

OVERDOSE PREVENTION IN COMMUNITY CORRECTIONS

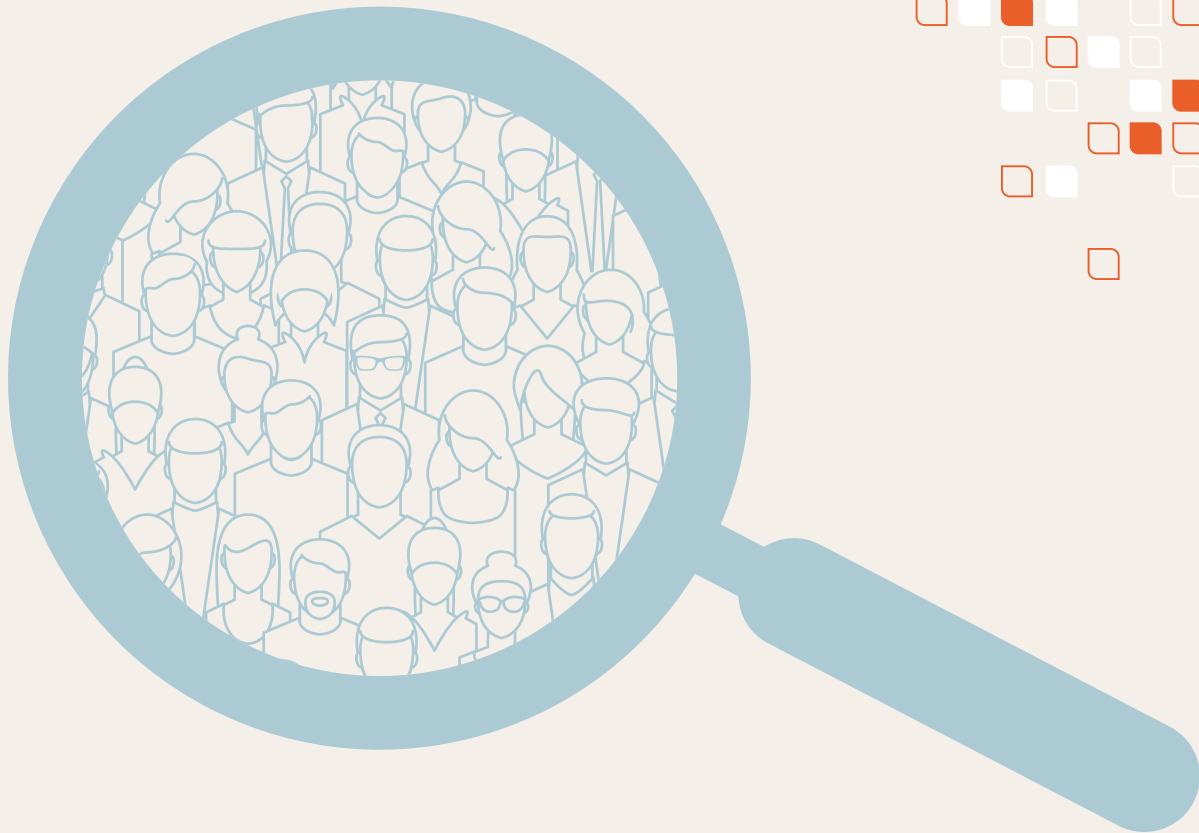
An Environmental Scan



NATIONAL
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for Mental
Wellbeing

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Acronyms

CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CJ-DATS	Criminal Justice Drug Abuse Treatment Studies
EBP	evidence-based practices
HHS	U.S. Department of Health and Human Services
MAT	medications for addiction treatment
MOUD	medications for opioid use disorder
NIDA	National Institute on Drug Abuse
OEND	overdose education and naloxone distribution
ODU	opioid use disorder
PWUD	people who use drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	substance use disorder

Executive Summary



Post-release opioid-related overdose mortality continues to be the leading cause of death among people released from correctional institutions, due to disruption of social networks, interruption in substance use treatment, and a return to solitary opioid use (Joudrey et al., 2019). People who were released from prison were 129 times more likely than the general population to die of a drug overdose within the two weeks following their release (Binswanger et al., 2007). People who are under community supervision after release from or as an alternative to incarceration often have a substance use disorder or are at an elevated risk of overdose (Binswanger et al., 2020). Therefore, community corrections has the potential to be a high-impact site for overdose prevention. However, many barriers hinder the successful implementation of evidence-based overdose prevention strategies in community corrections, such as stigma and a lack of access to treatment organizations.

To identify the extent to which overdose prevention and response efforts are implemented in community corrections, the National Council for Mental Wellbeing, with support from the Centers for Disease Control and Prevention, conducted an environmental scan consisting of a literature review, 19 key informant interviews, and a roundtable discussion with a diverse group of individuals with experience in community corrections, overdose prevention, or harm reduction.

This environmental scan found evidence for some cultural shifts in community corrections agencies towards incorporating recovery-oriented practices in supervision. Community corrections officers have a distinct and important role in preventing overdose, but to fulfill their role they need additional training in key topic areas such as substance use, medications for opioid use disorder, and overdose prevention strategies (including proper use of naloxone). Whereas evidence-based practices in overdose prevention can reduce the risk of overdose, barriers still exist in community corrections that impede their implementation. Collaborating with mental health and substance use treatment organizations or social service agencies can help to overcome some of those barriers.



Introduction

Many people under community supervision have a substance use disorder (SUD) or are at elevated risk of overdose. Because health services are only rarely provided by community corrections agencies directly and instead are made via referral to community providers (Welsh et al., 2016), functional health services for people under supervision typically require coordination with multiple agencies and treatment organizations. Recovery-oriented approaches to overdose prevention and response in community corrections facilitate access to evidence-based interventions and take a rehabilitative, rather than strictly punitive, approach to drug use.

To better understand the current landscape of overdose prevention and response in community corrections settings, and to inform the development of technical assistance tools that can enhance these efforts, the National Council for Mental Wellbeing (National Council), with the support of the Centers for Disease Control and Prevention (CDC), conducted an environmental scan that included a literature review and a series of key informant interviews and roundtables. The key findings from these activities are:

1. Community supervision is changing, providing opportunities for incorporating recovery-oriented approaches.

2. Community corrections officers have a distinct role in preventing overdose.

3. Community corrections officers require training to fulfill their role.

4. Evidence-based interventions for individuals under supervision can reduce overdose mortality.

5. Significant barriers impede the implementation of evidence-based overdose prevention in community corrections.

6. Changes to community correction policy and practice are needed to support recovery-oriented approaches.

7. Innovative overdose prevention interventions are happening in community corrections.

8. Closer collaborations are needed between community corrections and health and social services providers.

Why focus on community corrections as a site for overdose prevention initiatives?

There are four key reasons for focusing on overdose prevention and response in community corrections.

1. INCREASING NUMBER OF INDIVIDUALS UNDER SUPERVISION MEANS MORE INDIVIDUALS AT ELEVATED RISK OF OVERDOSE

In 2018, 1 in 58 adults in the U.S. was under some form of community supervision. That figure represents 4.5 million people, twice the incarcerated population (Horowitz & Utada, 2018; Kaeble, 2020). The number of people under community supervision has increased alongside the prison and jail population, suggesting that community supervision is an addition rather than an alternative to incarceration (Columbia University Justice Lab, 2018) and that the number of people at risk of overdose is increasing.

Defining Community Corrections and Community Supervision

Community corrections programs encompass non-prison sanctions, which can include forms of community supervision such as probation and parole (Pew Public Safety Performance Project, 2007). Community corrections and community supervision are terms which are often used interchangeably. Community supervision includes a range of supervisory modalities, from requiring stays in residential facilities to independent living situations requiring regular reporting to community corrections officers. Probation agencies typically supervise people sentenced directly to community supervision, generally as an alternative to incarceration, or people whose sentences involve a period of short-term incarceration followed by community supervision. While functionally similar to probation, parole refers to conditional supervised release from federal or state prison (Kaeble, 2020), including before the completion of their sentence (Brinkley-Rubinstein et al., 2018). Probation and parole are both forms of community supervision. People under all forms of community supervision must comply with certain requirements or risk legal consequences, including the potential for incarceration (Brinkley-Rubinstein et al., 2018).



2. RISK OF OPIOID-RELATED OVERDOSE IS HIGH POST-RELEASE

Opioid-related overdose mortality continues to be the leading cause of death among people released from jails or prisons (Joudrey et al., 2019). A longitudinal study tracking a cohort of people following release found that 15% of deaths during the study were attributed to overdose, seven times the overdose death rate in the general population of state residents. The study also found that 25% of those deaths occurred in the first month after release (Binswanger et al., 2020). Opioids were involved in more than half of the overdose deaths, in line with national trends (Binswanger et al., 2020).

Factors contributing to post-release overdose risk

There are many complex, interlocking factors contributing to the high rate of fatal overdose among individuals leaving correctional settings:

- Underlying conditions prevalent in the population — chronic pain, HIV, trauma, and suicidality (Binswanger et al., 2007).
- Intermediate determinants, pointing to the direct impacts of incarceration — disrupted social networks and support, poverty, interruptions in health care access, increased stigma, and exacerbated psychiatric and substance use disorders.
- Proximate determinants, directly influencing post-release opioid overdose risk — return to opioid use, interrupted opioid use disorder (OUD) treatment, polydrug use, solitary substance use, polypharmacy, and insufficient naloxone access (Joudrey et al., 2019).
- The increasing prevalence of synthetic opioids like illicit fentanyl and carfentanil in the drug supply. Synthetics are much stronger than heroin and even experienced users may be unable to gauge the content of their drugs (Joudrey et al., 2019).

