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Supporting Incarcerated People's Recovery: Linkage to Care Policies for People Entering and Exiting Incarceration with Substance Use Disorder

2024

Introduction

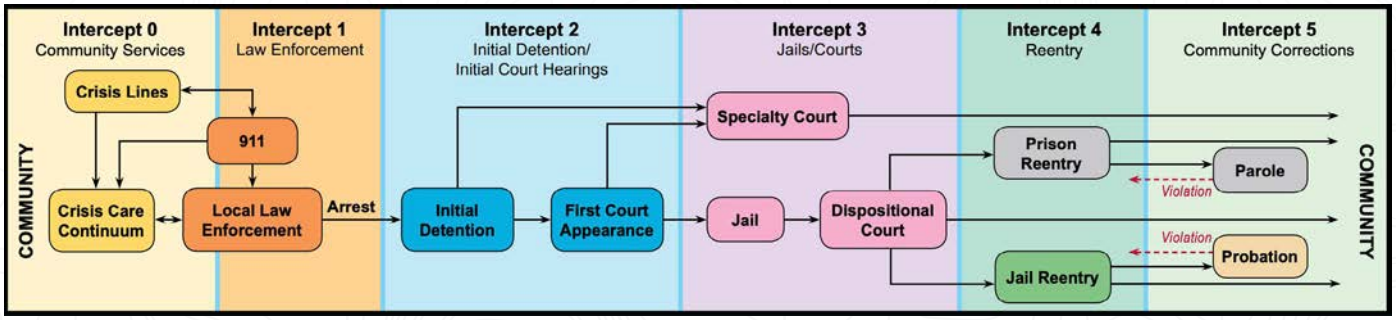
The drug overdose epidemic continues to be a prominent public health crisis with recent data indicating that nearly 108,000 individuals died of a drug overdose in 2022. As disparities grow, ongoing support of interventions to reduce overdose-related morbidity and mortality is necessary. It is particularly important to focus on populations that have been disproportionately impacted, such as people who use drugs who have been involved with the criminal justice system. Individuals with substance use disorder (SUD) released from incarceration are at an extremely high risk of experiencing overdose, specifically within the first days and weeks following release, with drug overdose being the leading cause of death following release from incarceration.

Individuals with SUD are more likely to be involved in the criminal justice system and experience higher rates of incarceration. An assessment of the 2015 – 2016 National Survey on Drug Use and Health found that people with prescription opioid use disorder (OUD) are 52% more likely to be involved in the criminal justice system, rising to 77% for people who use heroin, whereas people who have not used opioids within the past year were 16% more likely to be involved in the criminal justice system. It is estimated that one in five prisoners are currently incarcerated due to drug-related offenses, and the rate of recidivism is also high among this population—an estimated 68% of individuals with SUD involved in the criminal justice system are rearrested within three years of release.

Individuals with OUD who face incarceration also experience disproportionately high rates of death. Overdose is the third leading cause of death in U.S. jails and was the fastest growing cause of death in prisons and jails between 2001 – 2019. The risk of overdose death does not cease upon release, with one state finding that incarcerated individuals were up to 40 times more likely to die from an overdose within two weeks of release due to lower levels of tolerance following withdrawal during incarceration and a lack of supports both within the criminal justice system and upon release, including naloxone and linkage to care.

There are several intervention that can prevent overdose among justice-involved people, described in the sequential intercept model (SIM). The model outlines six interception points for someone involved in the criminal justice system ranging from non-law enforcement crisis support lines (Intercept 0) to law enforcement engagement, trial, incarceration, and community corrections like parole (Intercept 5). Developed to inform community-based responses for justice-involved people with SUD, SIM includes several best practices across the model to support culturally relevant and equitable approaches for overdose prevention. The National Council for Mental Wellbeing created core competencies for professionals and organizations to support intercepts across the SIM.

Figure 1. The Sequential Intercept Model



To help people with OUD access treatment rather than become incarcerated, many jurisdictions have set up deflection or diversion programs that connect people to community-based treatment and support. Occurring between Intercepts 0 and 1, these programs aim to remove the collateral consequences of involvement in the criminal justice system. Additionally, states have taken measures to screen, treat, and connect incarcerated people across Intercepts 2 through 5 to reduce the risk of recidivism and premature death among justice-involved people who use drugs. Evidence-based policies, including screening individuals for SUD upon entry and connecting people with SUD to care prior to release, have been implemented in a variety of ways nationwide ranging from facility or district policy to state law.
In summary, jurisdictions looking to reduce the risk of recidivism, overdose, and premature death among justice-involved people with SUD can consider policies that improve linkage to care across all stages of the criminal justice system, including entry and release, such as:

- Screening for SUD and mental illness upon entry.
- Referring individuals who screen positive to treatment, including medication for opioid use disorder (MOUD) or medication-assisted treatment (MAT).
- Linking individuals to options for their continued care following their release.
- Providing individuals with naloxone both while they are in the facility and prior to their release.

