OVERDOSE PREVENTION SERVICES IN JAILS

The 2019 Overdose Response Strategy Cornerstone Report

Funded by the Office of National Drug Control Policy
and the Centers for Disease Control and Prevention

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Project Overview

The Overdose Response Strategy's Cornerstone Projects

The Overdose Response Strategy (ORS) is a public health/public safety collaboration between the Centers for Disease Control and Prevention (CDC) and 21 High Intensity Drug Trafficking Areas (HIDTAs).[1] The partnership aims to reduce overdose (OD) by developing and sharing information across agencies and assisting communities with the implementation of evidence-based strategies.

Each year, the ORS undertakes a Cornerstone Project to answer a common question and address shared informational needs regarding the OD crisis. To date, the following Cornerstone Projects have been completed:

2016
The presence and status of fentanyl analogs

2017
Law enforcement knowledge, understanding, and experience implementing 911 Good Samaritan laws

2018
Public safety-led programs that link people with opioid use disorder (OUD) to evidence-based care

The 2019 Cornerstone Project examines **four** evidence-based OD prevention services in jails[2] serving counties most affected by the opioid OD crisis:

1. Screening for substance use disorder (SUD)
2. OD education and naloxone[3] distribution (OEND)
3. Linkage to care upon release
4. Maintenance medication-assisted treatment (maintenance MAT)

Medication-assisted treatment (MAT) refers to the use of FDA-approved medications (i.e., methadone, buprenorphine, and naltrexone) in conjunction with counseling for treating OUD[4]. In this report, we qualify MAT with the word "maintenance" to describe one type of MAT in which individuals are provided medication throughout incarceration as opposed to only at intake or at the time of release.[5]

DID YOU KNOW?

120 jails in 32 states offer at least one form of MAT. Although 3x the number in 2018, it is still only a fraction of all 3,200 jails [1].

Project Aims

The overall goal of this Cornerstone Project is to advance the scale-up of evidence-based services that reduce OD risk during and upon release from incarceration in jail. Specifically, we aim to:

- Describe evidence-based OD prevention services offered in jails to people with SUD.
- Identify barriers and facilitators to, and possible outcomes of, implementing services.
- Identify whether correctional staff show support for services and any knowledge gaps or concerns they may have.
- Examine differences by jail type (i.e., maintenance vs. non-maintenance jails).

[1]The 21 HIDTAs are: Appalachia, Arizona-Southwest Border, Atlanta/Carolinas, Chicago, Gulf Coast, Indiana, Liberty Mid-Atlantic, Los Angeles, Michigan, Midwest, New England, New Mexico-Southwest Border, New York/New Jersey, Nevada, North Central, North Florida, Northwest, Ohio, Oregon-Idaho, Rocky Mountain, and Washington/Baltimore.

[2]Jails are short-term facilities that hold individuals who are awaiting trial or serving relatively short sentences, usually less than a year. They are typically run by sheriffs or county corrections agencies and operate independently of prisons. Prisons are longer-term facilities that hold individuals who have been convicted and are serving longer sentences. They are run by states or the federal government. In some states, jails and prisons are integrated into a unified state-level correctional system. This project includes both types of jails: those functioning independently of prisons and within state unified systems.

[3]Naloxone is an opioid antagonist medication that can reverse a potentially fatal OD with timely administration.

[4]Because evidence shows that these medications can be effective without counseling [2], some OUD advocates and experts prefer the use of newer terminology, namely "medications for opioid use disorder" (MOUD) and "medications for addictions treatment" (MAT). We use "medication-assisted treatment" in this report because it has wider currency in corrections.

[5]MAT may be provided only at intake for the purposes of tapering off methadone or buprenorphine or treating withdrawal symptoms.

Project Rational

Nearly two-thirds of people incarcerated in jails meet the criteria for SUD and the period following release from incarceration is associated with a high risk of fatal OD [3, 4]. Providing MAT and other evidence-based OD prevention services for people with SUD in criminal justice settings can reduce OD risk, morbidity, mortality, and recidivism [5-7]. Yet such services are not widely available in jails [8-10], despite endorsements by the National Commission on Correctional Health Care, National Sheriffs' Association, Law Enforcement Action Partnership, and American Correctional Association [11].

This picture is starting to change. Some jails are taking steps to implement and expand evidence-based OD prevention services in line with national and international standards [12-14]. Their efforts suggest the feasibility of such services in correctional settings and growing support among correctional professionals dedicated to combatting the OD crisis.

Because implementation of these evidence-based services can reduce OD deaths and improve other social and health outcomes, scale-up across jail settings is critical. To that end, there is an urgent need to learn from jail personnel about how they provide services and what strategies they use to address common operational challenges. Additionally, a better understanding of why many jails are still not providing these services is needed. To address these knowledge gaps, we conducted interviews and surveys with staff in 36 jails in 20 states. In an effort to capture the widest possible range of experiences and perspectives, we included in the sample staff working in jails with and without existing programs that maintain individuals on MAT as needed, which we term "maintenance" and "non-maintenance" jails, respectively. We elaborate on this distinction below.

This report summarizes our main findings and recommendations. While the report is largely descriptive, we also incorporate more evaluative and instructive observations. Our primary audience are jail administrators interested in learning more about OD prevention, saving lives, or initiating or improving OD prevention services. Several excellent tools already exist to guide the implementation of MAT in jails and prisons [15-19]. This report adds to that knowledge by:

- Examining additional OD prevention services.
- Underscoring that jails operate along a continuum of criminal justice interventions and within communities where multiple opportunities to reduce OD exist.
- Providing additional real-life examples of barriers, facilitators, solutions, and successes from the perspectives of those providing services.

Types of Jails

Medical directors and other correctional staff in two types of jails were included in the project:

Maintenance Jails

Jails that provide maintenance MAT; for example,

- Allowing individuals already on MAT to continue their regimen
- Initiating and maintaining MAT throughout incarceration for individuals diagnosed after booking

Non-Maintenance Jails

Jails that provide no MAT or limited MAT; for example:

- Administering MAT upon arrival for managing opioid withdrawal or tapering off
- Providing 1-2 doses of MAT prior to release
- Providing MAT only to pregnant individuals

ACKNOWLEDGEMENTS

The authors wish to thank the PHAs and DIOs within the ORS for completing the steps associated with this project (see Appendix 1). We also thank members of the CDC ORS team, ORS Executive Board, PHA/DIO Advisory Group, and wider ORS community for providing feedback on this project and report. Finally, we are grateful for the interviewees and survey respondents who kindly agreed to share their observations and experiences with us and made this project possible.

Project Methods

This project was implemented from October 2019 to January 2020 across 20 ORS states (see Figure 1) with staff (i.e., Public Health Analysts [PHAs] and/or Drug Intelligence Officers [DIOs]) available at the time to collect information.

In each state, ORS staff completed the following steps:

1 Determined high-burden counties

- Using 2017 surveillance data, determined the 5 counties in their state with the highest opioid OD death rates
- Using this sampling frame ensured that issues related to OUD and OD were relevant to all jails included in the project.

2 Identified jails

- Within those counties, identified 2 jails willing to participate in the project
- Ideally, 1 maintenance jail and 1 non-maintenance jail were identified. When this was not possible, 1 jail of either type or 2 jails of the same type were identified and enrolled in the project.

3 Conducted interviews

- Conducted interviews with jail medical directors or other jail leadership in the identified jails
- The interview aimed to obtain detailed information about the OD prevention services available in that jail.

4 Disseminated survey

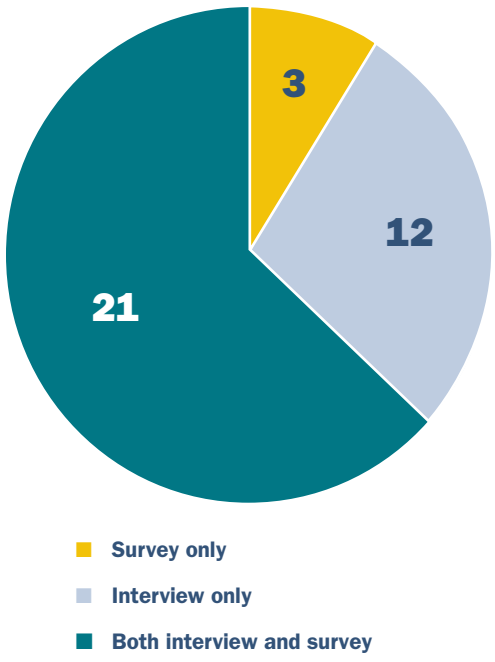
- Disseminated a link for an online survey to all correctional staff in the identified jails
- The survey aimed to assess correctional staff's knowledge of OD risk and prevention services.

As mentioned, a total of 36 jails were included in the project. Per Figure 2:

- Individual or small group interviews were conducted in 33 jails (one interview per jail).
- Surveys with 483 jail staff were administered in 24 jails.
- Both interviews and surveys were conducted in 21 jails.

Figure 1: Participating states included Connecticut, Delaware, Georgia, Illinois, Indiana, Kentucky, Massachusetts, Maryland, Michigan, North Carolina, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia, and Vermont.