A period of abstinence following repeated opioid use can cause a rapid loss of “respiratory tolerance” — meaning that a person returning to use who administers the same dose they used previously to successfully induce a high may find that the same dose causes dangerous levels of respiratory depression and possible overdose (Joudrey et al., 2019). This is a common scenario among people who use opioids who are released from jails and prisons, where abstinence from drugs frequently occurs (though not universal).

The transition from community supervision back into the community is also an important juncture for overdose risk reduction interventions, as people lose access to ancillary services provided by community corrections and are no longer monitored (Binswanger et al., 2020).

3. LIMITED ACCESS TO SERVICES POSES BARRIERS TO ADEQUATE CARE

Access to evidence-based programs for overdose prevention is limited for people involved in the criminal justice system despite the high risk of overdose upon release (Belenko et al., 2013). In 2014, only 4.6% of people with criminal justice system involvement, including community corrections, referred to OUD treatment received either methadone or buprenorphine compared to 40.9% of those referred in the community (Krawczyk et al., 2017). Across all criminal justice settings, community corrections agencies were the least likely to offer medications for opioid use disorder (MOUD) for either detoxification or maintenance. Jails and prisons were more likely to offer MOUD, but it was typically restricted to pregnant women or for people taking the medications upon entry (Friedmann et al., 2012).

4. COMMUNITY CORRECTIONS HAS POTENTIAL TO BE A HIGH IMPACT SITE FOR OVERDOSE INTERVENTION

Given community corrections' frequency of contact with a sizable portion of people involved in the criminal justice system, community corrections officers have a vital role to play in identifying people at risk for overdose, preventing overdose, and facilitating recovery (Brinkley-Rubinstein et al., 2018). But community corrections settings have largely been overlooked as intervention points for overdose prevention, despite the heightened risk that remains for people who are released to or sentenced directly to community supervision.

Although evidence-based practices (EBPs) to mitigate overdose risks have progressed, most focus on detention settings, which have a legal obligation to provide medical and mental health care to people who are incarcerated (Grella et al., 2021), a right that does not exist for people under community supervision. Limited research has examined the factors shaping access to MOUD, for example, in community corrections settings. In 2021, the first qualitative study examined access to MOUD in the context of the overdose epidemic for people under community supervision and found that services offered to people under supervision were limited by treatment availability in the community (Kennedy-Hendricks et al., 2021).

Overall, there is a need to bolster community corrections as a site for overdose prevention and doing so has potential to reduce overdose rates nationally. This environmental scan describes key findings on and recommendations for implementing overdose prevention and response in community corrections settings.



Environmental Scan Methods

Between May and August 2021, the National Council conducted an environmental scan supported by a literature review, 19 key informant interviews, and one expert roundtable.

LITERATURE REVIEW

The National Council reviewed academic, peer-reviewed journals, and white and grey literature to understand existing research and best practices and to identify potential gaps around the state of overdose prevention programming in community corrections agencies. Keyword searches were conducted in academic databases, online search engines, and key public health and criminal justice system websites to identify relevant work. The literature review and key informant interviews were conducted concurrently.

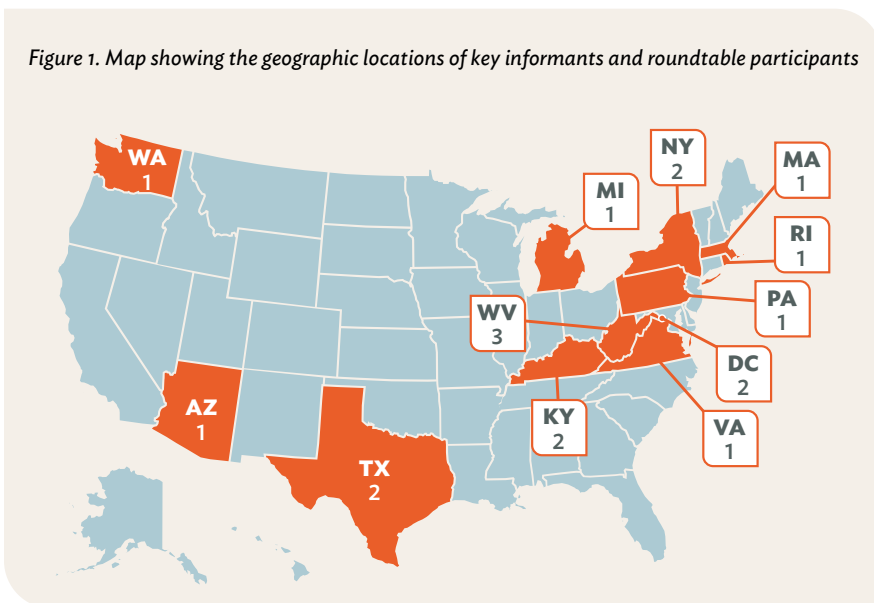
KEY INFORMANT INTERVIEWS AND ROUNDTABLE DISCUSSION

Using a semi-structured interview tool (see Appendix), National Council staff conducted 19 key informant interviews with subject matter experts representing the fields of academia and nongovernmental organizations, as well as leadership and frontline staff in community corrections and partnering health services providers. An initial group of key informants were recruited from the National Council's extensive list of key collaborators and thought partners working at the intersection of overdose prevention and community corrections. Additional key informants were identified by the first group, using a snowball sampling method. While all experts were committed to expanding opioid overdose interventions in community corrections settings, the National Council sought to pool a range of professional roles, agency affiliations, geographies, and perspectives in the group.

National Council staff also facilitated a roundtable discussion with the key informants. The purpose of the roundtable was to: (1) summarize the progress of the project and validate initial findings gleaned from the literature review and key informant interviews; (2) learn more about ongoing overdose prevention practices in community settings including innovative practices and barriers to implementation; and (3) gather information to inform the development of technical assistance.

The key informant interviews (roughly 60 minutes) and roundtable discussion (120 minutes) were conducted via Zoom videoconferencing software. Each session was recorded and transcribed with the consent of the participants. The transcriptions were then thematically coded independently by a consultant and two National Council staff members. The results were analyzed, synthesized, and interpreted for this report.

Figure 1. Map showing the geographic locations of key informants and roundtable participants



Findings

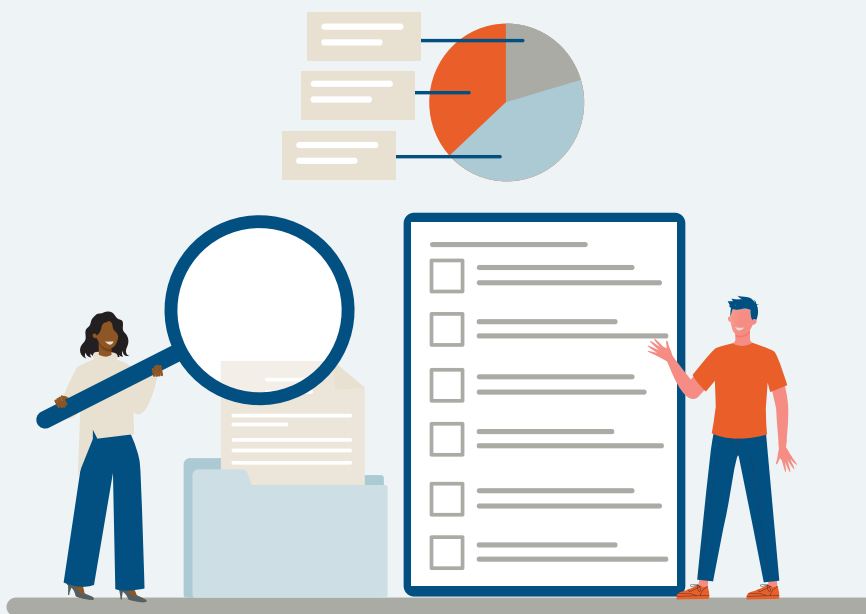
The findings from the literature review, key informant interviews, and expert roundtable indicate that although there have been some efforts made in community corrections to provide evidence-based overdose prevention and response programs, there are still challenges and barriers that need to be addressed. The key themes that emerged from interviews and roundtable discussions with key informants are summarized below.

FINDING 1: COMMUNITY SUPERVISION IS CHANGING, PROVIDING OPPORTUNITIES FOR INCORPORATING RECOVERY-ORIENTED APPROACHES

Community supervision practices were originally intended to provide a less punitive alternative to incarceration, but a growing body of evidence indicates that the emphasis on surveillance and monitoring and the increasing caseloads has morphed community supervision into a leading driver of incarceration (Horowitz et al., 2020). For people with substance use or mental health challenges, this is compounded by the lack of access to treatment, which can contribute to unsuccessful supervision outcomes.

Over the last few years, the culture of supervision has begun to change. Three broad goals have emerged for the future of supervision: (1) better outcomes for people on supervision, their families, and communities; (2) a smaller system with fewer people on supervision; and (3) less use of incarceration as a sanction for violations (Horowitz et al., 2020). Local jurisdictions are innovating community supervision practice. Some jurisdictions are piloting new EBPs, like shortening probation lengths and limiting the use of technical violations and revocations (Horowitz et al., 2020). Others are increasing the use of goal-based supervision practices, such as earned compliance credits, which incentivize success rather than punish failure (Banister & Strom, 2021). While these efforts do not specifically focus on overdose prevention or SUD, the effects of these changes also mitigate overdose risk for people under supervision.

Qualitative research indicates that supervision has become more rehabilitation-focused over time; this includes a more nuanced understanding of return to drug use as part of the recovery process, and tailored supervision and treatment approaches as a result (Kennedy-Hendricks et al., 2021). Some agencies no longer initiate automatic court review or reincarceration following a positive drug screen; instead, they give community corrections officers more discretion to determine next steps. Community corrections officers want individuals under supervision to succeed, and some view MOUD as a tool to facilitate success (Kennedy-Hendricks et al., 2021).