Methodology

ASTHO, with support from CDC's Overdose Data to Action cooperative agreement, explored linkage to care for incarcerated people with SUD with assistance from Temple University's Center for Public Health Law Research (CPHLR). A CPHLR legal research team searched for state statutes and rules that established:

- Whether jurisdictional law requires all incarcerated individuals in correctional facilities to be screened for SUD.
- Whether jurisdictional law facilitates linkages to care for individuals diagnosed with SUD upon release.
- Whether jurisdictional law facilitates naloxone access in correctional facilities.
- Whether jurisdictional law facilitates direct access to naloxone upon release from the correctional facility.

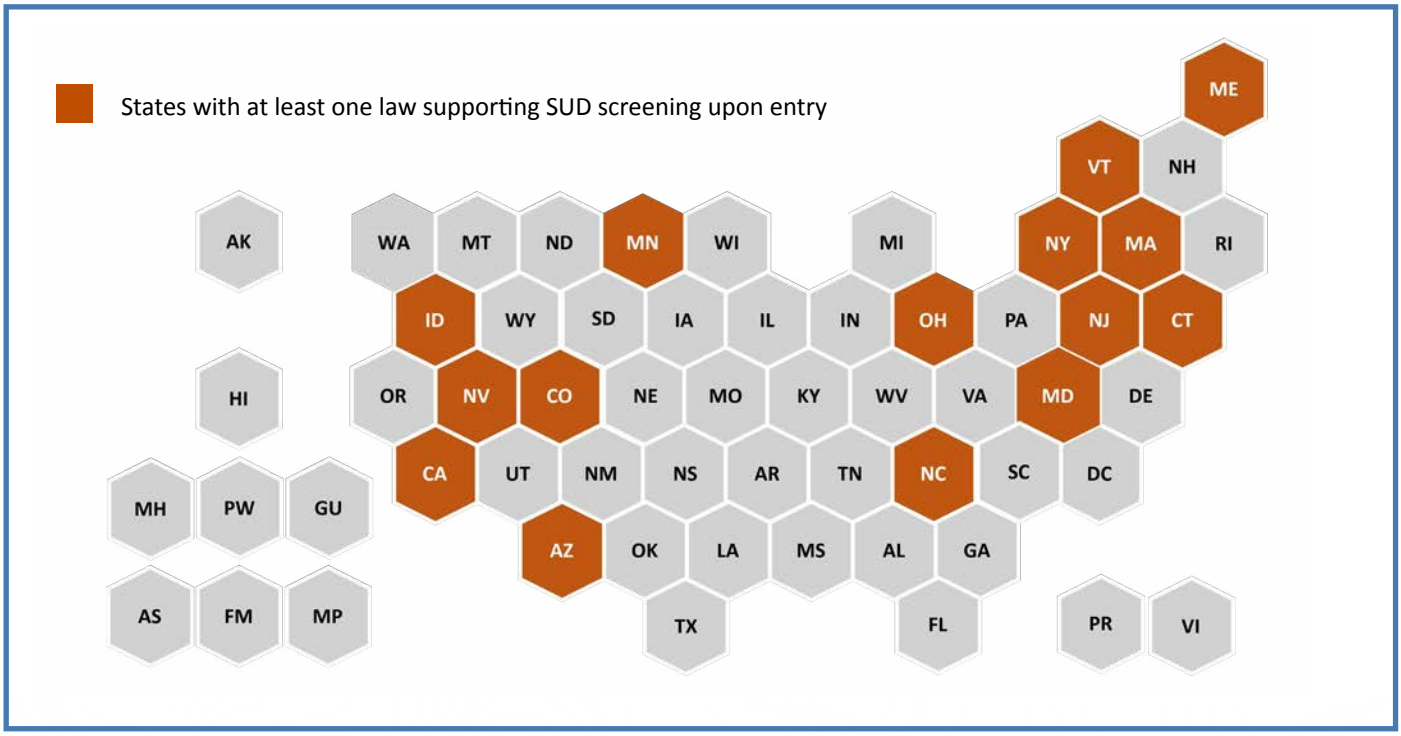
The team conducted thorough research and independently recorded the relevant citations from every jurisdiction, including statutes and regulations. Once the researchers identified all relevant laws, they created a master sheet for each jurisdiction, which included the legislative history and the effective date for every version of jurisdictional law recorded. The supervisor reviewed the original master sheet and individual master sheets for each jurisdiction, and the team resolved each divergence prior to collecting the relevant laws.