Figure 2: Distribution of data collection methods across jail sample



SECTION

II

Snapshot of Jails and Staff

This section details characteristics of the 36 jails (Table 1 and Figures 3A-F) and 483 survey respondents (Figures 4A-B) included in this project.

Jail Sample

Table 1: Characteristics of 36 jails

	# of Jails*	% of Jails
Number of jails	**36**	
Rurality		
Urban	22	73
Mostly rural	8	27
Completely rural	0	0
Maintenance Jail		
No	12	31
Offers MAT supported withdrawal	3	25
Offers naltrexone before release	2	20
Transitioning to maintenance jail	2	17
Demonstrates at least minimal support for MAT	8	67
Yes	24	67
Offers methadone	17	77
Offers buprenorphine	19	86
Offers naltrexone	17	77
Only offers naltrexone	2	8
Offers all 3 MAT medications	13	59
Average daily population (Range: 38-4551)		
Less than 200	7	35
200-999	9	45
More than 1000	4	20
Sex primarily served		
Men	34	94
Women	2	6
Contracts health vendor		
No	3	14
Yes	18	86
Average stay of individuals in jail (Range: 17-300)		
30 days or less	10	63
More than 30 days	6	37
Reincarceration rate (Range: 30-90)		
Less than 50%	5	45
50% or more	6	55

**Totals may not equal 36 due to missing values.*

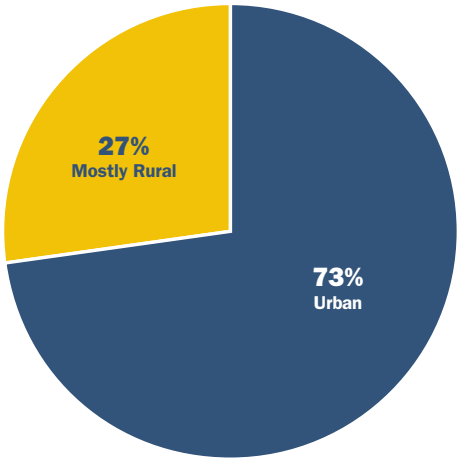


Figure 3A: Rurality

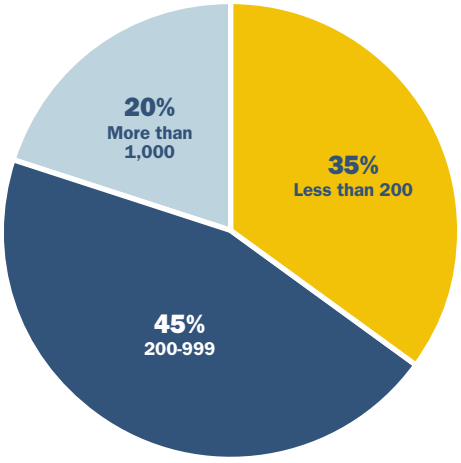


Figure 3B: Average Daily Population

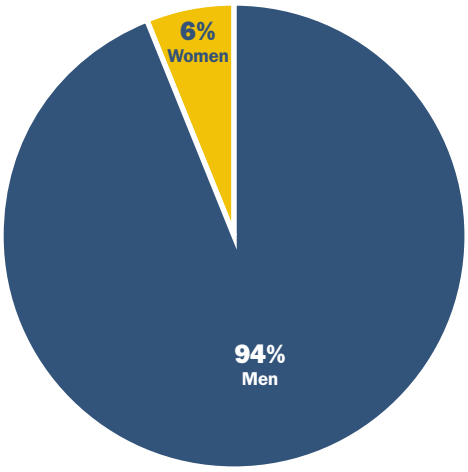


Figure 3C: Sex Primarily Served

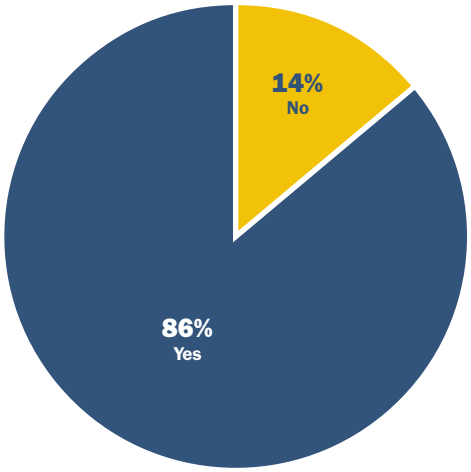


Figure 3D: Contracts with Health Vendor

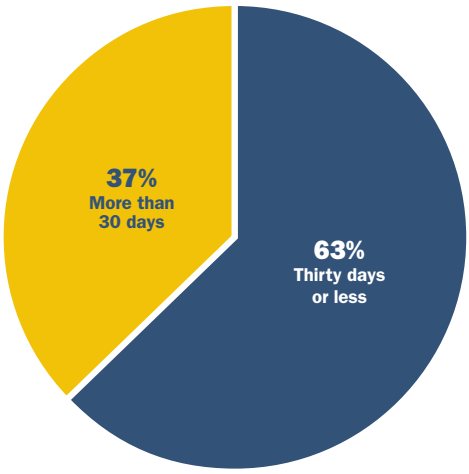


Figure 3E: Average Stay of Individuals in Jail

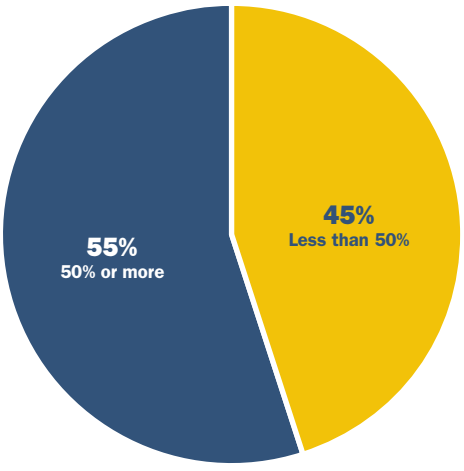


Figure 3F: Reincarceration Rate

Staff Sample

Of the 483 respondents in 24 jails (represented in Figure 4A and 4B) who completed the online survey. Per Figure 4A and 4B:

- The most common job function was jail security and transportation
- Roughly two-thirds had been working in jails for at least six years.

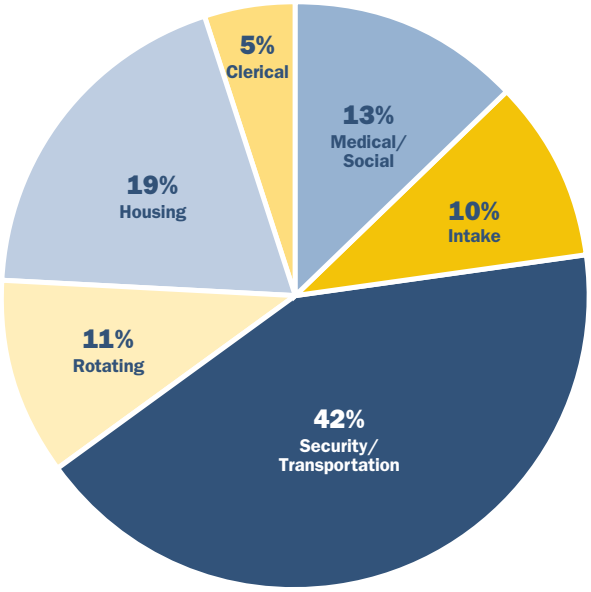


Figure 4A: Job Function of Staff Sample

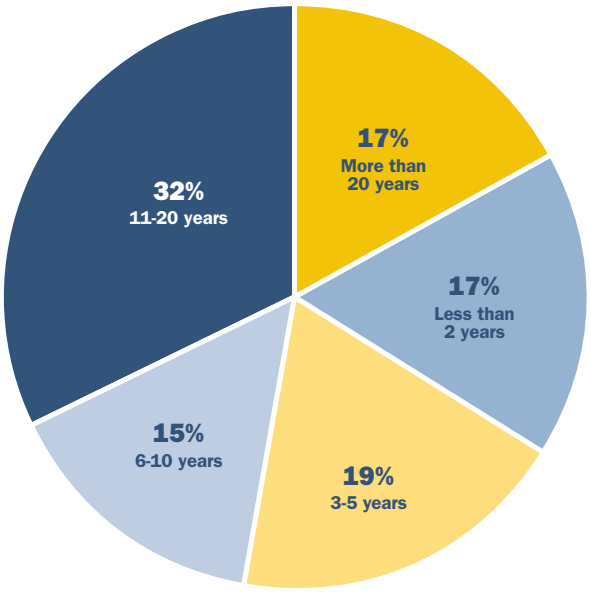


Figure 4B: Years of Experience of Staff Sample

SECTION

III

SETTING THE STAGE:

Why Overdose Prevention Services Are Needed in Jails

Based on interview and survey data, this section describes how drugs and overdose adversely affect daily operations, staff, and incarcerated individuals in jails, showing why some jail administrators are seeking new approaches to addressing these challenges.