Key informants identified a similar evolution that directly impacts overdose prevention. Community corrections is moving toward:

Being more rehabilitative

Community corrections has started to take a more rehabilitative, rather than strictly punitive, approach in working with people who use drugs (PWUD), where people under supervision are evaluated on the overall progress towards supervision goals rather than being punished for every instance of return to use.

There's been this punitive measure that's historically, you know, people won't go into their parole and probation officers because if they've used [drugs], their likelihood of losing their freedom is great. So, working with ... parole and probation officers, I think is important around the whole societal shift on how we work with individuals... I think that even the parole and probation officers have found themselves surprised at the outcomes when they're honest and open with people about you know, if you come in here and if you're working towards trying to improve your life and we see those things happening, and you come up with a dirty urine, we're going to still work with you. We're not going to incarcerate you just because you had a reoccurrence of addiction. And which is really, it's a much more effective way to work with people, when they know that their freedom is not necessarily on the line. (11)

Prioritizing evidence-based and best practices

EBPs, such as MOUD or naloxone distribution, are increasingly being integrated into supervision to lower the risk of overdose.

Recognizing that you know, best practices change over time, evidence-based treatment changes over time and that individuals we serve have every right to receive the highest quality treatment that's available to any individual in the community, and it is our obligation to make sure that we stay up to date with those. (1)

Hopefully, as we gain more research, we recognize that punish[ment]-based interventions for people that use substances and have risk for overdose are not effective interventions to change behavior. (10)

Being person-centered

Centering people with lived experience in the design of overdose interventions is perhaps the most well-tested of all interventions. PWUD have driven the advent and uptake of every effective harm reduction tool, from bleaching syringes to the widespread use of naloxone to reverse opioid overdoses. Seeking input from people under community supervision at the outset of designing any intervention that will impact them is critical to the intervention's success.

Making sure that they [people with histories of incarceration] are at the table with the service providers on the inside, but also service providers on the outside. That they have a role within the whole process. (11)

Community corrections has also begun to recognize the individual nature of recovery and that there can be different routes to recovery for different people.

Recovery is individual... Some people may go to treatment. Some people choose to engage in a spiritual process. They don't want to go to clinical treatment. Some people utilize a completely peer-process...so it's really understanding, just because you're not going to a clinic and getting treatment does not mean that you're not working on your recovery. So, it's really brought me...that perspective and making sure that how we look at success and what we're expecting people to do also matches, and that's...I think that's part of being person-centered and providing trauma-informed interventions and approaches, where you know, it's not just us sitting at a table deciding what success looks like. It's going to look different for different people. (2)

Combining public safety and public health goals

Community corrections has seen a shift in perspective, which recognizes that public safety and public health goals are not in conflict with each other. In fact, some community corrections agencies have started to combine public health goals in their supervision practices.

I think that probation and parole officers now truly want both [public safety and public health outcomes]. That's a difference [from before]. You don't have to work as hard at this integration of mission than we had to before. Because it's now become part of our social you know, what, everything about the community now is overdose prevention, suicide prevention, as well as the harm that behaviors resultant of mental health disorders and substance use disorders cause others in the community. It's not all about the victim. It's now actually seen as everybody is victimized by something and we need to intervene at many levels, just not separating folks between those that are committing the crime and those that are the recipients of the crime. (3)

Identifying alternative measures of success

Some community corrections agencies have begun to identify alternative measures of success as opposed to abstinence-only policies, which include graduated sanctions to drug use and incorporation of treatment into supervision.

Oftentimes starting out, it's like people...it's like, "Well they're still using" or "They're using this." Success is not measured by that...testing is important, but that's not the ultimate measure. Our goal is to get people reintegrated, to be...into the community, to be productive citizens, be able to have a stable, affordable housing and income, employment or whatever. So explaining and educating on...recovery is a process, and so we don't...you want to know how many people relapsed or...we don't consider that as a failure. That's a natural progression of the disease that could happen. That doesn't mean that the person wasn't successful. Let's talk about "Is this person engaged." Now, as long as they're still engaging and we're able to work with them, that's good. (2)

So I have seen that they [community corrections officers] are more open to involving treatment as an intervention instead of saying, "Hey. We're just going to violate you because you've got your first positive." Instead of that, let's see if we can kind of work with your team to get you the assistance that you need. (2)

The shifting culture within community corrections can be increasingly supportive of overdose prevention initiatives and parallels growing awareness in the community corrections field about procedural justice, which ensures fair processes and recognizes that people perceive fairness based on their experiences with the process and the outcomes (Tyler, 2006). Early research on procedural justice suggests that it can improve probation supervision and core supervision outcomes (Janetta et al., 2021).

However, as key informants noted, it can take time to shift culture; there are long-time community corrections officers who are unwilling to consider rehabilitation as part of their mission.

FINDING 2: COMMUNITY CORRECTIONS OFFICERS HAVE A DISTINCT ROLE IN PREVENTING OVERDOSE

As the organizational culture of community corrections has shifted, the role of individual community corrections officers has evolved, particularly as they work with mental health and substance use treatment organizations to implement overdose prevention interventions and refer people who need it to treatment.

Collaborative planning across mental health and substance use treatment organizations, community corrections, and other stakeholders to ensure continuity of care and access to (or continuation of) treatment is essential for people returning to the community who are at risk of overdose. At the same time, some people are sentenced directly to probation, and they too need access to treatment. Thus, effective screening and assessment done by qualified staff to determine needs should occur at community supervision intake for those starting probation or before release for people entering community supervision from a detention setting (Banister & Strom, 2021).

Community corrections staff need to understand the standard screening and assessment tools used by SUD providers to determine the appropriate treatment or recovery resources. This informs effective collaboration with mental health and substance use treatment staff. Routine screening for substance use and overdose risk can support individuals in at least four ways: (1) identifying and reducing risk for overdose, (2) connecting to treatment and recovery support services, (3) supporting successful completion of supervision, and (4) reducing technical violations and revocations (Banister & Strom, 2021).

In addition, an opportunity exists to use an overdose risk index to screen for levels of social support, financial resources, exposure/access to drugs, access to housing, history of overdose, and intention to return to substance use. The tool could be administered by jail or prison staff before discharge and shared with both community treatment organizations and community corrections partners (Brinkley-Rubinstein et al., 2018).

Key informants indicated that while treatment recommendations have historically been the purview of community corrections officers, in general, they do not have the training to do so. Recent trends have shifted the community corrections officer's role toward collaborating with mental health and substance use treatment organizations, with recommendations being made by the latter (whether they are also government employees or private contractors). Key informants noted the distinct roles of community corrections and mental health and substance use treatment organizations in preventing overdose.

My [behavioral health] staff, really that are out in the probation offices, they are kind of like case managers. They do the initial assessment, they provide linkage to treatment resources, and then they're monitoring to make sure that they don't need to get back involved [...] but they're really providing more kind of loose case management and aren't in that regular contact like the probation and parole officers are because they're the ones that they're reporting to. (1)

I mean probation and parole officers are not treatment providers. We just need them to make the warm hand-off and stay engaged in the conversation so that even if the hand-off is successful, they're still present to know that there's ongoing engagement. (8)

The frequent communication between community corrections officers and individuals under supervision presents the opportunity to form a trusting relationship, which can facilitate service uptake and success and lead to overall positive health and public safety outcomes:

I think that acknowledging upfront, and I know a lot of — some probation officers and parole officers do this on their own, but I think acknowledging upfront, that like look, we're not looking for perfection, we're just looking for general improvement. I don't want you to — I don't want you to just disappear if you think you're going to have a dirty urine, like I want you to come in, we'll definitely talk about it, let's build and figure out what were some of the triggers that kind of led to that relapse. If that kind of rapport is built, then I feel like they can actually address and help them connect to the other resources they need. (6)

I would love for probation officers to have fewer probationers on their caseloads. To in the beginning, develop a close working relationship with that individual...the probation officer has a tremendous amount of influence in somebody's life, if they want to have it. (3)

Key informants recommended several specific roles for community corrections officers in preventing overdose that would be within their purview:

- Recognize when a client may be at risk of overdose.
- Refer individuals under supervision to mental health and substance use treatment organizations that offer MOUD.
- Support individuals under supervision to attend medical appointments.
- Be trained and train individuals under supervision and their family members to use and administer naloxone.



FINDING 3: COMMUNITY CORRECTIONS OFFICERS REQUIRE TRAINING TO FULFILL THEIR ROLE

When equipped with the necessary knowledge and skills, community corrections officers are uniquely positioned to link people under supervision to mental health and substance use treatment organizations and ancillary services and resources to reduce the risk of overdose. To functionally fulfill this role, community corrections officers need to have a general understanding of SUD, EBPs, and the skills to build trust and rapport with those they supervise.

Social service providers who serve people under community supervision found that community corrections officers “lacked a general understanding of OUD, treatment options, and particularly misunderstood MAT,” with some not allowing their individuals under supervision to receive either buprenorphine or methadone and others not knowing, functionally, how to link people under supervision to MOUD providers (Reichert & Gleicher, 2019). The social services providers recommended more formal education for the community corrections side on these topics (Bunting et al., 2018).

Community corrections leadership and staff have received limited training on each medication for MOUD. In one study, about 40% of community corrections officers knew where to refer people under supervision for each of the three medications, and leaders had little to moderate familiarity with the purpose, use, administration, efficacy, and mechanisms of MOUD (Reichert & Gleicher, 2019).

There are many community corrections officers who do not believe medication to be an effective form of treatment (Mitchell et al., 2016). Limited knowledge and misconceptions about SUD and MOUD may impact an officer’s referrals to mental health or substance use treatment organizations, which hinders adoption of treatment and access to care.