Using CPHLR's master sheets, ASTHO staff assessed and coded the included laws to determine if they required SUD screening upon entry, post-incarceration linkage to care, or supporting incarcerated individuals accessing naloxone during or upon leaving incarceration.

Screening Upon Entering Incarceration

It is industry best practice for corrections facilities to perform medical screenings for inmates arriving to their intake facilities. For prison systems, a medical screening upon entry can identify physical and mental health issues, ensuring continuity of care for existing medical treatments and identifying any additional medical needs an incarcerated person may have. This often includes screening for SUD so that staff can anticipate and respond to behavioral and medical issues, including potentially life-threatening ones like withdrawal. By identifying which incarcerated person may need medical management for SUD, jail or prison staff can take the necessary steps to make withdrawal safer for an incarcerated person (potentially preventing death and mitigating pain and discomfort). Further, this assessment can lay the groundwork for continued SUD treatment during incarceration, including MAT or MOUD.

Figure 2.



In addition to being an industry best practice, at least 16 states have laws requiring prison systems to screen incarcerated individuals for SUD upon entry. Of those, only 11 states specified a timeframe in which an incarcerated person must receive an SUD screening in statute, ranging from immediately at reception to a facility (e.g., California) to within 30 days (e.g., New Mexico).

Whether laws require SUD screening upon entry or not, health departments should support timely and adequate SUD screening to identify people with SUD and connect them with appropriate care. Specifically, public health leaders can work with corrections to ensure that staff at carceral facilities are trained to screen for SUD and recognize symptoms of withdrawal or SUD. Additionally, health departments can help jails, prisons, and other carceral settings develop strategies for connecting people with SUD to care—including MOUD or MAT—while in custody.

New Jersey

In 2015, New Jersey enacted S 2380, which required the Department of Human Services (NJDHS) and the Department of Corrections (NJDOC) to formulate a plan for adequate and appropriate SUD services for incarcerated individuals in all state-owned, operated, or contracted correctional facilities. The law (N.J. Stat. § 30:4-82.2) required the plan to include procedures for identifying a person with an SUD on initial admission to a correctional facility and providing MOUD as appropriate and available.

In 2017, NJDOC and NJDHS reopened the Mid-State Correctional Facility (which previously closed in 2014) as an addiction treatment center for incarcerated people. Under the New Jersey program, when a person enters the NJDOC system, they are screened for SUD needs as required by law (N.J.A.C. 10A:24-2.2). Those who are screened and deemed to have a medium to present SUD are then eligible to take part in SUD-related care at specific corrections facilities. In these programs, all three FDA-approved MOUD—buprenorphine, naltrexone, and methadone—are available.

Linkage to Care Post-Release

Connecting a person with SUD to treatment as they prepare to leave incarceration can lower the risk of overdose as they re-enter the community. The most common types of linkage and transition services that jail substance use treatment programs provide are assessment of aftercare needs, discharge planning, placement planning, and coordination with community treatment agencies. Effective coordination of linkage to care post-release is necessary to facilitate improved outcomes in those with SUD leaving jails and prisons.

Figure 3

At least 12 states have laws requiring that an incarcerated person with SUD, particularly those receiving MOUD or MAT, receive care coordination and connection to services in the community after their release. Among the states identified, at least six—California, Colorado, Maine, Massachusetts, Nevada, and New Mexico—require specific supports for these individuals, like establishing appointments for the person with a community-based organization and/or assisting them in enrolling in Medicaid. This can create a warm handoff or meaningful connection for a recently released individual and lead to improved outcomes including fewer missed primary care visits, increased behavioral health interactions, and a reduction in overdose-related harm.