The Problem

This project confirms what is already well-documented: SUD is highly prevalent among people incarcerated in jail. As mentioned, the Bureau of Justice Statistics estimates that 63% of sentenced individuals in jail meet the DSM-IV criteria for SUD [3]. Most interviewees in this sample reported an SUD prevalence notably higher than the national average, ranging from 80 to 95%.[6]

> "Right now SUD is the biggest thing on our radar. I mean it's what everybody's talking about; it's what we're trying to develop our programs around."
>
> ***—Maintenance jail interviewee***

In most jail populations, OUD figured most prominently. In some, methamphetamine use disorder was more common. In several jails, where SUDs had once been dominated by OUD, interviewees had seen a shift toward greater marijuana, methamphetamine, and polysubstance use, which aligns with national trends [20].

SUD is not a standalone issue. When describing the major health challenges facing their facilities, nearly all interviewees mentioned mental illness and SUD, noting that they often co-occur [20]. The most commonly diagnosed mental illnesses were schizophrenia, depression, anxiety, and bipolar disorder. Many interviewees also pointed to the below health conditions that often accompany SUD and mental illness in jail populations and pose added challenges for service provision:

- Diabetes
- Hypertension
- Dental Problems
- Seizure Disorders
- Infectious diseases (HIV, STDs, Hepatitis C)
- Trauma

> "The illness burden is, or as we call it, illness opportunity, is quite substantial because 75-80% of the people here are SUD patients… and then 36% are on the behavioral health caseload."
>
> ***—Maintenance jail interviewee***

Contributing Factors

It is well documented that individuals with SUD are frequently and repeatedly incarcerated because of drug possession laws and other incidents, like theft or vagrancy, that may be propelled by SUD [21]. Interviewees called attention to yet another factor contributing to the high SUD prevalence among jail populations: a lack of community treatment options. They described their communities as "medical deserts," where "everybody's impoverished," suggesting that even individuals who desired treatment, care, and other support services were hard-pressed to find them, which made them vulnerable to arrest and incarceration. This seemed especially true for individuals who use drugs and have mental health disorders or are unhoused. Interviewees observed that these individuals are often arrested not because they "knowingly break the law," but because police officers have "nowhere else to take them."

> "Although it's wonderful to treat people in the community, generally, the community is not prepared to serve as many people as need to be served. And so, folks get arrested, they get sent to us, and we [treat them]. It's kind of a backwards way of doing things, but that's what's happening nationwide."
>
> ***—Maintenance jail interviewee***

[6] Such an increase may reflect:

- The sampling strategy, which purposively recruited jails in counties burdened by the opioid OD epidemic.
- An actual increase of individuals with SUD in jails since the Bureau of Justice Statistics carried out its survey in 2007-2009.
- The possible inclusion of pre-trial individuals in the calculations, assuming that more pre-trial than sentenced individuals have SUD.

We should note that one interviewee in this study reported a rate that was far lower; the SUD prevalence in this jail was 40%.

Implications for Jails

The high SUD prevalence in jails has redefined their meaning and function. Interviewees from both maintenance and non-maintenance jails readily described jails as "psychiatric and substance abuse facilities" as opposed to correctional settings. One interviewee equated jail intake to an "emergency room" given the number of people who require monitoring for withdrawal symptoms upon booking.

Withdrawal

2/3 Some jails reported that **two-thirds of all individuals** are in withdrawal at intake.

25% **25% of non-maintenance jails** and **63% of maintenance jails** reported providing methadone or buprenorphine to treat withdrawal symptoms.

63%

Survey respondents also recognized the burden of SUD on their facilities; the vast majority (93%) indicated that individuals entering jail with SUD was an issue.

The influx of individuals with SUD into jails is not only dangerous for the individuals themselves, who are made vulnerable in the absence of services; it also affects daily operations, staff, and other incarcerated individuals in ways that underscore the need for improvement. Some of those effects are outlined below:

1. **Individuals with SUD require urgent medical attention unavailable in many jails.**

   During intake, individuals who use drugs or have SUD may be intoxicated and at risk of OD, in need of critical care for open wounds or sores, or in withdrawal. Many interviewees reported being ill-equipped to address these immediate concerns, sometimes requiring them to transfer individuals to nearby hospitals. In addition, 24% of survey respondents identified individuals overdosing in jails as an issue.

> "We [use] Narcan on people at intake 2 or 3 times a week, and… our emergency room trip rate, per thousand, is 40% higher than it was a year ago. This increase is entirely people in such serious withdrawal that we can't handle it. We handle most of them, but 70% of the people that we send to an emergency room for withdrawal symptoms end up being admitted. That's how sick they are."
>
> ***—Maintenance jail interviewee***

2. **Forceful withdrawal negatively affects individuals with OUD and those around them.**

   The inability to immediately and effectively treat withdrawal from opioids can compromise institutional safety and security, individual well-being, and staff morale. Indeed, 24% of survey respondents indicated that individuals needing detoxification services for opioids and not receiving it in jails was an issue, and this was higher in non-maintenance jails compared to maintenance jails (29% vs. 20%).

> "It can be difficult to engage them [individuals who use drugs], when they are sick. They are worked up and sick for the first 2 weeks [of incarceration], which makes it hard to your job."
>
> ***—Maintenance jail interviewee***

> "[Individuals who use drugs] come to us in a vulnerable state. It's already horrific that they're going to jail and then you add the instability of withdrawing from [opioids]… Then there's resentment from custody… [for] having to deal with them, having to deal with vomit and feces, having to listen to them fight with other individuals…"
>
> ***—Maintenance jail interviewee***

3 Relapses and ODs among recently released individuals are deeply troubling for all.

It is well known that formerly incarcerated individuals are at high risk of relapse and OD upon release; less widely recognized is that such events can be devastating for the correctional officers and other incarcerated individuals who knew them.

> "When you're trying to get somebody clean… and then they go back out in the community and they relapse, it's really frustrating... And then they come back in and, you know, they're right back where they started at square one, so, it makes it difficult."
>
> ***—Maintenance jail interviewee***

> "After they leave, usually it's the inmates who tell us that someone has overdosed. They are very connected. It's extremely troublesome for the staff and other inmates to learn of these deaths… The overdoses on the outside, the ones in the community, they are very troublesome…"
>
> ***—Maintenance jail interviewee***

The challenges posed by drugs and OD are why some jails have moved away from traditional abstinence-based programming toward newer evidence-based services, such as OD education and naloxone distribution, linkage to care upon release, and maintenance MAT, which we turn to next.

SECTION

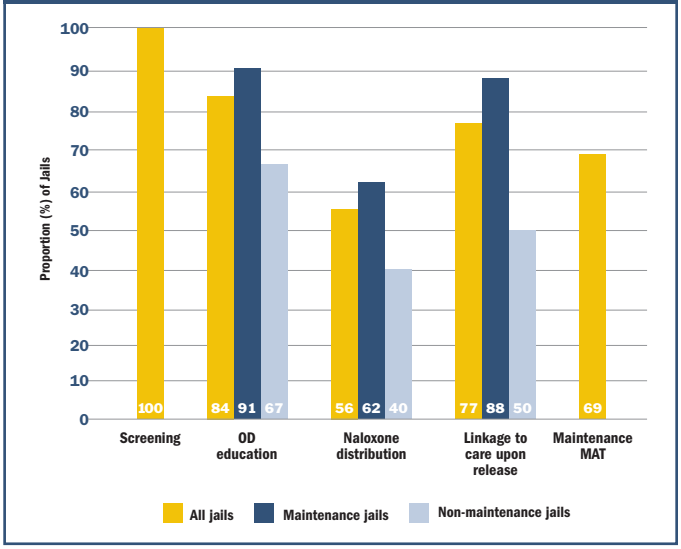
IV

Providing Evidence-Based Overdose Prevention Services in Jails

Figure 5 presents jail-level data on the availability of evidence-based OD prevention services in the jails included in this project:

- About two-third (69%) of jails provide maintenance MAT.
- More than half of jails also provide OD education, naloxone distribution, or linkage to care upon release.
- Three jails provide no OD prevention services.
- Maintenance jails are more likely to provide the other OD prevention services (OD education, naloxone distribution, and linkage to care) compared to non-maintenance jails. This suggests that either maintenance MAT is the gateway to providing more comprehensive OD prevention services or that jails implementing other OD prevention services are more likely to initiate maintenance MAT.

Figure 5: Services Provided by Jails, by Jail Type



In what follows, we address two types of audiences:

1. Jail administrators who are just starting, or wanting to start, maintenance MAT and are looking for information on how to identify and address implementation barriers.
2. Others who are already providing OD prevention services and would benefit from knowing how others are operating similar programs and what practices work best.

Readers in the first camp may want to continue to Part A, where we discuss maintenance MAT barriers and facilitators.

Readers in the second camp may want to skip to Part B, where we describe each OD prevention service in turn and:

- Catalog variations in practices associated with that service.
- Recommend best practices based on the literature and experiential knowledge of interviewees.
- Provide troubleshooting tips for commonly faced operational challenges.

> "Medical can't do what they need to do without the help of security. We are talking about a correctional institution. Safety is first and foremost, so it has to be a collaborative effort."

> "Anything… [new] starts at the head. This sheriff has made it very clear… [MAT] is what we're doing… It's not going to fail and we're gonna be in compliance… When I say he's made that clear, [I mean] loud and clear, crystal clear. I haven't met any resistance and I'm the MAT guy. I've met with security all the way down."

Part A

Just starting or wanting to start maintenance medication-assisted treatment?