The probation and parole officers, I think this is, there’s a bit of a cultural piece to it. [...] A lot of folks that have been around a long time, they believe in a 12-step program of total abstinence. They believe this isn’t medicine, it’s a substitute. And a lot of that is so deeply ingrained that often it becomes part of somebody’s who they are, and how they help. (3)

Community corrections officers have expressed skepticism that treatment alone, without psychosocial support, is effective, and hold a similar outlook regarding treatment partners. Additionally, there can be distrust for providers who are perceived to prescribe medications to generate income and not because it was in the best interests of the patient (Kennedy-Hendricks et al., 2021). Methadone was viewed negatively in the same study, with people receiving methadone treatment perceived as not serious about their recovery by community corrections officers. However, evidence does not support either of these perceptions.

The frequent touchpoints that community corrections officers have with people under supervision make them an ideal intervention point for increased access to naloxone. Evidence underscores that the most effective way to use naloxone is to put it directly in the hands of PWUD and their peers (Florida Alliance for Healthy Communities, 2020).

However, key informants found that community corrections officers were rarely trained to administer naloxone — sometimes this was due to a lack of education or financial resources, or to policy barriers that prevent them from distributing medication. Even rarer were examples of community corrections agencies educating people under supervision about overdose and naloxone and putting it directly in their hands.

Everyone in our [community corrections] office is Narcan trained, and we all have Narcan with us at all times, but we're not allowed to actually dispense it...we're not approved to. It would have to go through like a physician or something like that for us to be able to do it, just because of the liability. (12)

We still have a lot of [people under supervision] that don't have any idea where to access Narcan and in my opinion that's just unacceptable. If they've had that much contact with our division and our department, they should know where to access it and we have to do better to make sure that we're getting that information in every person's hand. (1)

We [Probation] don't provide Narcan to anybody, we're not allowed to give it out. I have given out information of where people can get it on their own and get the training. There is a program around here that hands out, from the health department, to the general public. (12).

To adopt EBPs with fidelity, staff need training. While individual community corrections officers may find trainings on a one-off basis through resources such as the Bureau of Justice Assistance or the Center for Substance Abuse Treatment, more focused and systematized trainings are needed.

[T]here's a national effort to really change probation and parole officers, to have them adopt evidence-based practices... Right now, there isn't material that's available for probations per se and officers themselves, if they get trained, they only get trained because you know, they might have happened on something, instead of having it a national initiative. And, I would highly recommend working with the American Probation and Parole Association, because that is the national association that really pushes out new ideas to the field. (13)

Specific recommendations to carry out effective trainings include making them:

- **Site-specific:** Trainings should be tailored to the local context, rather than a statewide audience. Community corrections in Kentucky offered site-specific trainings to its departments, recognizing that the fragmented nature of the system means that issues that arise are contextually specific.
- **Applicable:** Trainings should also include “practical applicability” of the information learned and how it relates to the officer’s job (Fixsen et al., 2005). They should also follow best practices in instructional design for adults by including opportunities for peer-to-peer learning, incorporating officers’ experiences, and delivering information in formats that are appealing to the learner.
- **Embedded in infrastructure:** Trainings should not take place on a one-off basis; instead, they should be fully integrated into the agency’s operations.

Training topic 1: Substance use disorders and medications for opioid use disorders

One area of opportunity would be to offer education to community corrections officers about the nature of SUD, as well as MOUD as an option for treatment (SAMHSA, 2019). Such a training should be required of all employees who work with people with SUD (Streisel, 2018) and could be added to current training requirements.

A randomized control study of medications for addiction treatment in community corrections found that community corrections officers who were more knowledgeable about MOUD, who viewed their role as supporting people under supervision's reintegration, and who acknowledged the importance of treatment for SUD to meet those needs largely held more positive views of methadone and buprenorphine (Mitchell et al., 2016). The same study found a limited understanding about SUD and the benefits of MOUD among community corrections staff: they understood MOUD as useful for detoxification or short-term stabilization, but they did not support other longer term treatment applications of MOUD (Mitchell et al., 2016). Other research recommends that trainings dispel misconceptions that MOUD are merely swapping one drug for another and provide information about the three FDA-approved MOUD (Streisel, 2018).

Training community corrections officers on SUD is particularly important because this knowledge is critical to effective collaboration with mental health and substance use treatment organizations, particularly among officers who align themselves more closely with public safety and surveillance as opposed to rehabilitation (Belenko et al., 2018).

People under supervision with OUD should have the ability to access all three FDA-approved MOUD as deemed appropriate by a medical provider — not a judge, community corrections officer, or other corrections staff (Reichert & Gleicher, 2019). While clinical assessment is not an appropriate role for community corrections officers, “improved recognition of indicators of SUDs could trigger expanded and more appropriate referrals to assessment staff” (Belenko et al., 2018).

Inadequate screening, whether for specific substances or for overdose risk, was frequently named by key informants as a barrier to connecting people to the appropriate resources.

You know in the criminal justice system, there's been a really big push to use what's called risk and needs assessment tools, and those include things like the level of service inventory... you know there's a whole bunch of homegrown ones, and all these tools, they have usually a category for substance use but they're not — you know, they're not as well defined as if you were going to use an ASAM [American Society of Addiction Medicine] criteria or if you were going to actually use like the ASI [Addiction Severity Index], which asks about issues about what type — you know drug of choice and frequency of use, and issues about you know, how do people use drugs. All of those aren't on the sort of criminal justice domains. (13)

Critically, however, community corrections officers' initial referral to a community provider *may itself preclude the use of medication*, if the referral does not offer MOUD (Kennedy-Hendricks et al., 2021). This too underscores the need for proper training of community corrections officers on the benefits of MOUD — even while they continue to grapple with the realities of their jurisdictions, including limited provider availability in many areas — as they develop contracting relationships and make referrals. Community corrections officers also should be trained to use evidence-based screening tools for SUD and have a screening protocol in place (Brinkley-Rubinstein et al., 2018).

Training topic 2: Overdose risk reduction and naloxone distribution

Community corrections officers should receive training on how and when to administer naloxone and should have naloxone readily accessible onsite. In addition to community corrections officers, the American Society of Addiction Medicine also advocates for overdose education and naloxone distribution (OEND) directly to PWUD and other people in a position to respond to an opioid overdose, including “people re-entering the community from correctional settings and their family members” (American Society of Addiction Medicine, 2021). Access to naloxone for people under supervision should be as low-threshold as possible:

Ideally you want to have Narcan and naloxone available at the probation and parole offices for people to take without having to fill out a 30-page survey or whatever it is. Low-threshold access to this benign lifesaving medication for people that are coming in. (11)





FINDING 4: EVIDENCE-BASED PRACTICES FOR PEOPLE UNDER SUPERVISION CAN REDUCE OVERDOSE MORTALITY

Evidence-based strategies to address overdose such as MOUD, naloxone, and fentanyl test strips are effective in reducing rates of overdose.

Intervention 1: Access to FDA-approved medications for OUD

Expanding access to MOUD during and following incarceration can stem the cycle of arrest, minimize the risk of post-release overdose and death, and facilitate a path to recovery for individuals with SUD.

MOUD have been proven to be effective for people with OUD to enter recovery, and preventive of infectious disease transmission associated with injection drug use, like HIV and Hepatitis C (SAMHSA, 2021f). There are three U.S. FDA-approved MOUD: methadone, buprenorphine, and extended-release injectable naltrexone (XR-NTX).

- Methadone is a full opioid agonist and provided only within Substance Abuse and Mental Health Services Administration (SAMHSA)-certified and Drug Enforcement Administration (DEA)-regulated opioid treatment programs (SAMHSA, 2021a).
- Buprenorphine is a partial opioid agonist and can be prescribed in non-specialty settings if physicians, nurse practitioners, and physician assistants obtain a SAMHSA waiver after completing required training (SAMHSA, 2021b).
- Extended-release injectable naltrexone (XR-NTX) can be prescribed by any clinician who is licensed to prescribe medication (SAMHSA, 2021c). It is an opioid antagonist and not a controlled substance.

Research shows that agonist treatments like methadone and buprenorphine reduces overdose and mortality risk (Clausen et al., 2009). More recently, research has demonstrated conclusively that receipt of buprenorphine or methadone during incarceration can prevent the loss of opioid tolerance in people released from jails and prisons, thereby reducing the risk of opioid overdose post-release (Degenhardt et al., 2014; Marsden et al., 2017). Methadone has been associated with reduced levels of criminal activity (Bukten et al., 2012; Schwartz et al., 2009). The impact of buprenorphine treatment on criminal activity has not been well-studied to date. Initial studies have not found any significant differences between buprenorphine and methadone with regard to their impact on criminal activity (Sun et al., 2015).

XR-NTX reduces cravings but does not reduce symptoms of withdrawal. Initiating individuals on XR-NTX generally requires medically supervised withdrawal followed by a minimum of seven to ten days without opioids, including opioid-based MAT medications, therefore increasing the failure rate (Mattick et al., 2003; Sullivan et al., 2017). For people released from jails and prisons, there is also concern about the risk of overdose following cessation of XR-NTX due to a loss in opioid tolerance that is not present for people discontinuing agonist treatments like buprenorphine or methadone (Saucier et al., 2018).

Intervention 2: OEND directly to people under supervision, friends, and family

Naloxone (commonly known by its brand name Narcan) is an FDA-approved medication that reverses opioid overdoses and prevents overdose death. In addition to saving a life, providing OEND to people under supervision can be a meaningful way to start a larger, honest conversation about drug use and harm reduction:

Narcan training access, the whole milieu around Narcan is really a gateway. I think that we're limiting ourselves if we only see it as an opportunity to reverse an overdose or train someone else to reverse an overdose... there's a whole array of information and knowledge that comes along with having the opportunity to give someone Narcan and teach them how to use it...it's also an opportunity to have a conversation about safer consumption in general. A lot of the folks that are getting out of jail don't have access to syringes. They don't have access to fentanyl test strips... They don't know a lot of things about how to use safely and not die. And there's just so much that comes with being able to have an honest conversation about someone's use that Narcan I think can be a gateway to. (11)

Harm reduction-based education for people under community supervision is an important method of overdose prevention. A person returning to the community from incarceration will not be aware of changes to the current drug supply at the same time that their tolerance is down. They also may not be aware of current harm reduction techniques.

