Women, Tuberculosis, and IV drug users.

   Recommendation: all Hub providers working to support MAT for inmates shall continue to adhere to the 45 CFR, Part 96: Priority Populations (see response to question *i* above).

   ii. **DOC to opiate-addicted persons prior to their release from prison**

Currently, individuals receiving community based MAT services who are subsequently incarcerated are not necessarily referred upon release, nor do they return to, their previous

community-based providers (sometimes by their own preference). Variances from this best practice may be both system and patient-related.

Recommendation: Those individuals continuing to receive MAT through their incarceration will be transitioned upon release as seamlessly as possible to a community-based MAT provider through the coordinated efforts of ADAP/Hub and Spokes and DOC unless determined to be clinically ineligible or treatment is contraindicated based upon a medical or other appropriate determination. In this case, all reasonable efforts will be made to taper the inmate's medication in a clinically appropriate manner.

Recommendation: Those persons who are administered MAT while incarcerated but who were tapered off for cause may be considered for medication re-induction in the community prior to release. Otherwise, referral to a community-based provider may be made upon discharge.

5. **Are there other factors to determine prioritization for medication-assisted treatment?**

Finding:

While all persons entering, residing in and leaving Corrections do not strictly fall under the Federal guidelines for priority populations, it may be in the best interest of the individual, the community and indeed the State of Vermont to continue MAT during incarceration. Many of the individuals requiring and receiving treatment in the community, move bi-directionally over time between the community and DOC. By extending the length of time incarcerated individuals may continue MAT, the workgroup expects that this continuity of care will generate positive effects for both the inmate and community.

Planned Actions

There was consensus among VDH, DOC and Work Group members about the following planned actions. Unless otherwise specified, the action steps discussed below are intended for implementation within 2014, and are targeted to individuals who have been receiving MAT services immediately *prior* to incarceration.

A. Implement a Demonstration Project:

A one-year demonstration project should be implemented to pilot the continued use of MAT within DOC facilities for detainees and sentenced inmates in the following manner:

1) **For detainee populations:** persons incarcerated on detainee status and taking MAT as prescribed in the community may be allowed to continue on MAT up to 180 days. If the need for MAT discontinuation arises it will be done so through use of a prescribed taper.
2) **For sentenced populations:** those persons sentenced to a minimum of 1 year and receiving MAT as prescribed in the community may be allowed to continue MAT during the first year of their sentence. Beyond that year, discontinuation will proceed as per the prescribed taper.

The group agreed that the following guidelines should apply to participants in the demonstration project:

- Individuals can continue on MAT, as above, as long as they continue to benefit from it, maintain interest in continuing treatment, and consistently meet the expectations set forth by the MAT clinical provider and DOC in collaboration with the DOC medical provider.[v]
- An individual within DOC who is determined to have violated a condition or agreement related to MAT, including diversion or misuse/abuse of other substances, will be discontinued by taper upon notification of the community treatment provider.
- Discontinuation of MAT, if necessary, should be accomplished through a prescribed tapering protocol.

- Protocols shall be established for smooth transitioning in and out of treatment settings, or in and out of DOC facilities to treatment services.

- Treatment protocols involving transport of inmates to off-site care shall not disrupt DOC facility schedules nor should the implementation or use of the treatment protocols interfere with the orderly running of any DOC facility.

- DOC has a predetermined cap on the number of beds it fills, and when the number of sentenced inmates equals or exceeds that cap, some must be sent to out-of-state facilities. The states with whom DOC currently contracts to house Vermont inmates do not have MAT programs, therefore, individuals who are on MAT and who also meet the criteria for transfer need to be tapered by using a prescribed tapering protocol.

- The demonstration pilot should be evaluated, with an evaluation plan established prior to implementation. The evaluation should include appropriate metrics for determining treatment efficacy, re-incarceration episodes, DOC and community based collaboration challenges and system cost. The reporting and release of findings should be done through a joint VDH and DOC review and approval process.

C. Revise the DOC Methadone Facilities Directive

The Work Group concluded that DOC should prepare an interim revision memo to the Facilities Directive 363.01 in preparation for the demonstration project discussed above. The memo will note the extension of MAT and define the population. The memo is not a clinical guideline for care and will be written to inform custody staff of the changes. Local policy and procedures will be formulated appropriately and separately as will clinical guidelines from DOC Health Services. It is noted that any change to this directive is not binding for individuals placed in Vermont DOC facilities under the supervision of the Federal Justice System. A representative from VDH/ADAP will plan to discuss the feasibility and willingness of extending this, or a similar, protocol to federally sentenced or detained inmates.

B. Continue MAT Work Group

The MAT Work Group should continue its collaborative work to improve access to clinically-appropriate use of MAT for detainees and sentenced inmates in the DOC system. The group should advise the implementation of the demonstration project and monitor its progress.

Additional Considerations for Future Work

The Work Group was able to articulate and outline a limited list of operational and policy issues which are bulleted below. The Work Group was clear, however, that as the demonstration project unfolds, unforeseen operational and policy issues will undoubtedly emerge, all of which they agree will benefit from the on-going collaborative efforts, expertise and advice of the group members.