In addition to statutory or regulatory requirements to assist care coordination, several states use flexibilities within Medicaid to support continued MOUD care from incarceration to release. Recent CMS guidance outlines how jurisdictions can provide coverage for soon-to-be formerly incarcerated people who are also eligible for Medicaid. As of April 16, 2024, California, Montana, and Washington have approved 1115 waivers to provide pre-release services to certain Medicaid eligible individuals who are incarcerated. Policies like this enhance access to MOUD or MAT, which can be a harm reduction practice and reduce the risk of overdose by providing treatment at a particularly high-risk transition period.

Many jurisdictions have policies connecting people with SUD to treatment as they leave incarceration, even if there is not a state law requiring a facility to do so. For example, Franklin County, OH started the Rapid Resource Center in 2021, where those leaving incarceration can be linked to a variety of services and treatment. With hours that span morning, afternoon, and evening, released individuals can meet in person with staff members at their time of release to learn about their options, including linkage to MOUD. Further, released individuals can contact the center after the initial consultation to learn more about their options and opportunities.

Franklin County, Ohio

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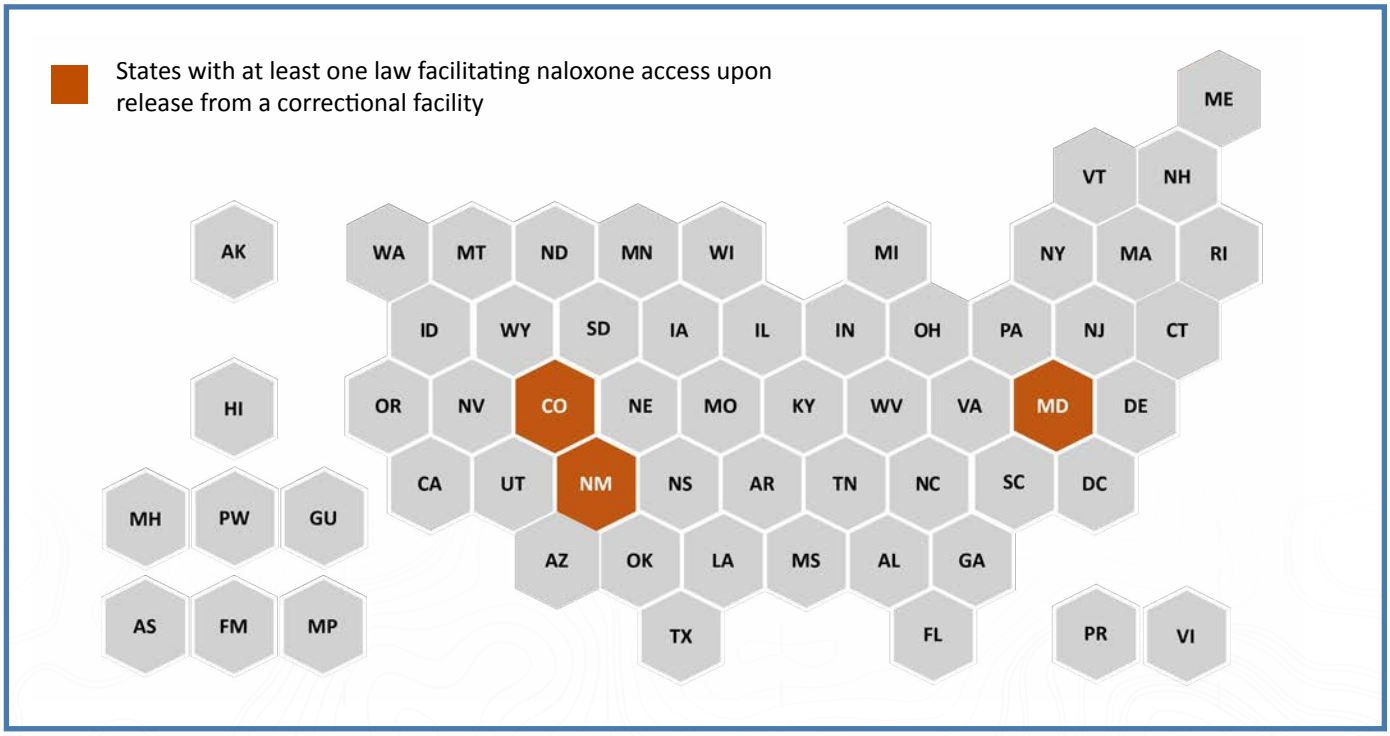
Making Opioid Antagonists Accessible in Correctional Facilities and Upon Release

Opioid antagonist drugs like naloxone reverse opioid overdose and prevent death, and making them available to those who may overdose or encounter a person experiencing an overdose is an evidence-based intervention to reduce opioid overdose deaths. Although nearly every state has laws facilitating the distribution and use of opioid antagonists like naloxone, very few jurisdictions have policies providing access to people in correctional facilities or upon release. The National Commission on Correctional Healthcare recently reaffirmed its position that naloxone kits should be readily available to all people in a correctional facility—including people who are incarcerated—noting that drug overdose is the third leading cause of death in jail.