Because even when we're in there talking to individuals that may seem motivated to not use anymore, there's never really been enough talk about okay, that's great. We encourage you to seek that avenue. But if you happen to come across hard times and you find yourself in a position where you want to use again, there are safer things that you can do... Because the likelihood of somebody using upon release is great, and they don't know what to do. [...] Where we started doing this, we saw individuals that normally would not have gotten this information, get this information and stay alive as a direct result of that. And one thing we do know is that keeping people alive is of the most importance one way or another. (11)

This harm reduction approach has been practiced by syringe services programs for decades. Harm reduction recognizes that PWUD may be uninterested in, unwilling to, or unable to cease their drug use, and are nevertheless deserving of access to health services that can help to reduce the harms associated with drug use. The goal of harm reduction is to “meet people where they're at, but not leave them there” (Harm Reduction International, 2021). As described by the key informant, this can be offering sterile syringes to people who inject drugs to reduce the transmission of infectious diseases like HIV and Hepatitis C; providing fentanyl test strips to people to test their drugs for the presence of fentanyl and other synthetic opioids; and educating people about safer drug use techniques to avoid overdose, support vein care, and other methods of keeping themselves safe.

Intervention 3: Access to fentanyl test strips

Use of fentanyl test strips by PWUD fosters autonomy and dignity by enabling PWUD to make decisions about their health. Most PWUD are interested in using fentanyl test strips and view them as an important overdose prevention tool (Sherman et al., 2018). SAMHSA and CDC recently allowed its funding pools to go toward the purchase of the test strips, citing a convincing evidence base supporting the intervention (Appel et al., 2021; CDC, 2021). As one key informant noted, community corrections officers can educate people under supervision on using fentanyl test strips.

[People under supervision] don't know safer consumption techniques. They don't know what the street medications or drugs are like, because they only knew them when they got incarcerated. They might think they're the same thing, and they're not. And so we've talked to people about how to test their drugs, whether it's with the fentanyl test strips or other manner. We make sure that people, if they find themselves using again, that they don't use alone. Using alone in this epidemic is you know, it's a recipe for disaster, is what it is. And letting people know that listen, I'm using, can you check on me in a few minutes, make sure I'm okay. (11)





FINDING 5: SIGNIFICANT BARRIERS IMPEDE THE IMPLEMENTATION OF EVIDENCE-BASED OVERDOSE PREVENTION IN COMMUNITY CORRECTIONS

Although cultural shifts are happening in community corrections, significant barriers to implementing EBPs for overdose prevention remain.

Barrier 1: Criminal justice system context leads to a fragmented approach

When implementing EBPs for overdose prevention within community corrections, different hyperlocal criminal justice system contexts exist in every state. For example, Rhode Island's Department of Corrections has jurisdiction over all people incarcerated in jails and prisons, as well as over community corrections. North Carolina has a state prison system, which includes community corrections, in addition to 100 county jail systems. In some jurisdictions, detention settings may be housed under the same government unit as community corrections, but in others not.

[E]very system and every state operate in such a different way. Some states have the executive branch that covers both probation and parole, so they're kind of a little bit more uniform. Some states, you know, one is under the judiciary, another is executive, some have county-based systems, so having that kind of variety, really, I think makes it challenging for states to operate most effectively, or at least to kind of promulgate some kind of broad-based national evidence-based practices. (6)

In addition to governance structures, community corrections can function differently across jurisdictions, which also poses challenges to implementing systems-level overdose prevention programs. As one key informant put it,

Prison, I think in some ways it's just like, you know it's prison, right, some of them have more or less resources but you kind of know what you're what you're going to get, but community supervising is kind of such a mixed bag, especially when you can throw in private probation into that mix, which I would imagine most people who have substance use issues ...they are probably not in that category but I could be wrong. So I think that having that, like just those kind of like varied ways of conducting supervision, I think make it really challenging, to think about what would be a broad policy reform, if that makes sense. (6)

Another contextual consideration is how naloxone access laws vary significantly by state (Legislative Analysis and Public Policy Association, 2020). One key informant noted that not all pharmacies in their area stock naloxone and that access to naloxone was largely determined by people's geographic location.

I think [access to naloxone or lack of it is] really based on where [people under supervision] are at geographically. We have some communities that have much more resources, [and] they do outreach in other areas that don't have that information as widely distributed. So in my opinion, I think, you know, reaching out and having more community involvement in all of the areas across the State, making sure that those resources are getting out, even if there isn't currently an infrastructure in the community to distribute that. (1)

While some people obtain naloxone through prisons or jails, access to naloxone is largely mediated by its availability in the community, often through syringe services providers or other community organizations. While providing naloxone at discharge is important, linking people under supervision to ongoing access to naloxone within the community is also key (Grella et al., 2021).

The extent to which data is shared between community corrections agencies and mental health and substance use treatment organizations should also be considered. Data sharing between SUD treatment organizations and government agencies (as governed by state information privacy laws and federal regulations, such as HIPAA and 42 CFR Part 2) exist at two levels: tracking the services and care people under supervision receive across facilities and systems to improve individual outcomes, and linking population-level administration data to evaluate and improve population-level health and outcomes.

Federal laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2, should be followed when sharing information about people with SUD. Some state laws can be more restrictive than federal laws. States should review their privacy laws to ensure that laws are not overly restrictive and do not preclude the sharing of necessary and meaningful information that can enhance an individuals' access to treatment and services.

One key informant shared the fractured and incomplete picture that community corrections agencies have of people under supervision, despite their many touchpoints with government surveillance apparatuses, and how this impedes the ability to understand the population of people under supervision in general:

Linkage of criminal justice and health records, that helps with service provision for the individual and for tracking people across multiple different data systems. It helps to know if the services and the efforts that people in the community are doing are actually working. And that you can see if individuals in these data systems might not be engaging in services. That's an opportunity for maybe those individuals who are overseeing them in the community can then provide an additional resource. Say like, "Hey, I noticed that you might need some transportation to get to the doctor's office. Or perhaps we can get you reengaged in Medicaid so that way you can engage in all of the recovery services that you previously engaged in." (9)



Barrier 2: Social and structural determinants of health impede access and uptake

Social and structural determinants of health need to be taken into consideration when implementing overdose prevention efforts, and more broadly, when working with PWUD. Barriers such as housing, transportation, economic opportunity, and health care coverage, to name a few, can impact whether people can access or engage in treatment and other services (Dasgupta et al., 2018; Park et al., 2020).

You have a lot of just the basic needs that create barriers [to treatment]. You know it's really hard to focus on treatment when you don't know where you're going to sleep tonight, or you don't know how you're going to feed your family or keep the lights on, so there's those financial barriers that folks face with transportation, with employment. (1)

Things that people in the community take for granted are very important for people who are leaving incarceration or might be cycling through incarceration. Things like having an ID, having a telephone. Those things we take for granted. And things that we see in prisons and jails that they're now prioritizing. For example, our partners at the New Jersey Department of Corrections, they assist people with obtaining a state ID. They provide cell phones to people who are leaving incarceration. And all of that is to ensure that people are able to engage in services once they're released. (9)

Housing

Structural determinants of health and basic needs like safe, stable housing are critical components of successful reentry and are often the most pressing need for a person leaving prison or jail. Housing instability can affect whether an individual is able to find and keep employment, comply with conditions of probation or parole, and access health care (Chavira & Jason, 2017).

Access to housing at the time of community reentry is often restricted by systems-level factors like a lack of affordable housing, legal barriers to regulations restricting housing options for people arrested for or convicted of certain crimes, or property owners who are unwilling to rent to justice-involved people (Rowings, 2017).

One study found that living with friends or family had among the strongest associations with post-release substance use. This did not change when participants who were not monitored on parole were removed from the sample. The authors posit that structured housing solutions for people on release may support people to avoid return to use and the incumbent risk of overdose (Chamberlain et al., 2019).

Transportation

Inadequate access to transportation can be a barrier for people under community supervision, since they need reliable transportation to attend weekly supervision meetings or to attend addiction and mental health meetings that are required as a part of supervision (Bohmert, 2016). In particular, a lack of transportation to appointments poses both a client-level barrier as well as a systems-level barrier for accessing overdose prevention programming, particularly in rural areas without access to the public transportation more prevalent in urban centers. In one study, people under supervision in rural areas relied on family networks to attend appointments, a stressor for both the client and the family (Bunting et al., 2018). As one key informant commenting on the importance of access to transportation remarked:

Transportation is huge. A lot of our people can't drive. They've lost their licenses for whatever reason, not paying fines or drug trafficking, all of that. So, getting the transportation to and from these multiple appointments can be difficult for them. (12)

Barrier 3: Lack of community corrections' funding for medications limits access

MOUD are often cost-prohibitive for people on community supervision, particularly in states that have not chosen to expand Medicaid under provisions of the Affordable Care Act. A study of social service providers working with community corrections individuals under supervision in Kentucky noted that Medicaid expansion in the state and ease of enrollment facilitates insurance coverage, and therefore access to MOUD, for low-income adults (Bunting et al., 2018).