You are not alone. Most non-maintenance jail interviewees in this sample reported that their jails either had plans to initiate maintenance MAT or had leadership that was open to providing or discussing it.

If you are wondering about barriers to implementation, non-maintenance jail interviewees as well as other studies [8,9,12,22] on this topic offer some insights (see Table 2).

Table 2 : Maintenance MAT implementation barriers

Barriers identified by non-maintenance jail interviewees	Barriers found in other studies
1 Lack of leadership or interest among jail administrators. 2 Pushback from county officials or community members opposed to the use of tax dollars for maintenance MAT. 3 In jails that prioritize quick releases, concern that maintenance MAT would be impossible, if not potentially harmful as it could prolong an individual's stay. 4 Belief that incarcerated individuals do not need MAT because they do not experience cravings or need drugs to "cope" while in jail.	1. Security concerns associated with the control of buprenorphine, a medication that is understood to be "contraband." 2. Lack of affordable MAT providers in the community for continuation of treatment upon release. 3. Lack of staffing to accommodate extra medication lines, medical tests, monitoring, mouth checks, and transportation to outside clinics. 4. Inability to cover medication costs and associated expenses. 5. Negative attitudes toward MAT among jail staff, namely that "substituting one drug for another" does not constitute treatment.

If you want to know how to address these barriers, maintenance jail interviewees suggest making use of the following resources and strategies:

1 External grants

While not all jails need external funding to initiate maintenance MAT, it certainly helps address staffing concerns and cover medication costs. Jails reported receiving grants from their governor's office, other state agencies, or SAMHSA, though CDC, DOJ, HIDTAs, and county sheriffs are other known funders [16]. Amounts varied, as shown below:

Amount Received	Purpose
$683,000	buprenorphine, methadone, and naltrexone program
$400,000	buprenorphine program
$200,000	construction of MAT clinic

In addition to grants, non-monetary awards, such as a technical assistance award from Arnold Ventures and the Bureau of Justice Assistance, were also mentioned.

Among Survey Respondents:

55% 55% in both maintenance and non-maintenance jails agreed that MAT **substitutes 1 drug for another** and 27% agreed that MAT should be available as **lifelong treatment**.

27%

37% 37% in non-maintenance jails saw MAT as effective OUD treatment.

2 High-level support

Leadership has been described as a "critical driver" of MAT programs [12, 22]. Not only does it generate interest and support, it can also override barriers posed by negative staff attitudes. One interviewee explained this best when describing how maintenance MAT started in their jail:

In addition to sheriffs, other key champions of maintenance MAT included mayors, jail commanders, deputies, state corrections departments, governors, and directors of medical contracting agencies.

3 Frontline support

One jail established maintenance MAT when correctional officers took action, initially without support from upper management. Concerned about the large numbers of individuals in withdrawal after booking and overdosing in the community after release, the officers started by consulting other jails with similar programs, identifying a vendor that could supply methadone, establishing an appropriate dosing room, and outlining exactly how the medication would be delivered and dispensed. Despite their earlier reservations, the deputy wardens in this case could not refuse such a carefully designed plan.

4 Teamwork

Numerous interviewees were clear that their programs would have never launched without coordination across medical and security staff, as illustrated by this quote:

Teamwork matters not simply because both medical and security are needed to operate programs, but also because it encourages buy-in. Several interviewees noted that security staff who initially opposed maintenance MAT began to support it once they were directly involved and made to feel part of the solution.

How Can Jails Foster Teamwork?

1. Make sure everyone is "on the same page" and understands the value of the services provided, even if this slows down the implementation process. Security is more likely to collaborate with medical if they understand what MAT is, how it works, and how it can improve their own work, jail safety, and community safety.
2. Choose a medication delivery model that all endorse. See solutions for addressing diversion in Part B.
3. Encourage open, honest communication and validate different perspectives.

5 Vendor support

Some medical vendors oppose maintenance MAT with all three medications for ideological or financial reasons. Choosing a medical vendor that "understands MAT" and "wants to help" is thus key. Vendors can also help relieve the logistical burdens that such programs pose.

6 ACLU involvement

A lawsuit filed by the American Civil Liberties Union (ACLU) against one jail for failing to continue an individual's OUD treatment during the person's incarceration was the catalyst for change. Required to treat this individual as part of the settlement, jail administrators realized that maintenance MAT was far more doable than anticipated.

7 Legislative change

In four states, new legislation required jails to provide a maintenance option for individuals diagnosed with OUD at intake or else in compliance with an existing MAT provider.

8 Starting small

Some jails used a staged approach. For example, they started on a pilot basis, where they offered one medication to a small population, or with a single strategy, where they used buprenorphine to treat withdrawal before expanding to include maintenance. Such an approach allows jails to address operational challenges on a smaller scale and see whether their concerns about diversion or the impact on release times are valid. It also helps foster teamwork because staff see firsthand the short-term benefits of implementation.

9 Staff education

Jails that provide maintenance MAT reported several positive outcomes, most notably a reduction in safety and security issues and an improvement in the health of incarcerated individuals (see Section V). Maintenance jail interviewees found that educating staff about these benefits not only fosters teamwork, as mentioned, but also directly addresses any negative attitudes or misconceptions about OUD and treatment that can impede implementation.

Introducing Suboxone*: A Case Example

One of few states with a unified correctional system has a long provided methadone maintenance to pre-sentenced individuals and individuals with shorter sentences. Last year, this state expanded its program to include buprenorphine and naltrexone and induct into maintenance MAT anyone not already receiving it. The plan to induct was an easy sell to correctional officers. The introduction of buprenorphine was not.

> "Suboxone is a drug that correctional officers work on keeping out. It's contraband… And now we are asking them to allow it in as a treatment mechanism."
>
> ***—Maintenance jail interviewee***

What built support for this program?

1 Education

The program manager and medical director provided training on MAT to all involved staff.

2 Beginning with a pilot

Rather than expand the program in all facilities at once, the state piloted the expansion in its smallest facility where it was able to identify and resolve challenges more easily.

3 Easing the burden on correctional officers

One of the challenges of introducing any new medication into jails is that it requires officers to accommodate new medication lines and observed dosing. The introduction of buprenorphine was especially difficult because it required officers to directly observe individuals for 15 minutes at a time, until each pill had dissolved. The state quickly switched from the pill form of buprenorphine to the sublingual film, which dissolves more quickly. The added cost of the film was justified because it minimized the burden on staff.

4 Involving officers in more than security

The state started to train officers in naloxone administration and give every officer who requested it a naloxone kit. This helped correctional staff feel more prepared, better equipped, and thus better able to do their job. Further, asking officers to opt into this program, which many did, increased their investment in the full spectrum of OD prevention services.

**Suboxone is a formulation of buprenorphine used to treat OUD and opioid withdrawal.*

Part B

Already providing overdose prevention services and want to know more?

Here is further guidance on how each service is differently operationalized, when it works best, and what solutions can address common challenges associated with service delivery.

Screening

Screening refers to jail intake procedures that identify individuals with SUD and other medical needs. Because individuals arrive at jail in need of urgent medical attention, screening of incarcerated individuals is essential as an immediate life-saving measure and pathway to other OD prevention services.

TABLE 3: SCREENING PRACTICES

	Variations in Screening Practices	Screening Works Best When…	
Screening for what?	• Signs of OD and other acute medical needs • Withdrawal symptoms, drug use, SUD • Current treatment use and treatment needs	• All jails screen for drug use and withdrawal symptoms. • All jails screen for current and past use of treatment [23]. This includes non-maintenance jails because it can serve as a proxy for substance use and inform linkage to care plans.	
Who conducts screening?	• Medical staff (e.g., nurse or mental health counselor) • Arresting or correctional officer	• Medical staff as opposed to correctional officers conduct screening. Individuals are more open and willing to disclose personal or sensitive information to the former. • Those conducting screening are properly trained [23].	**60-67%** **of survey respondents reported a need for training on identifying SUD, withdrawal, and OD.**
How is screening conducted?	• Observation, sometimes using validated tools (e.g., Clinical Opioid Withdrawal Scale) • Self-report, sometimes using validated screening tools (e.g., TCU5, DSM-V) or vendor-specific tools • Urinalysis with consent	• It includes universal urinalysis, following consent. Conducting urinalysis allows jails to identify all in need of detoxification and OD prevention services. • Validated screening tools are used, as they facilitate the rapid collection of information to inform a care plan.	
When is screening conducted?	• Immediately, within 4-8 hours of entry (for OD signs, withdrawal, medical needs) • Short-term, within 24-48 hours of entry (for withdrawal, treatment needs) • Long-term, post-booking, in the sentenced population, within 14 days of entry (for more extensive screening of SUD and care needs)	• Screening for OD prevention and detoxification services are universally conducted immediately upon entry, as many jails report individuals presenting with OD, withdrawal symptoms, and other acute medical needs at intake.	