Departments of Correction across the country have developed programs monitoring the effectiveness of providing opioid antagonists to incarcerated individuals and those who are being released. For example, the New York Department of Health and Department of Corrections and Community Supervision partnered with the Harm Reduction Coalition in 2015 to launch an Overdose Education and Naloxone Distribution Program at the Queensboro Correctional Facility. Participants received a naloxone kit upon release to keep as their personal property, with over 6,000 distributed, and 14 overdose reversals were attributed to the program, which resulted in its expansion to all New York State prisons in 2017.

Anecdotally, the availability of naloxone in a local California jail saved the lives of two incarcerated individuals after staff within the facility administered naloxone to individuals suffering from suspected overdoses. Lastly, at least one local jail provided naloxone and a prescription to refill it upon a person's release between 2013 and 2017. During that time, 637 people participated in the program, 67% of whom received naloxone upon release. Among those who received naloxone, 32% reported reversing an overdose and 44% of people refilled their prescription from community-based programs following re-entry, indicating broader use in the community.

Figure 4



At least three states have laws requiring that a person with SUD be provided with an opioid antagonist upon release and no states were identified with laws requiring access to opioid antagonists during incarceration. Typically, these laws require a person who received MOUD or MAT while incarcerated to receive an opioid antagonist when released from custody or transferred into community-supervised release.

North Carolina

Although few states have laws requiring the distribution of naloxone in or on release from a correctional facility, many jails have established programs to do so. One creative solution has been the incorporation of harm reduction vending machines—holding opioid antagonists and other harm reduction supplies—in public areas of the facility, accessible to people leaving incarceration, family members, and friends. Multiple North Carolina counties installed naloxone vending machines in the lobbies of jail facilities. As these are in a jail setting, there is daily access to a population who is at high risk of overdose, and the public that surrounds them.

Conclusion

People with SUD are incarcerated more often than people without SUD, with overdose remaining a leading cause of death among incarcerated people and among persons reentering the community shortly after release from incarceration. As public health leaders continue working to reduce overdose nationwide, building stronger partnerships with correctional facilities can effectively reduce overdose and support continuity of treatment from incarceration to the community setting upon release. These measures not only reduce overdose-related harm, but they also create positive additional health outcomes for those individuals, such as improved access to and adherence to treatment. A multi-layered approach with stakeholder coordination, including state and local health departments and corrections departments, is necessary to ensure supports are effective.

Appendix

Table 1: CPHLR's thoroughly researched laws for screening on entry, as coded by ASTHO.

State	Citation	Brief Description
Arizona	Ariz. Rev. Stat. § 11-392	Authorizes counties to establish a coordinated reentry planning services program, including screening for SUD for people booked in county jail, and connect an arrestee to services post-incarceration.
California	Cal. Penal Code § 2694.5.	Establishes pilot program to provide MAT for SUD throughout the period of incarceration and up to and including immediately prior to release in one or more institutions. Programs are to consider comprehensive pretreatment and posttreatment assessments and linkages to community-based treatment upon parole. Department of Corrections provides yearly reports on the planned capacity of the program, number of enrollees, and percentage of participants with negative toxicology screens while incarcerated and number of those successfully linked to post release treatment.
	Cal. Code Regs. Tit. 15, § 3375.6.	Requires the use of an automated needs assessment tool to assess criminogenic needs (including SUD) at the reception center process for all incarcerated people, administered at initial or annual review process for all people who have not completed the auto assessment tool.
Colorado	C.R.S. 16-11.5-102	Creates a standard procedure for substance abuse assessment to be used to link people to care when placed on parole or in community corrections.
	C.R.S. 18-1.3-209	Requires substance abuse assessment for all people convicted of a felony, misdemeanor, or petty offense.
	Colo. Rev. Stat. § 17-1-113.4.	Requires correctional facilities (including private contract prisons) to make opioid antagonists available to people in custody with SUD and upon release as funds allow.
	Colo. Rev. Stat. § 27-60-106.	Provides a grant funding to county jails—prioritizing rural and frontier jails—requiring that the jail conduct behavioral health and SUD screening, and coordinate services on release.
Connecticut	Conn. Gen. Stat. § 18-81pp.	Requires incarcerated people s to receive an initial health assessment within 14 days of intake, and trained providers to oversee any withdrawal symptoms and offer counseling. At time of discharge, the incarcerated person may be referred to community treatment programs.
Idaho	Idaho Code § 19-2524.	Requires a person guilty of a felony to be screened for SUD within seven days of guilty plea or finding as part of presentencing process.
Maine	Me. Rev. Stat. tit. 34-A, § 1208-B.	Requires all jails to screen on intake, provide treatment including MAT, counseling and peer support services while incarcerated, and transitional support for reentry.
	Me. Rev. Stat. tit. 34-A, § 3052.	Requires comprehensive SUD treatment programs, including medically managed withdrawal, MAT, individual and group counseling, and screening and assessment at intake.
Maryland	Md. Code, Correctional Services § 9-603.	Requires all local correctional facilities to conduct assessments for SUD to determine if an incarcerated person has an OUD and if MAT is appropriate treatment.