I think that — there's like only a handful of jurisdictions that I know have vouchers for people to be able to access treatment if they don't have the means to afford it. We know that a lot of — many of the folks on probation and parole are indigent and so they can't afford to like get the kind of health needs taken care of. I think that's a challenge. (6)

Multiple key informants pointed to limited funding as a key reason they have not expanded overdose prevention initiatives: “Funding is always an issue. I mean our funding is always an issue, we always have limited dollars that have to be targeted at, you know, what the needs of the department are.” Others opined on the necessity of funding for overdose prevention as well as its instability from year to year:

You know, it [the ability to improve] all comes back to funding. I'm sorry. I wish it didn't. But it does, you know? Yeah, it's because what's going to make [the initiative] successful is having excellent supervision for the peers. Excellent supervision... I think being able to provide really competent supervision is what I think will bring this around. And because this is a, you know, a ... study, there's going to be money for that. But you know, three years from now ... is there going to be money for that? And unfortunately, you know if I had to bet, it wouldn't be. (3)

We're working from short temporary funding sources and stable long-term funding would increase confidence, especially in some of these programs or jails that are kind of interested in dipping their toe into the water... but if we tell them we can only offer this to you for the next nine months or year and a half, it doesn't engender confidence, and so more stable resources to support the work I think would help people be willing to transition. (8)



Barrier 4: Stigma and limited knowledge impedes access

Public health focuses on a harm reduction approach to drug use that acknowledges the likelihood of return to use. Across the criminal justice system, the predilection for abstinence-based recovery — one that does not involve MOUD — is common (Belenko et al., 2013), including among community corrections officers (Mitchell et al., 2016).

Reflecting deep-seated stigma, in many agencies, policies and procedures or court orders restrict community corrections officers' ability to refer people under supervision to MOUD. One study's survey of community corrections officers found that 32% were affected by agency policies restricting referrals to MOUD (Mitchell et al., 2016). Judges' personal preferences can limit access, as can embedded practices at jails and drug courts that continue despite new rules.

Limited knowledge perpetuates the officers' stigma around MOUD; for example, the myth that prescriptions like buprenorphine and methadone is swapping one drug for another — that MOUD is just a substitution for illicit drug use (Streisel, 2018). The logic follows that once an individual has arrived in the community corrections (or detention) setting, they have been without access to illicit drugs and are therefore abstinent. Once they are perceived as abstinent, it is not important or necessary to initiate them to MOUD (Streisel, 2018).

Harder to affect than policies and procedures may be the stigma that pervades not only community corrections organizations but also partnering community organizations that do not consider people who take MOUD to be in recovery. As one key informant noted:

I mean you're always going to have pockets of that. You know there's pockets of that even with my staff that have been clinically trained on why we're utilizing MOUD. You know there's some of that personal stigma that's associated with that, and so we do talk about that. (1)

Furthermore, the lack of broader community understanding about the nature of SUD as a chronic condition, in which return to use is common, and about the effectiveness of MOUD poses a barrier to people with SUD who might, for example, be embarrassed to be seen entering a treatment provider's office for fear of being recognized by a neighbor. Some communities opposed having treatment organizations located in the community, fearing "loitering" and "smoking" outside, posing yet one more barrier to adequate treatment availability (Bunting et al., 2018). On the other hand, there are communities that are supportive of interventions, engaging in practices such as encouraging a person with criminal justice system involvement to carry naloxone (Grella et al., 2021).

Sufficient access to MOUD to prevent overdose requires policy changes at agency, state, and federal levels, which currently restrict access at multiple decision points: the ability for providers to prescribe, patients to obtain, and criminal justice system providers to facilitate access to evidence-based interventions. Stigma is embedded in many of the barriers detailed here.

Stigma is huge, which is underneath everything. It's, you know, we internalize it as providers. We internalize it as patients. We internalize it, you know. We are over, there's overregulation due to stigma, and under compensation due to stigma. So the entire system struggles with this. So I really think that it's more general now, because there's been so much tragedy hit across the country, where almost no family has not been touched either by a loss of a friend or a family member, that we don't have to work quite so hard to fight the individual stigma. It's the structural stigma that is really causing barriers. (3)

Barrier 5: Lack of treatment organizations offering MOUD limits access

Most community corrections agencies outsource OUD treatment by linking individuals to mental health and substance use treatment organizations. Most community corrections agencies believe, falsely, that MOUD can be obtained easily through local treatment organizations, which constrains efforts to refer the right people to the right programs, where MOUD are available (Friedmann et al., 2013).

Availability of MOUD

In a study examining the use of MOUD in the criminal justice system, community corrections agencies cited the limited availability of MOUD from community treatment programs as the major barrier to implementation (Friedmann et al., 2012).

There are times, I don't know, say somebody was getting paroled and the parole hearing went well and they said you're out in two days. Well, you know, your discharge planner calls and says [the client] is going to be out in two days, and she needs her buprenorphine. She's been doing great on MOUD in the system here. And the doc says great, can't wait to see her. Let me give you to the office manager who says great, can't wait to see her. We can see her in three and a half weeks. And so now you have the barrier of capacity. (3)

[We need] more treatment providers if possible. I mean there seems sometimes the gap between when you can get somebody who's interested in having an appointment and is wanting more information that sort of stuff. Sometimes – to begin counseling. Or start reaching out for help sometimes. The initial appointments to get them involved in the outpatient or I.O.P. [intensive outpatient program] started, sometimes that is a little bit longer period than I would like to see... I've talked to somebody who – it was like a three week out for their first intake appointment. (7)

Permutations of this barrier include a lack of organizations providing treatment, the limited prevalence of specialty inpatient and outpatient treatment programs, and long waiting lists (Banister & Strom, 2021; Kennedy-Hendricks et al., 2021), especially in rural areas (Bunting et al., 2018). This barrier is mostly about access to treatment organizations offering long-term, individualized treatment (Reichert & Gleicher, 2019).

Participants in another study of community corrections staff worked with community treatment partners who were actively opposed to MOUD (Kennedy-Hendricks et al., 2021). Similarly, one key informant offered, “I’ve been talking about probation, but we also need to talk about the treatment organizations and counselors, because they need the same openness [to MOUD] as probation officers, but you know, the probation agency is only as good as the health agency that they rely on.”

Licensing and regulations

A large driver of the capacity issue is provider licensing to prescribe MOUDs. While there are no federal requirements for administering naltrexone, methadone and buprenorphine are governed much more strictly. Methadone may be obtained only from an opioid treatment provider (OTP) that is accredited and certified by SAMHSA plus other state-required certifications. Buprenorphine providers must undergo a lengthy training to obtain a waiver from the DEA that places a cap on the number of patients they can see (Reichert & Gleicher, 2019). The “X” waiver requirement for buprenorphine has created a large supply and demand gap, and activists are lobbying the federal government to “X the X waiver” completely. It’s also possible that the gap in supply is driven by providers who decline to provide agonist treatment, lack time for more patients, or do not receive full insurance reimbursement (Hunh & Dunn, 2017).

Some states have licensing, credentialing, and regulations processes that restrict efficient and effective use of MOUD, such as limitations on prescribing MOUD through telemedicine. These policies may discourage correctional facilities from becoming a provider of MOUD or may limit the number of community-based providers available. Some states maintain scope of practice laws that prohibit nurse practitioners or physicians' assistants from prescribing MOUD without the oversight of a physician, and three states preclude nurse practitioners from prescribing buprenorphine at all (SAMHSA, 2019).

Barrier 6: Distinct organizational cultures present challenges

Key Informants noted that community corrections and mental health and substance use treatment organizations have distinct cultures — punitive versus rehabilitative — that may present challenges to collaboration.

The most important thing to be successful and effective is the public health approach to their [community corrections'] engagement with the client. And less punitive approach to the engagement with the client. Because we know that individuals with substance use disorder will have setbacks. It's part of how substance use disorder works. So being mindful that setbacks are part of the substance use disorder recovery process and taking a public health and not punitive approach is how the probation and parole officer and that client become successful. (9)

And while community corrections and mental health and substance use treatment staff retain distinct, complementary roles, it is also important for them to collaborate:

I do believe that it is very important that some kind of collaboration...they're not...this [treatment] is not your [community supervisor's] expertise. Your training and your purpose is to reinforce...so to try to turn [community corrections] into what our [behavioral health] roles are, is kind of like well, no. That's why you coordinate, and you...it's like you can't be everything. Just like us...Your area is, in terms of structure and reinforcing, accountability and those things... (2)

As EBPs for SUD and overdose prevention are scaled up, collaboration among community corrections agencies and mental health and substance use treatment organizations has become increasingly important. At the same time, the need for increased collaboration has surfaced differing views about the role of public safety vis-a-vis public health, how to weigh the different missions when caring for people with SUD, and how to navigate the public safety requirement of community corrections with the treatment needs of people with SUD or who are at risk of overdose (Banister & Strom, 2021).

You know, I think we have to make a decision sometimes if public safety becomes the main concern. I would think we're going very much the public safety route. And then if rehabilitation is still available after that, then the rehabilitation approach. But I think public safety always has to be kept in mind. (7)



FINDING 6: CHANGES TO COMMUNITY CORRECTION POLICY AND PRACTICE ARE NEEDED TO SUPPORT RECOVERY-ORIENTED APPROACHES

Community corrections policies and procedures that support public health broadly, and overdose prevention specifically, could also benefit from a rehabilitative approach to public safety. This will require a top-to-bottom review of policies and procedures, examples provided below, for their alignment with procedural justice and public health values. Trainings for community corrections officers will not effect change without revising policies that consider a drug screen that identifies naloxone as a violation rather than a positive behavior.

[S]o one of the evidence-based practices is incentivizing positive behaviors and if you know, if a probation officer basically suggested that if a person was in need of Naloxone, that that would be perceived as a positive behavior and not a negative, then that would be reinforcing to the person, that they could actually seek help. But because Naloxone... because right now if people test positive, you know that's considered a negative. They could be sanctioned; they could go back to jail. (13)

Guidance from SAMHSA also recommends a nuanced approach to drug use in the community corrections context and that officers should work collaboratively with treatment organizations to develop a “range of responses” along with graduated sanctions (SAMHSA, 2005) or no sanctions. Specific policy changes are summarized below.