TABLE 4: TROUBLESHOOTING SCREENING

Operational Challenges	Solutions
1 **Underreporting:** Individuals may be hesitant to disclose substance use and related issues owing to stigma or fear of possible disciplinary repercussions.	• Medical staff, or at least those who have been trained, should conduct screenings. Incarcerated individuals are more likely to underreport substance use and related issues to correctional officers and be more candid with clinicians [23, 24]. • Use multiple screening techniques (i.e., observation, questionnaires, and urinalysis) for best results. • Conduct screenings in a confidential space [23].
2 **Timing:** It can be difficult to screen for everything at intake.	• Prioritize which screenings should be conducted immediately upon entry (i.e., for acute needs like withdrawal) and which ones can be done in the days and weeks that follow. This also gives individuals initially hesitant to disclose substance use more time to gain confidence. • Use rapid, standardized, evidence-based screening tools to assess for drug use and withdrawal symptoms [25], rather than developing new ones.

Overdose Education and Naloxone Distribution

Overdose education and naloxone distribution (OEND) typically targets individuals who are likely to witness an OD—including individuals who use drugs, peers and family members, service providers, fire fighters, and police officers—and trains them to more effectively respond. Training may include:

1. Information about OD risk factors, signs, and symptoms
2. Tips for calling 911 and engaging with first responders (for laypersons)
3. Good Samaritan laws and other legal protections regarding naloxone possession and use
4. Common misconceptions about drugs, OD, naloxone, and people who use drugs
5. Instruction in administering naloxone
6. Provision of one or more doses of take-home naloxone. Some programs also cover rescue breathing and provide pocket masks.

Since the 1990s, OEND has been available in communities through harm reduction organizations, drug treatment programs, and pharmacies. Studies show that it is cost-effective, feasible, and associated with reduced OD deaths [26-28]. More recently, OEND has expanded to correctional settings [13].

In this Jail Sample:

25% provide OD education without naloxone distribution

3% provide naloxone distribution without OD education

11% provide neither service

TABLE 5: OEND PRACTICES

	Variations in OEND Practices	OEND Works Best When…
Who is trained?	• All incarcerated individuals • All visitors • Individuals who opt in • Individuals in specific programs (e.g., re-entry, drug treatment, hepatitis) • Individuals with drug charges or history of OUD	• Training is universal to maximize reach and reduce the stigma associated with participation [29]. • It is incorporated into the orientation curriculum to reach all incarcerated individuals. • Visitors are engaged individually or in small groups in or near waiting areas.
Who provides the training?	• Specialized trainers with lived experience • Contracted vendors • State or local health departments • Jail behavioral health staff	• Trainers have lived experience with drug use, OD, or incarceration. They may be better positioned to build rapport and communicate prevention messages. • A program protocol is developed to facilitate training, especially when different trainers are used [29].
When is it provided?	• At intake • Monthly • Quarterly	• Training is provided in the first few days of arrival or on a monthly basis [29]. In high turnover jails, monthly trainings may not be often enough.
What is the training format?	• Video shown in visiting areas and housing units • In-person groups	• All individuals eligible for in-person training are included and given the option to opt out [29]. • Videos help reinforce messages. Videos should not be the only training format because they place the onus on individuals to request naloxone [29]. • Classrooms are used for training groups; if classrooms are unavailable, exam or counseling rooms can be used [29]. • Visitors are trained 1:1 or in small groups using private areas or rooms near waiting areas [29].
How is naloxone distributed?	• Naloxone kit included in individual's property at discharge • Naloxone kit provided as part of release process • Naloxone prescription or voucher provided and filled in the community	• Naloxone kits are included in an individual's property to ensure receipt. • Jails wait until an individual's release date is approaching to include the kit [29].

TABLE 6: TROUBLESHOOTING OEND

Operational Challenges	Solutions
1 **Cost:** Cost is often the main challenge for sustaining or expanding OEND.	• Purchase the generic injectable form of naloxone. It is generally the least expensive of all available formulations. • Dispense naloxone through a pharmacy that can buy in bulk and bill Medicaid if the medication is dispensed after individuals are released but before they leave campus.

Operational Challenges	Solutions
2 **Stigma:** Jail administrators may shy away from endorsing OEND because they see it as enabling drug use. Incarcerated individuals may be reluctant to participate in OEND because they fear judgement or identification as someone who uses drugs.	• Build buy-in for OEND by addressing myths, such as the belief that it enables drug use [30]. • Offer training to all individuals in custody and all jail staff so that individuals are not singled out. • Emphasize that naloxone should be carried by anyone who may witness an OD or is worried about a friend or family member who could OD, even from prescribed opioids taken as instructed.
3 **Logistics:** Jails face challenges dispensing naloxone either because they do not have someone licensed to prescribe it or because they face delays getting it into the hands of individuals, if provided as part of the release process.	• Review your state's laws to explore all possible dispensing options. Pharmacists can dispense naloxone under a standing order in most states.[5] • Request naloxone from the dispensary prior to the release process to avoid delays, keeping in mind that jails are discouraged from putting naloxone in an individual's property weeks or months in advance. • Make naloxone available to recently released individuals at places they are likely to visit in the community, such as a public defender's office, in addition to pharmacies. • Establish partnerships with local health departments and community-based organizations that already purchase and distribute naloxone [29].

Linkage to Care upon Release

In correctional facilities, linkage to care refers to the assistance provided to individuals as they transition into the community after release from incarceration. There are many approaches to providing this service. It may:

- Begin the moment an individual is incarcerated or within hours of their release.
- End upon release or long after an individual has returned to the community.
- Be required or voluntary and available to everyone or only certain populations.
- Focus exclusively on an individual's immediate concerns, like access to food, shelter, medications, or medical care or encompass long-term needs, like employment or education.

For this project, we were most interested in linkage to care provided by jails to individuals with SUD with the goal of helping them resume or initiate drug treatment in the community. Assistance had to be more than a passive referral (i.e., individuals receive a list of community treatment providers to seek out on their own). Instead, jails had to facilitate treatment access (e.g., pre-screening providers, setting up appointments, calling ahead to ensure availability, or providing transportation).

More than three-fourth of jails included in this project provide linkage to care as defined above.

> "If we have to transport them to the outpatient MAT clinic, we're going to do that. You can't just give them the number to the clinic and expect them to go."
>
> ***—Non-maintenance jail interviewee***

> "The goal is not to see people again; you don't come back. There is a need to evaluate social determinants and upstream resources available to persons in society. Healthcare, housing, community support–those are all elements that can lead to an iota of success. It's commonsense."
>
> ***—Non-maintenance jail interviewee***

> "If you wanna keep them alive and you wanna keep them from coming back, post-release case management is where the money should be spent."
>
> ***—Maintenance jail interviewee***

[5] Find out more about your state's access rules and regulations at: https://www.safeproject.us/naloxone-awareness-project/state-rules/

TABLE 7: LINKAGE PRACTICES

	Variations in Linkage Practices	Linkage Works Best When…
Linkage to what?	• Drug treatment (e.g., MAT, intensive outpatient patient, residential treatment) • Hospitals (if someone is still in active withdrawal) • Primary care • Mental health services • Housing • Nutritional supports (e.g., food vouchers) • Educational opportunities • Job readiness programs • Medicaid • Peer support • Case management	• Jails develop linkage plans that address individual needs. • Jails use a simplified Medicaid application to expedite enrollments. • Individuals are enrolled in Medicaid prior to release. This facilitates linkage and incentivizes community-based providers to seek out formerly incarcerated individuals as new clients. • Jails become presumptive eligibility providers for Medicaid to activate short-term coverage for individuals upon release. • It is followed by longer-term recovery supports, such as case managers and peer support specialists who can provide coaching, transportation assistance, accompaniment to appointments and support groups, and help with upstream needs, like education, family support services, and employment.
Linkage to whom?	• Any community-based provider • Established community partners • Satellite clinics affiliated with the contracted medical vendor	• Jails establish partnerships with community-based providers. Some jails prefer establishing partnerships with many reputable providers to increase access. Others prefer limiting partnerships to providers that come to the jail in advance to meet individuals, which helps follow-up. • Jails choose medical vendors that have statewide satellite clinics that provide MAT. This makes linkage easier because released individuals are already registered patients. • For uninsured individuals, jails link to presumptive eligibility providers who can provide short-term coverage.
Who receives linkage?	• All individuals • Sentenced individuals • Individuals with chronic conditions, including OUD • Anyone upon request	• Linkage services are offered to everyone; participation is voluntary. • Individual preferences are honored. Some individuals know in advance what services they need and where they would like to receive them. Others should be offered different options based on a needs assessment.

	Variations in Linkage Practices	Linkage Works Best When…
How is linkage conducted?	• Once a provider is selected, jail sends referral and discharge summary with diagnoses, medications, and test results • Once a discharge date is set, jail makes intake appointment • Shortly after discharge, jail contacts provider or individual for follow-up	• Jails take a more active, involved approach by sending referrals and discharge summaries, arranging transportation, and contacting the provider or individual for follow-up, rather than only making intake appointments. • Jails obtain a release of information to follow up with providers. • Upon release, individuals are given basic supplies (e.g., socks, underwear, towels, and sheets) and any necessary medications or bridge scripts. • Jails provide medications (buprenorphine or naltrexone) rather than scripts. Pharmacists are known to deny prescriptions because they do not recognize the prescribing physician, believe in MAT, or trust that individuals will not misuse the medication. Individuals unable to fill prescriptions are vulnerable to re-arrest.
Who coordinates linkage?	• Correctional officer • MAT nurse or coordinator • Mental health clinician • Social worker • Discharge planner or re-entry worker • Chaplain	• The person coordinating linkage is familiar with the available treatment and service providers, including any exclusionary criteria. Such expertise helps jails quickly and appropriately make linkages.
When do linkage services begin and end?	• They begin at intake, upon starting MAT, or several days or months before release • They end at release or several months after	• Jails start planning linkage as soon as possible.
Who provides transportation?	• Jail provides bus tokens or transports individual • Community-based provider • Peer support specialist • The individual is responsible	• Transportation is guaranteed. • Jails transport individuals rather than providing bus tokens.