Table 1 (Continued): CPHLR's thoroughly researched laws for screening on entry, as coded by ASTHO.

State	Citation	Brief Description
Massachusetts	Mass. Gen. Laws ch. 127, § 16.	Requires examination for SUD for all people imprisoned 30 days or more.
	105 Mass. Code Regs 205.101:	Requires all incarcerated people committed for 30 days or more to have a physical exam at least two weeks following admission.
	105 Mass. Code Regs 205.200	Required assessment using a recommended tool to screen for SUD screening in physical exam.
Minnesota	Mo. Rev. Stat. § 191.1165.	Requires all correctional facilities to screen people for SUD and make MAT available to those incarcerated and in drug courts or other diversion programs.
Nevada	Nev. Rev. Stat. § 209.4237.	Requires the director of correctional institutions to develop a program to evaluate incarcerated people for SUD.
New Jersey	N.J. Stat. § 30:4-82.2.	Requires commissioners of Human Services and Corrections to develop a plan to identify and provide care to people with SUD in state-owned, operated, or contracted facilities such as individual or group counseling, MAT, and increased monitoring to prevent harm to self or others. Includes evaluation on admission. Also includes identifying providers to help a person reintegrate into the community.
	N.J. Admin. Code § 10A:24-2.2.	Rules outlining clinical screenings for substance use disorders that occur on intake or at any time deemed necessary in a facility.
New Mexico	N.M. Stat. § 33-1-22.	Requires correctional facilities to screen for SUD within 30 days of incarceration, enroll qualifying incarcerated people in Medicaid, and link qualified incarcerated people to care coordination with a MCO on release.
New York	N.Y. Mental Hygiene Law § 19.18-c.	Requires medical screening to determine if a person had SUD needing MAT, and includes care coordination and planning.
	9 NYCRR § 7011.5	Requires medical screening within 72 hours of referral.
North Carolina	10a N.C. Admin. Code 14J.1002	Requires SUD screening of each incarcerated person on admission.
Ohio	Ohio Admin. Code 5120-17-02	Requires all incarcerated people to be screened for SUD and transfer a community-based treatment program.
Vermont	Vt. Stat. tit. 28, § 801	Requires incarcerated people to be screened for SUD within 24 hours of admission.

Table 2: CPHLR's thoroughly researched laws for linkages to care on entry, as coded by ASTHO.