Policy update 1: Ensure legal protections for people prescribed MOUD under supervision

States can leverage laws and policies to protect people prescribed MOUD against deeply ingrained stigma around the medications in individuals and systems. As part of this, states should review supervision policies to ensure that SUD treatment and medication are not prohibited by the conditions or requirements of supervision (Banister & Strom, 2021).

For example, in 2015, New York State passed legislation that allows people on MOUD to participate in judicial diversion programs and ensures that those participants do not inadvertently face probation violation charges due to the presence of MOUD in a drug screen. Some jurisdictions have programs or policies in place that allow someone seeking MOUD to contact a criminal justice system agency for help without the threat of arrest (SAMHSA 2019).

Policy update 2: Extend Good Samaritan laws for people under supervision

Good Samaritan laws, state laws that protect people who report an overdose, frequently do not provide protection for people on probation or parole. States should extend coverage to include them (Brinkley-Rubinstein et al., 2018), as well as other people at risk of overdose.

Policy update 3: Allow the provision of telehealth and other technology assisted services

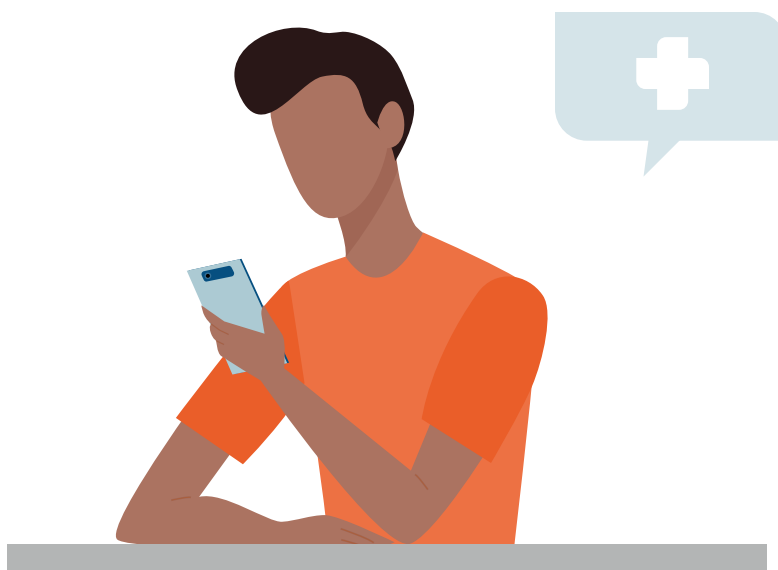
Telehealth may pose a solution, particularly for people in rural areas and with childcare, transportation, or work schedule barriers, to the paucity of MOUD providers (Reichert & Gleicher, 2019). COVID-19 provisions issued by the DEA to expand telehealth, particularly removing the requirement for in-person buprenorphine induction, should be maintained to support increased access to MOUD (Banister & Strom, 2021; Bunting et al., 2018).

We need relaxed policies, so tablets, telehealth, jails and prisons, corrections, almost need a different set of regulations for MAT [medications for addiction treatment]. We need more ability to bring meds into jails and prisons. We need more ability to support community corrections, wherever they send their folks. So, yeah, just I believe the future, especially for rural communities, as we're talking about, it's tablets, and so how do you put — how do you put education — how can you do pre-release planning on tablets and can somebody sitting somewhere in Indiana provide release services for somebody getting out in Washington? I think that's possible. So, yeah, I think we just need — we, corrections itself, needs more help, like technology, relaxed regulations. (4)

Policy update 4: Institutionalize recovery-oriented approaches

A person under supervision who yields a positive drug screen may be in violation of their supervision. From a public health perspective, however, a positive drug screen does not mean that the person's recovery has been unsuccessful. Bridging these two views, and the many conflicting policies and procedures that undergird each, is a challenge many states and local jurisdictions are facing. From the policy level to the individual level, coalitions of mental health and substance use treatment organizations and public health providers, local treatment organizations, state Medicaid agencies, and community corrections agencies are convening to increase partnership and coordination (Banister & Strom, 2021).

Three principles should be considered when changing policies and practices related to overdose: 1) communities of color and those with lived experience should be considered; 2) policy and planning must include the participation of individuals from the community and leadership throughout the entire process; and 3) public health and treatment interventions must be tailored to address the unique needs of the community.





FINDING 7: INNOVATIVE OVERDOSE PREVENTION INTERVENTIONS ARE HAPPENING IN COMMUNITY CORRECTIONS





While there is limited research and evidence on the impact of overdose prevention efforts within community corrections agencies, four examples of novel overdose prevention interventions were identified through this scan: 1) OEND, 2) specialized caseloads, 3) in-reach services, and 4) co-location.

Innovative intervention 1: Overdose education and naloxone distribution (OEND)

OEND within a community corrections context typically exist in two forms: 1) internally facing OEND programs for community corrections staff and 2) externally facing programs for people under supervision and their personal networks.

Officers that are in the community setting now have been receiving overdose prevention training. And so, there's a lot of different jurisdictions now that train officers in how to use naloxone and now have all of their officers carry naloxone. And you do see stories about how officers in the community supervision space have reversed somebody with naloxone who has experienced an overdose. (9)

Table 1. Examples of OEND Programs for Community Corrections Staff

Program	Location	Description
HEALing Communities Study	Kentucky 	A third-party cellphone application that facilitates communication between community corrections officer and client. It also provides a virtual naloxone training video, pushes out text messages asking about access to naloxone, and facilitates mailing it directly to the client's home (NIH HEAL Initiative, 2021).
Bringing naloxone to people incarcerated in New York State prisons	New York 	A train-the-trainer overdose prevention training for people who are incarcerated, corrections staff and parole officers, and family members of incarcerated people. Additionally, corrections staff can distribute naloxone directly to individuals when released from prison (Anthony-North et al., 2018).
West Virginia 2020-2022 Substance Use Response Plan	West Virginia 	Law enforcement agencies are educated and trained on distributing naloxone (West Virginia Department of Health & Human Resources, 2020).
Washington State Department of Corrections	Washington 	Through a State Targeted Response to the Opioid Crisis grant, naloxone is provided to underserved and vulnerable populations. Community corrections staff have received naloxone kits and training to act as first responders (National Association of State Alcohol and Drug Abuse Directors, 2019).

Innovative intervention 2: In-reach to detention settings to facilitate warm hand-offs

Continuity of care is an important element when people in jail or prison are released back into the community – even more so for those living with mental health or substance use challenges. Transition planning by the jail or in-reach providers (e.g., peers, mental health or substance use treatment organizations, or other community-based organizations) improves reentry outcomes by planning for necessary services prior to release (SAMHSA, 2021e). These programs may also work with people in the gap period between receiving their medications on the inside and connecting with a treatment provider in the community.



How we have mitigated some of that risk [of a client not being able to see a provider immediately after release] is when [organization] provides treatment in the prison or the jail and somebody comes out, we will meet with them every day, every single day. Give them their medicine every single day. And facilitate getting them into the provider of their choice in their home community. So they might be a little uncomfortable trying to run around, and maybe we can find them recovery housing or something. But we will at least be able to give them their medicine and be sure that they will get to an intake appointment with someone within, two weeks is what we usually do. We like it to be sooner. (3)

Most are led by mental health or substance use treatment organizations, but a more novel approach is using community corrections officers for in-reach services while clients are incarcerated and/or prior to release.

I think just even that kind of like having a soft hand-off, I think is one step that really could be supportive, and kind of laid out in a way that really makes a lot of sense. I think one example, I think both Arizona and Utah, they have kind of like a reach-in, where like a probation officer will go into the prison 90 days before somebody gets released, to try to start building a case plan with them, building a rapport, and then once they get out, there is some contact, but even that first instance when they get out, sometimes they don't show up, you know there's lots of challenges with that, but I think having that kind of like — having some kind of transitional specialist, I think it doesn't exist in a lot of places and I think that there is a need for that kind of warm hand-off and like how do you — can you build incentives to support people coming to meet with you, so that you can actually help them get the kind of support they need. (6)



Table 2. Examples of In-Reach Programs

Program	Location	Description
<p>Alaska Rehabilitation and Reentry</p>	<p>Alaska</p> 	<p>Alaska Department of Corrections (AK DOC) uses institutional probation officers (IPOs) to help incarcerated individuals navigate in-custody program options and develop an Offender Management Plan. IPOs also provide a warm hand-off to field probation officers for those who are released to probation or parole (Alaska Department of Corrections, 2020).</p>
<p>Student Opportunity for Achieving Results (SOAR)</p>	<p>Oregon</p> 	<p>SOAR is an intensive transition program for high-risk men with SUD through a collaboration between the Community Corrections Division of the Marion County Sheriff’s Office, Marion County Health and Human Services, and Chemeketa Community College. Participants are identified by probation and parole officers who continue to work with all SOAR participants and provide enhanced supervision while helping individuals under supervision increase treatment adherence and access community resources like stable housing (Oregon Department of Corrections, 2021).</p>
<p>Offender Management in Custody (OMiC)</p>	<p>United Kingdom</p> 	<p>The OMiC model is a new framework to coordinate an individual’s journey through custody and back into the community. Probation staff work in prisons to develop sentence plans, conduct assessments, and facilitate interventions. They are the bridge to community probation services and reentry into the community (Her Majesty’s Inspectorate of Probation, 2021).</p>

Innovative intervention 3: Specialized caseloads

Some jurisdictions have implemented specialized caseloads for community corrections officers, where officers working with people under supervision with SUD receive specialized training. Depending on the agency, they may carry out a range of additional duties and receive corresponding training on topics such as treatment resources available in the community, administering naloxone, and training people under supervision and their personal networks to administer it as well. Community corrections officers with specialized caseloads tend to have smaller caseloads, with more time devoted to each person. Community corrections officers with SUD-specific caseloads tend to be more focused on public health outcomes than are other officers, according to one key informant.