26%

Only 26% of survey respondents had received training on available community services, which indicates an area for improvement.

Naltrexone and Linkage to Care

Seventeen jails in this project offer a single dose of naltrexone prior to release in an effort to support re-entry and linkage to treatment and care. In two jails, this is the only MAT offered. However, this medication may be inadvertently acting as a deterrent to linkage in some cases. Interviewees from these two jails reported that individuals who received naltrexone were less likely to follow through with linkage, presumably because it provided them with a false sense of security.

As an interviewee explained, they refuse treatment post-release "not because they're detoxing, but because they feel like, 'I'm safe. I've taken a shot [of naltrexone].'" Studies that measure the effects of naltrexone on treatment entry and retention and even OD risk have mixed or inconclusive results [31,32]. Jails that offer naltrexone prior to release should expand programming to include methadone, buprenorphine, and naltrexone *maintenance* and actively address any misconceptions about single-dose naltrexone being a one-off cure.

Spotlight Program

One maintenance jail received a 3-year SAM-HSA grant that allows it to provide 3 months of case-managed aftercare to individuals upon release from incarceration. Services include:

- Seven weeks of paid residency at one of the state's Oxford Houses, democratically run, self-supporting, and drug free homes
- Two months of bus passes
- Mental health treatment
- Intensive outpatient programming
- Access to MAT providers
- Medicaid activation
- Job readiness training
- Psychosocial education
- Bedding, towels, socks, and underwear
- Food support until employment begins

Individuals who successfully complete the 3 month program are eligible for reductions in probation and parole.

TABLE 8: TROUBLESHOOTING LINKAGE TO CARE UPON RELEASE

Operational Challenges	Solutions
1 **Lack of follow through:** Individuals may not follow through with linkage, evidenced by self-report or their reincarceration.	• Examine barriers to linkage by querying incarcerated individuals or community providers. Holding a roundtable of community providers, including peer specialists, works well for this purpose. It is important to hear from persons with lived experience. • Link individuals to treatment programs that: o Offer same-day appointments. o Have alternating schedules to accommodate everyone. o Can induct or continue MAT at intake. o Are conveniently located. o Are receptive to treating individuals released from jail. • Hold a resource fair or invite providers to the jail, even pay them, to publicize their services, initiate enrollments, and establish rapport. • If not offering maintenance MAT, at least offer MAT for treating withdrawal. This increases an individual's willingness to seek MAT upon release [33]. • If an individual is required to undergo drug testing by multiple parties (e.g., parole officer, drug treatment provider, and post-release case manager), minimize testing burden and the chances of violating parole for a missed test by sharing test results.

	Operational Challenges	Solutions
2	**No proof of identity:** Individuals without documents proving their identity are often ineligible for post-release services, including treatment.	• Coordinate with the Department of Motor Vehicles to make new or renewed state identification cards for individuals prior to discharge [34]. • Upon release, provide individuals with their head shots and other identifying bio-information so they can verify their identity for community providers.
3	**Quick or unpredictable release times:** It is difficult to effectively plan for care post-release if individuals are incarcerated only briefly or if their discharge occurs unexpectedly.	• Begin planning for linkage upon release as soon as individuals enter jail or begin maintenance MAT in jail. • Immediately give individuals provider information in case they are released unexpectedly. • If an individual is taking buprenorphine or naltrexone, ensure that any necessary prescriptions, or preferably medications, are placed in their property. • If an individual is released while still in active withdrawal, transport them to a local hospital for care. • Regular meetings between re-entry and court staff, along with having the re-entry worker attend court hearings, help make linkage staff aware of upcoming release dates.
4	**Inconvenient release times:** Friday discharges pose a problem because MAT providers may be near closing and unable to accept new patients. Similarly, discharge dates that do not coincide with next available MAT appointments can further impede follow through.	• Request that courts reschedule inconvenient release dates to days when same-day intake to treatment is possible. • If rescheduling is not possible, provide buprenorphine upon release or a bridge script to cover individuals' medication needs until their appointment. For individuals on naltrexone, provide their monthly dose if due. For individuals on methadone, utilize the three-day rule to administer methadone onsite if the individuals can return daily for dosing.

Maintenance Medication-assisted Treatment

As mentioned at the start of this report, medication-assisted treatment (MAT) refers to the use of FDA-approved medications (i.e., methadone, buprenorphine, and naltrexone) in conjunction with counseling for treating OUD; further, we use the term maintenance MAT when describing the provision of MAT to individuals throughout incarceration. Many jails provide MAT to individuals only at intake, for the purposes of tapering off methadone or buprenorphine or treating withdrawal symptoms, or in limited quantities (one to two doses) at the time of release. While the latter could serve as a bridge to maintenance treatment, neither practice is preferred. Experts agree that MAT is most effective and safe when treatment is not time-limited [35].

> "We have found… [that] a person is far more likely to go to a clinic… when they already know the person [there], already talked to them, than when they walk into a building they've never been in and see a person they've never seen."
>
> ***—Maintenance jail interviewee***

TABLE 9: MAINTENANCE MAT PRACTICES

	Variations in Maintenance MAT Practices	Maintenance MAT Works Best When…
Which program models are used?	• Licensed clinician administers buprenorphine within jail • External provider administers medications within jail • Jail retrieves medications from external provider for administration within facility • Jail transports individuals to external providers for medication	• An external provider can administer all three medications within the jail. This approach is logistically easier for most jails. • Jails can retrieve medications from an external provider weekly or biweekly, if the above is not possible. • Jails have enough buprenorphine prescribers to prevent any barriers posed by patient caps.
Who is eligible?	**Individuals:** • With OUD • On MAT prior to booking • On MAT prior to booking with negative illicit drug test or in "good standing" with provider • With low-level charges and minimal likelihood of transfer to prison • With less than two year sentences	• All individuals with OUD are eligible to receive it. There is no evidence to suggest that an individual's charge, sentence length, prior illicit drug use, or status with previous providers will determine their treatment outcomes.
What are the consequences for diversion or noncompliance?	• Immediate treatment termination • Treatment termination after second violation • Decisions made on case-by-case basis	• Decisions about treatment termination are made solely by medical staff, in conversation with the individual [16,17]. • Diversion or violence is not grounds for termination. • Individuals sign a contract that they will follow rules.
What are requirements for participation?	• None • Counseling • Counseling and groups • Ceiling doses on buprenorphine of eight or 16 mL	• Counseling and groups are available to all individuals but not required for treatment. • Dosing determinations are specific to the needs of individuals.

TABLE 10: TROUBLESHOOTING MAINTENANCE MAT

Operational Challenges	Solutions
1 **Insufficient resources for sustaining programs:** Maintenance MAT can be costly and is not covered by Medicaid while an individual is incarcerated; while the cost of methadone is relatively low, a single dose of injectable naltrexone or buprenorphine, which lasts a month, can cost $1,000 and $1,500, respectively. In addition, programs require doctors, nurses, screening tests, dosing rooms, medication lockers, staff and vehicles for transportation to outside facilities, as needed, and an ability to cover related health and dental needs.	• Enroll in the federal 340B Drug Pricing Program and use savings from other prescription drug costs to cover the cost of maintenance MAT. • Add naltrexone, methadone, and buprenorphine to the formulary or list of preferred drugs. • Request free medication samples or price reductions from manufacturers. Significant (e.g., 90%) price reductions are possible. • Capitalize on community support for MAT and tap community resources for ongoing funding. • Put program costs in perspective. Jails that have reduced recidivism by providing maintenance MAT are saving on average $25,000 annually per person who is not re-arrested.

Operational Challenges		Solutions
2 **Overburdening staff:** Operating a program with existing staff can be burdensome. Staff must be assigned new time-intensive tasks, such as completing paperwork, doing additional shakedowns and rounds, monitoring medication lines, retrieving medications from community-based providers, and starting shifts before dawn to dose patients outside the normal medication schedule.		• Know the OUD prevalence in the jail before starting and select a program model accordingly. o If OUD prevalence is high, beyond the capacity of existing staff, bring in an external provider to dose and monitor patients. o If OUD prevalence is low, within the capacity of existing staff, compensate staff for the time and energy they invest in the program. • Staff programs with those who have elected to participate. They are more likely to be invested and follow protocols. • Reduce staff burnout and improve morale by: o Reducing recidivism through maintenance MAT and linkage services. o Increase staff knowledge on the benefits of providing MAT and other OD prevention services. o Measuring and sharing successes of service implementation.
3 **Short length of stay:** It is difficult to initiate MAT if incarceration periods are brief and community-based MAT is limited. Pre-sentenced individuals pose a unique challenge because they can be discharged unexpectedly.		• Aim for same-day dosing, whenever possible, by increasing the amount of staff available to complete screening requirements. • Start discharge planning at the time of booking.
4 **Diversion:** Buprenorphine diversion makes the provision of maintenance MAT challenging. It can limit staff buy-in and support.	**1/4** **About 1/4 of survey respondents indicated that diversion is an issue in jails.**	• Recognize that while some diversion is inevitable, the issue is manageable with non-punitive means. • Document the scope of the problem because its magnitude might be more perceived than real. • Employ basic strategies to reduce diversion: o Alter the administration route from oral tablet to sublingual films or injections. o Improve dose monitoring. o Dose and house individuals on MAT separately. • Identify and address root causes: o Are individuals being underdosed? Adjust doses as needed. o Are individuals being bullied, pressured, or threatened with violence for their medication? Expand screening and access to MAT to reduce demand for diverted medications. • Train staff on the risks and consequences of diversion, MAT as treatment and not contraband, and the trade-off between occasional diversion and the benefits of maintenance MAT.