State	Citation	Brief Description
Arizona	Ariz. Rev. Stat. § 11-392	Authorizes counties to establish a coordinated reentry planning services program, including screening for SUD for people booked in county jail, and connect an arrestee to services post-incarceration.
California	Cal. Penal Code § 2694.5.	Establishes pilot program to provide MAT for SUD in one or more institutions. Programs are to consider comprehensive pretreatment and posttreatment assessments and linkages to community-based treatment upon parole. Department of Corrections provides yearly reports on the planned capacity of the program, number of enrollees, and percentage of participants with negative toxicology screens while incarcerated and number of those successfully linked to post release treatment.
	Cal. Penal Code § 6047.1.	Creates a MAT grant program to support county programs, including funding to increase capacity of community-based treatment and improve care coordination and connections post-incarceration.
Colorado	C.R.S. 16-11.5-102	Creates a standard procedure for substance abuse assessment to be used to link people to care when placed on parole or in community corrections.
	C.R.S. 17-26-140	Requires all persons who were treated for SUD while incarcerated to be provided a continuity of care on release, including providing a list of SUD providers and at least 8mg of an opiate antagonist. Also requires the jail to provide Medicaid enrollment or re-enrollment information.
	C.R.S. 17-1-113.2	Requires all people released from custody to comply with the linkage to care requirements in 17-26-140.
	Colo. Rev. Stat. § 17-1-114.5	Requires linkage to care for persons with capacity for pregnancy diagnosed with SUD.
	Colo. Rev. Stat. § 27-60-106.	Provides a grant funding to county jails—prioritizing rural and frontier jails—requiring that the jail conduct behavioral health and SUD screening, and coordinate services on release.
Connecticut	Conn. Gen. Stat. § 18-81mm	Requires corrections commissioner to provide an incarcerated person with OUD information about treatment options and how to access them, no later than 45 days before scheduled release (including parole and supervised community settings).
	Conn. Gen. Stat. § 18-81pp.	Requires incarcerated people to receive an initial health assessment within 14 days of intake, and trained providers to oversee any withdrawal symptoms and offer counseling. At time of discharge, incarcerated people may be referred to community treatment programs.
Maine	Me. Rev. Stat. tit. 25, § 5101.	Establishes SUD Assistance program, providing grants for municipal and county governments or regional jails to refer 'low-level' offenders to community-based treatment and support services.
	Me. Rev. Stat. tit. 34-A, § 1208-B	Requires all jails to screen on intake, provide treatment while incarcerated, and transitional support for reentry.

Table 2 (Continued): CPHLR's thoroughly researched laws for linkages to care on entry, as coded by ASTHO.

State	Citation	Brief Description
Massachusetts	Mass. Gen. Laws ch. 127, § 17C.	Requires a person with OUD linkage to care, including MAT in final 90 days of incarceration, reestablishing Medicaid, as part of the re-entry plan.
Nevada	Nev. Rev. Stat. § 211.140.	Requires sheriffs/local marshals to arrange coordination of care with human service providers for when a person is released. On release, HHS arranges care and the jail is released from responsibility.
New Jersey	N.J. Stat. § 30:4-82.2.	Requires commissioners of HHS and Corrections to develop a plan to identify and provide care to people with SUD in state-owned, operated, or contracted facilities. Includes evaluation on admission. Also includes identifying providers to help with an individual's reintegration into the community.
New Mexico	N.M. Stat. § 33-1-22.	Requires correctional facilities to screen for SUD within 30 days of incarceration, enroll qualifying incarcerated people in Medicaid, and link qualified incarcerated people to care coordination with a MCO on release.
New York	N.Y. Correction Law § 626.	Requires linking a prisoner from the MAT program to care on release, including information on available treatment and supporting Medicaid enrollment.
	9 NYCRR § 7011.5	Requires program to include conditions for reentry strategy for incarcerated people participating in MAT, including housing and Medicaid supports.
Vermont	Vt. Stat. tit. 28, § 801b.	Requires the department to ensure comprehensive care coordination on release for people with OUD on MAT.
Washington	Wash. Rev. Code § 71.24.599	City and county jails must provide MAT to incarcerated people no less than thirty days before release and make reasonable efforts to connect incarcerated peoplereceiving MAT with post-release providers in the geographic region. Must document if not possible.

Table 3: CPHLR's thoroughly researched laws for availability of opioid antagonists, as coded by ASTHO.

State	Citation	Brief Description
Colorado	C.R.S. 17-26-140	Requires all persons who were treated for SUD while incarcerated to be provided a continuity of care on release, including providing a list of SUD providers and at least 8mg of an opiate antagonist.
Maryland	Md. Code, Correctional Services § 9-603. Opioid use disorder screening, evaluation, and treatment.	Requires all local correctional facilities to conduct assessments for SUD to determine if they have OUD. Requires local facilities to make opioid antagonists available.
	Md. Code, Health § 8-408. Protocol to offer opioid overdose reversal drugs.	Requires correctional facilities to have a protocol in place to offer an opioid antagonists at time of release and on parole, free of charge.
New Mexico	N.M. Stat. § 33-2-51.	Requires providing incarcerated people with OUD with two doses of an opioid antagonist and a prescription for naloxone on release as department funding allows.