- ADAP will convene a group of physicians and prescribers to discuss how to shift responsibilities for coordinating prescribing guest dosing, and to define coordination and communication for consistent patient care. ADAP will organize this.
- Memoranda of Understanding (MOUs) between Hub providers and DOC facilities need to be established to address MAT for inmates and transitions to and from community-based services. ADAP and DOC will facilitate this.
- MOUs among all Hub providers will need to be clarified and made more predictable and uniform across the state when addressing MAT for inmates and transitions to and from community-based services. ADAP will coordinate this.
- Procedures allowing for a reduction in the transporting of inmates from a DOC facility to treatment providers are permissible under federal laws and regulations governing opiate replacement medication chain of custody. To increase efficiency of MAT administration for inmates, procedures should be adopted that will enable less frequent transport by providing DOC custody staff to pick up take-home inmate dosing with subsequent administration at the DOC facility.

Conclusion

The Work Group's examination of the issues called for in Act 67, Section 15a culminated in agreement that extending the duration of MAT for individuals receiving community based MAT prior to incarceration was an important and viable option at this time. The Work Group will continue to meet to support, examine emerging data about and evaluate the demonstration project as it is implemented. Regulatory challenges increase the complexity of this effort. However, the Work Group members are confident that reasonable solutions exist.to these challenges. The demonstration project will offer significant experience to inform future changes related to the use MAT as a potentially effective strategy to address opioid addiction for incarcerated persons.

Appendix I: Key Resources

- Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the research, August 2009, SAMHSA, http://partnersforrecovery.samhsa.gov/docs/Guiding_Principles_Whitepaper.pdf
- Larke Huang, Director, Office of Behavioral Health Equity, Team Leader, Leading Change: A Plan for SAMHSA's Roles and Actions, SAMHSA. http://store.samhsa.gov/shin/content/SMA11-4629/04-TraumaAndJustice.pdf.
- Walter Ling, et al. Buprenorphine tapering schedule and illicit opioid use. Author manuscript; available in PMC 2011 August 4. Published in final edited form as: Addiction. 2009 February; 104(2): 256–265. doi: 10.1111/j.1360-0443.2008.02455.x
- Morgane Thomas-Chollier, et al. RSAT: regulatory sequence analysis tools in Nucleic Acids Res. 2008 July 1; 36(Web Server issue): W119–W127. Published online 2008 May 21.
- Fred Osher, M.D., et al. Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery, National Criminal justice Reference Service, NCJ239596, 2012.
- Anna Pecoraro and George E. Woody. Medication-assisted treatment for opioid dependence: making a difference in prisons. Department of Psychiatry, University of Pennsylvania, 600 Public Ledger Building, 150 South Independence Mall, West, Philadelphia, PA 19106, USA
- Dr. Josiah D. Rich MD, et al. Attitudes and practices regarding the use of methadone in US State and federal prisons in Journal of Urban Health
- September 2005, Volume 82, Issue 3, pp 411-419. Data
- Medication Assisted Treatment Research with Criminal Justice Populations: Challenges of Implementation
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3243915/
- Roger Allen LMHC, Jessica Burgess MSN, RN, Barnstable County Sheriff's Office's Educating Inmates on Medication Assisted Recovery. Slide Presentation on Vivitrol.
- Jeff Baxter, MD, Joshua Lee, MD, MS, Medication Assisted Treatment For Opiate Addiction in Correctional Settings, UMASS, Slide Presentation on detox, opiate substitutions, Rikers.
- Holly Catania, JD, A Global Look at Opioid Agonist Treatment and Harm Reduction in Prison.
- International Center for Advancement of Addiction Treatment, Rico March 25, 2008, San Juan, Puerto, slide presentation.
- Miguel Pereira Castillo, Esq., MEDICATION ASSISTED THERAPY, Perspectives of Correctional Administrators, Commonwealth of Puerto Rico, 2008, Slide Presentation.
- Prevailing medical standards -- language from Vermont's Title 28.
- 42 CFR, Part 8, Federal Opioid Treatment Standards. Federal Register, Volume 66, No. 11, January 17, 2001, Rules and Regulations.

APPENDIX II:

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- John Brooklyn, MD: Medical Director Howard Center/Chittenden Center
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- Connie Schutz, PhD: Blueprint for Health/DVHA
- Seth Lipschutz, JD: Office of Defender General/Prisoners Rights
- Emily Tredeau, JD: Office of Defender General/Prisoners Rights
- Tom Dalton: Howard Center/Safe Recovery Program
- Tony Folland: VDH/ADAP

ENDNOTES

[i] Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.10.11.

[ii] Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.10.11.

[iii] In other words, the challenge before the Work Group was not to develop a treatment protocol or assess the effectiveness of MAT as a treatment approach. This is already very well established (and accepted here) as best-practice.

[iv] 42 CFR, Part 8, Federal Opioid Treatment Standards. Federal Register, Volume 66, No. 11, January 17, 2001, Rules and Regulations.

[v] New proposed time limits for this 'demonstration project' based on 2012 DOC F and F:Flow View of Full Population (page 68):

- 55% of population come and go in less than one (1) year
- > 33% come and go in less than one (1) month