SECTION

V

Training Opportunities

Knowledge of Available Services

When surveyed about the availability of evidence-based services for people with SUD in the jail where they work (Figures 6A-B):

- A substantial proportion (between 28-44%) of respondents did not know whether each service was available.
- Non-maintenance jail staff were more likely to be unaware of their availability than maintenance jail staff.
- Medical/social staff were the most likely to be aware of their availability, while rotating, housing, and security/transportation staff were the least likely.

TAKEAWAY

Many correctional staff need more information about the availability of services for people with SUD in their jails. Providing this information can improve awareness and facilitate buy-in for these services.

Figure 6A: Respondents Who Don't Know About Available Services in Jails, by Jail Type

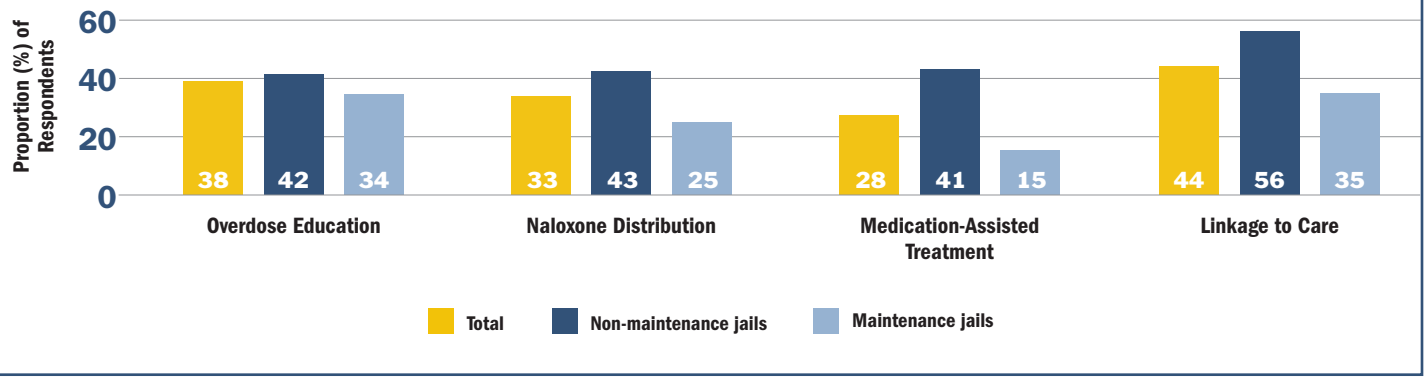
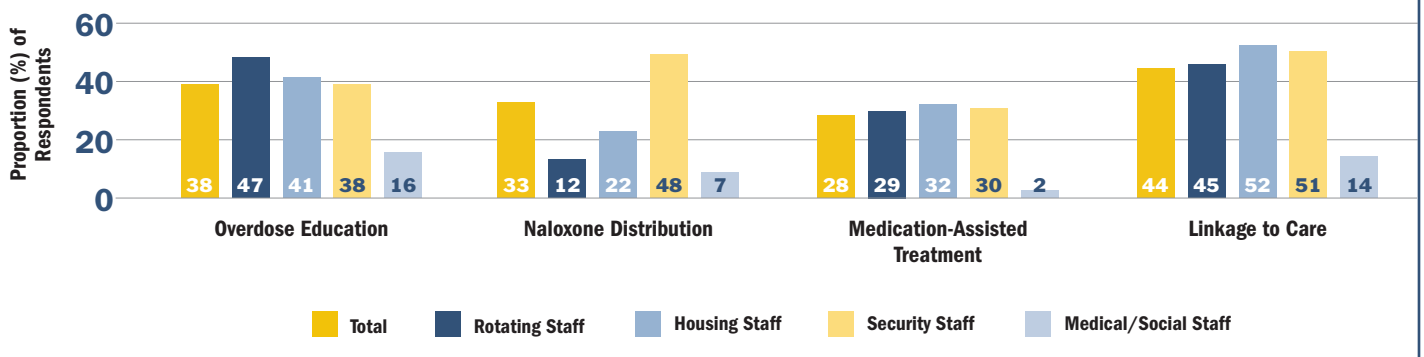


Figure 6B: Respondents Who Don't Know about Available Services in Jails, by Staff Type



Receipt of Training and Training Needs

For training on 1) identifying people with SUD, 2) identifying signs of and/or responding to withdrawal, 3) identifying signs of and/or responding to OD, and 4) administering naloxone (Figure 7A):

- Both survey respondents and interviewees indicated that training in these areas was commonly available to all correctional staff.
- Trainings were offered regularly through pre-service and in-service trainings, both through in-person and online formats.

TAKEAWAY

Many correctional staff need more information about the availability of services for people with SUD in their jails and in the community, SUD in general, and the benefits of MAT. Providing this information can facilitate implementation of these services.

Figure 7A: Receipt of training among jail staff

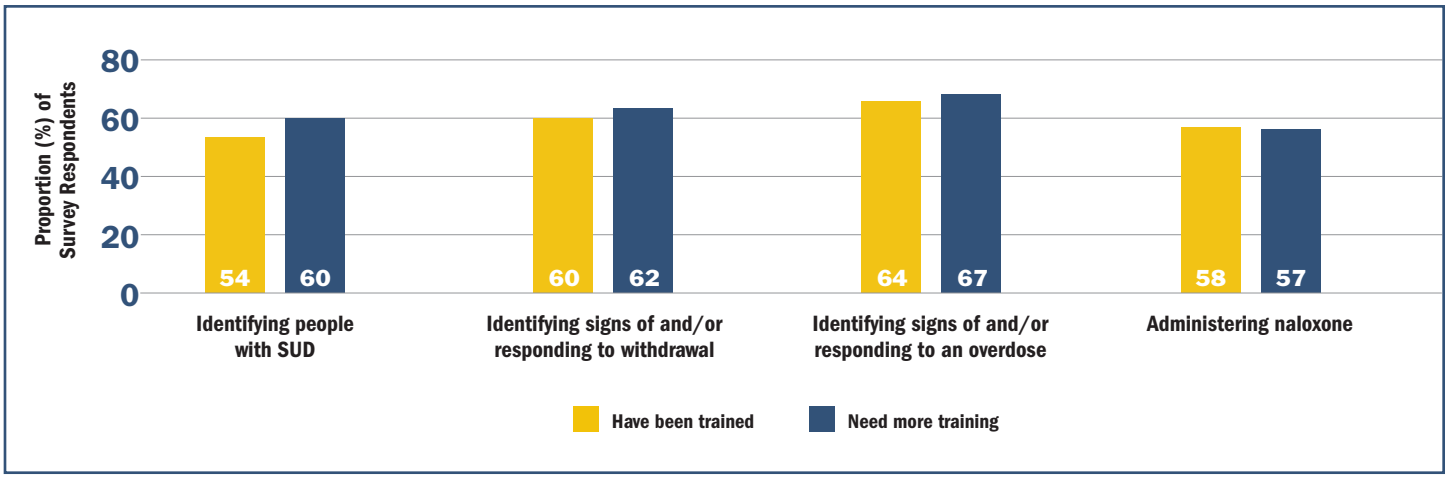
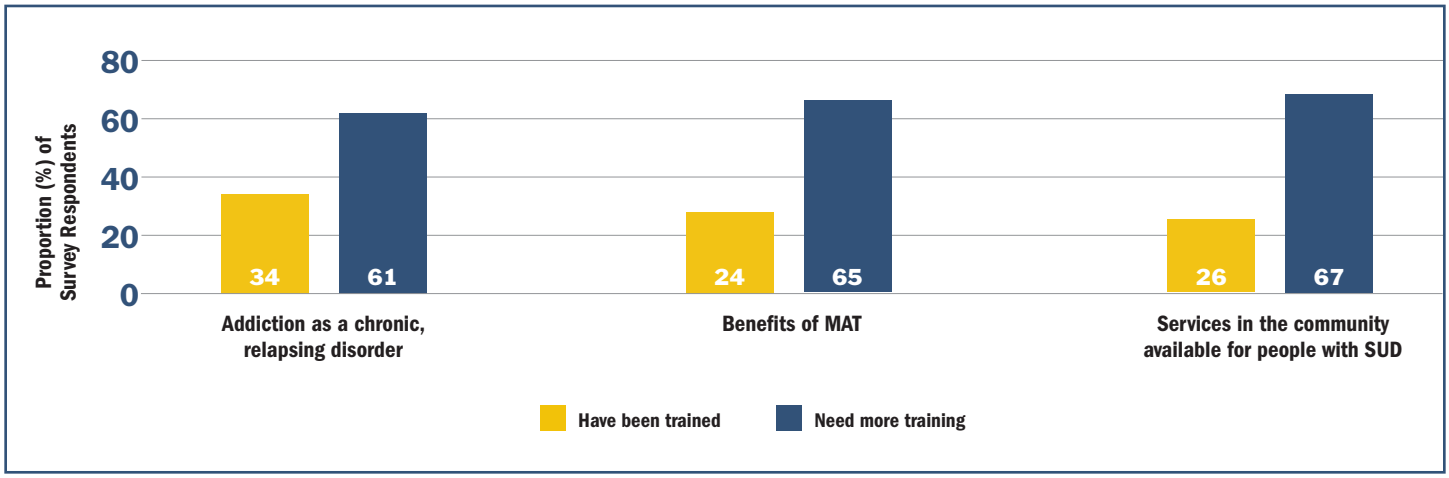


Figure 7B: Receipt of training among jail staff



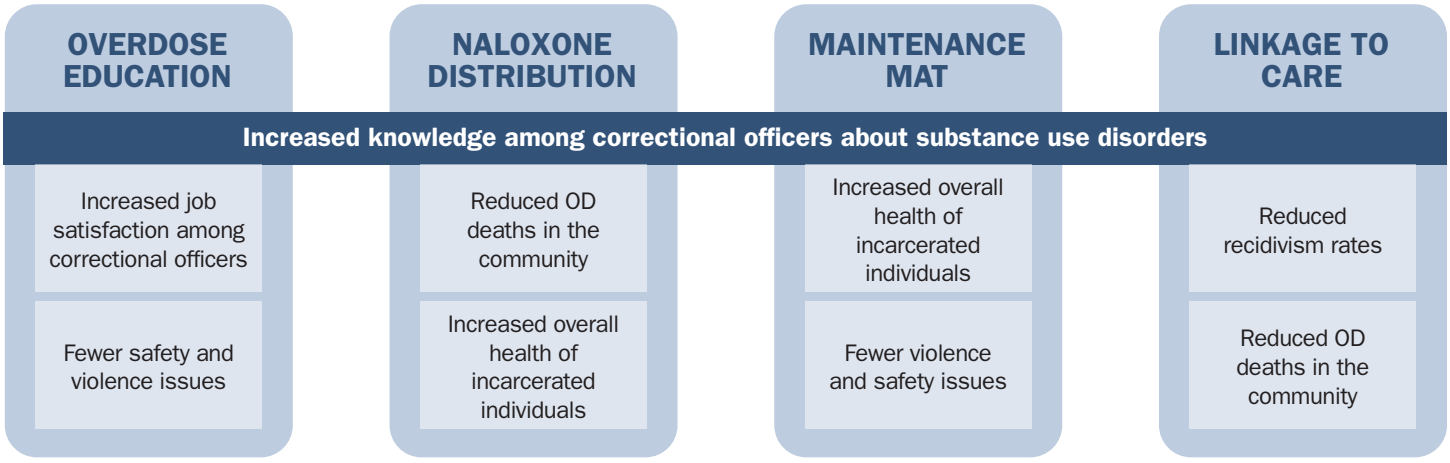
For training on 1) addiction as a chronic, relapsing disorder, 2) the benefits of MAT, and 3) services in the community available for people with SUD, the following discrepancies were noted (Figure 7B):

- A minority (24-34%) of all staff reported receiving training in these areas.
- Compared to medical/social and clerical staff, all other staff types (intake, rotating, housing, security/transportation) were less likely to have received training in these areas.
    - One maintenance jail interviewee stressed the importance of training security staff on the benefits of MAT, including reduction of mortality risk post-release, because it can minimize any resistance that they may have toward this service.
- A significantly higher proportion of staff in maintenance jails have received training on the benefits of MAT, compared to staff in non-maintenance jails (35% vs. 20%).
- Fewer staff received training in non-maintenance jails, compared to maintenance jails.
- Staff who have not received training had higher levels of stigma toward addiction.
- Most survey respondents in both maintenance and non-maintenance jails (61-67%) indicated a need for more training on these topics.

Benefits of Service Implementation from the Perspectives of Correctional Staff

Survey respondents and interviewees with experience providing OD prevention services identified many benefits, both directly observed and anticipated, of service provision. We list them in Figure 8 because they can inform staff training activities. Educating staff about these benefits can help garner support for services, dispel myths, and improve staff morale. Any jail contemplating the initiation or expansion of OD prevention services may also find this information helpful.

Figure 8: Benefits of Service Implementation from the Perspectives of Correctional Staff



> "We started in 2018 with the MAT and it's helping people to stay engaged in their recovery for longer periods of time. They're succeeding. They're working. They're being part of their family. The benefits are exponential. I can't even really begin to try to quantify the benefits of it."
>
> ***—Maintenance jail interviewee***

A few maintenance jails provided concrete indicators of program success:

- An 80-90% decrease in the number of violence-type codes following implementation of maintenance MAT
- A 60% reduction in recidivism among individuals who completed the MAT program, which includes screening for OUD, maintenance MAT, and discharge planning
- No reported re-incarcerations among individuals who were engaged in the MAT program
- Successful linkage to their first treatment appointment post-release among 91% of individuals who participated in discharge planning

Almost one-third (32%) of survey respondents cited the influx of individuals with SUD as a driver of low staff morale. Strategies to improve morale are critically important to retain staff and reduce compassion fatigue and turnover. Jail interviewees linked the effects of MAT implementation, including a calmer and quieter jail environment, improved inmate health and stability upon release, and less contraband coming into jails, to improved morale for jail staff.

TAKEAWAY

Jail staff cited a range of positive outcomes of implementing OD prevention services in jails. This can be used to advocate for implementation and expansion of these services.

SECTION

VI

Lessons Learned

Based on the information collected, we identified five lessons learned to guide jail leadership in the implementation of OD prevention services.

1 Concerns about cost and diversion are manageable.

Concerns that maintenance MAT is too costly or too much of a security risk, two of the most widely recognized barriers to initiating or expanding this and other OD prevention services, are not well founded. Jails demonstrate numerous ways to effectively address both cost and diversion in their facilities, such as planning based on the burden within the jail, starting small, and housing individuals on MAT separately.

2 Non-maintenance jails may be more open to and interested in providing MAT than before.

The non-maintenance jails in this project showed an unexpected readiness and openness to offering maintenance MAT and other OD prevention services. This suggests a paradigm shift in how jails have conventionally managed drug use and OD among individuals in custody. It also suggests a need for more opportunities for jails to exchange information on how to provide services most effectively.

3 Support from security staff is essential.

Security staff must support programs for them to function well. Jails have found ways to build their support. For example, they have:

- Allowed their involvement to be optional yet remunerated for the extra time, energy, and expertise it requires.
- Started slowly so that staff are not overwhelmed and that implementation challenges can be addressed on a small scale.
- Raised awareness about the benefits of services, both real and anticipated, to boost staff morale and generate buy-in.

4 Availability of services in the community is key.

Many jail personnel feel strongly that individuals with SUD or at immediate risk of OD are better served in the community than in jail. Their observations call for a coordinated effort by all involved parties (jails, law enforcement, courts, and community programs) to promote and facilitate alternatives to incarceration, such as pre-arrest diversion to a treatment program, crisis center, or hospital.

5 Collaboration with community partners is essential.

For individuals who are still incarcerated rather than diverted to treatment, jails must work closely with community providers to ensure continuity of care upon release. This requires initiating discharge planning as soon as possible and encouraging community providers to establish relationships with individuals before release. Individuals are more likely to follow through with treatment when a personal connection has been made.

Appendix 1: ORS Teams Participating in Cornerstone Project

State	Drug Intelligence Officer (DIO)	Public Health Analyst (PHA)
Connecticut	Robert Lawlor	Sarah Ali
Delaware	Glenn Condon	
Georgia	Armando Roche	Stephanie Gitukui
Illinois	Vic Markowski	Oscar Garduno
Indiana	Robert Glynn	Meredith Canada
Kentucky	Al Katcher	Yolanda Sowards
Maryland	Kevin Welkner	Lauren Whiteman
Massachusetts	James Cormier	Margaret Hester
Michigan	Bob Kerr	Amanda Ballesteros
New Hampshire	Ken Bradley	Nick Adams
New Jersey	Donald Ciaccio	Nava Bastola
New York	Bill Murphy	Nicole D'Anna
North Carolina	Aaron Higginbotham	Sherani Jagroep
Ohio	Shawn Bain	Orman Hall
Pennsylvania	Van Jackson	Tamar Wallace
Rhode Island	Bryan Volpe	Thomas Chadronet
South Carolina	John Saager	
Tennessee	Greg Roberts	Yolanda Sowards
Vermont	James Downes	Stephanie Thompson
Virginia	Kevin Butts	Julia Mandeville

SECTION

VII

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