I think that [in terms of the role of community corrections] it's like a mix between kind of that law enforcement and social work part of it. It really depends, I think, on how your jurisdiction handles their caseloads, whether or not it's a specialized caseload or if it's mixed. You know, I think that even though there's been so much research and kind of guidance that you should use more incentives, to sanctions in order to support behavior change, we know that a lot of probation officers just use sanctions and they, you know get so fed up with maybe noncompliance or the lack of perfection that people on supervision have when, you know, if they have a substance use issue. If they are, you know, if they were testing positive every week for the last six months and they are now moving into like every third week they're testing positive, I mean that should be supported as a move in the right direction as opposed to kind of sanctions, but I think that a lot of probation and parole officers don't necessarily have that mindset and those that do, you know may have — like run up against other challenges because their caseloads are so high, or maybe they don't have the support and resources within the community that can really help this person advance. (6)

Community corrections officers who have specialized SUD-specific caseloads are somewhat more supportive of rehabilitative responses than officers with non-specialized caseloads. While this might be an effect of self-selection bias, it may also be that specialized caseloads sensitize officers to rehabilitative approaches, or that additional training or exposure to treatment options as part of specialized caseload preparation increases support for rehabilitative responses. The last two possibilities suggest that rotating all community corrections officers through specialized caseload assignments may support a larger agency shift in the direction of rehabilitative approaches or additional training for officers supervising general caseloads (Belenko et al., 2018).

There's training for people who are on probation, and parole officers, if they are able to create substance use, specialized caseloads, those probation officers typically have, you know enhanced training in terms of how to treat relapses. (6)

Innovative intervention 4: Co-locating behavioral health with community corrections

Maricopa County (Arizona) has created a unique model that co-locates SUD treatment services and probation. The Human Services Campus in Phoenix is a collaboration of 16 partner organizations on 13 acres with seven buildings. One of the buildings, the Lodestar Day Resource Center, includes integrated health services (physical, mental, and substance use treatment) and Maricopa County Adult Probation, among other comprehensive, holistic services (Human Services Campus, 2021).

I would definitely say that Arizona's [co-location] program is unique. Because they have recognized that these particular individuals under supervision are in need of services and need to reduce any barriers to engaging in services. And so they're meeting people where they are. And that is important for any population...as a public health person, we're always told, "Meet people where they are. And don't make it burdensome for people to engage in services." And Arizona has recognized that through their program. (9)

FINDING 8: CLOSER COLLABORATIONS ARE NEEDED BETWEEN COMMUNITY CORRECTIONS AND HEALTH AND SOCIAL SERVICES PROVIDERS

Community corrections agencies need not take on a service delivery role. A survey of probation and parole officers did not perceive a need to take on this role, as addiction pharmacotherapy could be obtained from local providers (Friedmann et al., 2012). Rather, community corrections agencies need to work more effectively with community MOUD providers (Friedmann et al., 2012).

Stronger, more intentional collaboration between local treatment organizations and community corrections agencies is a critical method of supporting MOUD uptake and other EBPs (Friedmann et al., 2012), thereby reducing overdose (SAMHSA, 2019). Intentional, strategic interventions to improve relationships between corrections agencies and providers have proven useful and could be scaled (Friedmann et al., 2015).

Additionally, OEND trainings for people under supervision appear to be an effective way to quickly offer education when they check in to the office. To support this, community corrections agencies should establish partnerships with harm reduction organizations, like syringe services programs, that can provide this education.

The importance of partnerships between community corrections and other service agencies emerged during key informant interviews as one of the most critical aspects for success when initiating and maintaining overdose prevention interventions for people under supervision. Key informants acknowledged that overdose is too large a problem for any one agency to solve, and that working in siloes is not in the best interests of the agencies or the people they serve.

Key partners facilitating overdose prevention programs named in interviews include SUD treatment organizations, government public health agencies, harm reduction groups, pharmacists, state Medicaid officials, community mental health centers, judges, and family organizations. These relationships might be formalized via a contract or memorandum of understanding, or may be in the form of informal partnerships that convene on an ad hoc basis.

But the most critical partnership for key informants was often the relationship between community corrections and the treatment provider, who form the core team supporting the client:

It's about creating a holding environment for that individual in the community that is at risk for opioid overdose. So it's a holding environment. It's a close-knit community, and it starts with the provider and the probation officer. (3)

Collaboration idea 1: Ensure access to supportive services

Partnerships with organizations attending to basic needs like housing, food, and employment are essential to achieving baseline success and must work in tandem with interventions specific to overdose prevention for people under supervision.

[Successful referrals to community services] only happens with the partnership between probation and parole and community-based organizations that can actually tap [individuals under supervision] into things like food stamps and maybe rental assistance and things like that. So these are all major partnerships...it doesn't take individuals that are being released a whole lot to get knocked off the beam a little bit, and finding themselves in a place where they don't want to be. So the more connected that we are in the community with the providers...that can get us... access to food and housing and employment and those types of things. So, there should be a very fluid relationship between probation and parole and community-based organizations that really should have been developed over many years and should not be a big issue when we have new people coming in for services. Should be easy to connect people. (11)

Referring people under supervision to basic needs like housing, transportation, and employment services were seen as crucial aspects of community corrections that are protective against overdose.

I think it's kind of the same set of evidence-based practices [regarding overdose prevention] in terms of transitional connections between somebody who is incarcerated, into the community, making sure that their behavioral health issues are addressed, reinstating [Medicaid] when they get out, helping with ID, helping with housing and other issues that individuals may have when they're coming out of prison or out of an incarcerate setting. (6)

Participating in cross-sector collaborations with community-based organizations can raise awareness of available resources in a community and foster relationships between service providers. Understanding how different programs operate and how workflows are managed can provide key opportunities for linking people under supervision to additional resources.

SAMHSA's faith-based community initiatives are models for how effective partnerships can be created between federal programs and faith-based and community-based organizations (SAMHSA, 2021d). Faith-based organizations play a key role in increasing access to SUD treatment and mental health services in underserved or culturally diverse communities (SAMHSA, 2021d) and can be a partner in delivering overdose prevention services to people under supervision.

Collaboration idea 2: Leverage certified community behavioral health clinics

Certified community behavioral health clinics (CCBHCs) offer a key mechanism for coordinating, delivering, and often paying for substance use services for people involved with the criminal justice system. CCBHCs provide person-centered, integrated care regardless of ability to pay while absorbing costs for services such as screening and assessments and for court liaisons who are coordinating access to care (National Council, 2021a). As of 2021, there are more than 430 CCBHCs operating in 40 states, plus Washington, D.C. and Guam.

As part of their certification criteria, CCBHCs are required to have partnerships or formal contracts with criminal justice agencies and provide evidence-based practices for mental health and substance use treatment (SAMHSA, 2016). In fact, 95% of CCBHCs are engaged in one or more innovative practices (e.g., care coordination, training) in collaboration with law enforcement and criminal justice agencies (National Council, 2021b).

CCBHCs have the potential to improve criminal justice and health care outcomes through expanding access to MAT, with 70% of CCBHCs offering two or more forms of MAT, and providing decreased wait times for treatment (National Council, 2021b). Several key informants cited long waitlists and lack of capacity at local substance use treatment organizations as a barrier to accessing MOUD. Dramatically reducing wait times for services, 50% of CCBHCs offer same-day access to care and 93% report being able to set a first appointment within 10 days (National Council, 2021b).

We have every service that the individual might need in terms of helping their recovery. So we have the case management, we have the counseling, we have the peer, we have the medication...everything under that CCBHC umbrella of all their array of services that you need to address someone's behavior health needs. We have that, and we're able to provide that...And then in addition to being a CCBHC, we also happen to have a whole umbrella. We have a robust housing department, outreach areas, we're a health home...So I think it has helped in terms of knowing if I link this person here, as a CCBHC, they're going to automatically be linked and connected with all these services that's included in there. (2)



Relationships between CCBHCs and community corrections have not been fully documented; however, at least 5% of CCBHCs include corrections staff such as probation and parole officers as a part of a treatment team (Siegwarth et al., 2020). The majority (89%) of CCBHCs offer direct access to MOUD (with the remainder partnering with other organizations to deliver this service), compared with only 56% of substance use treatment organizations nationwide (National Council, 2021b). CCBHCs can be notable partners when looking to address social and structural barriers to care – they tend to be well-positioned within a community to create partnerships with community-based organizations that provide job training, housing, and other needed supports (National Council, 2021a).

Conclusion

Although some efforts exist to integrate evidence-based overdose prevention in community corrections, there are still challenges and barriers that need to be addressed. Based on environmental scan findings, recommendations for enhancing overdose prevention in community corrections — such as increasing training of community corrections staff on key topics related to overdose prevention, fostering effective collaborations between community corrections and health and social services providers, and making changes to community corrections policy to support recovery-oriented overdose prevention and response programs — offer a way to address those challenges and barriers.

Overall, there is still a need to shift the culture of community corrections to one that is more supportive of evidence-based practices for overdose prevention and in line with emerging best practices for community corrections broadly.

Community corrections should also consider reframing success measures from recidivism-only to more responsive outcome measures related to desistance and social re-integration (Butts & Schiraldi, 2018). In re-orienting toward these outcomes, interventions can focus on supporting desistance and allow for degrees of success even with setbacks (Butts & Schiraldi, 2018). For overdose prevention efforts to be successful in community correction settings, this type of reframing is essential as it aligns with an asset-based recovery orientation and promotes progress toward positive outcomes.

In addition, any changes to current practices should also employ a racial justice lens to understand the impact on communities of color, who are disproportionately represented in the criminal justice system. For example, how is drug testing being used within community corrections? Some communities are using drug testing to identify treatment needs rather than monitor violations of community supervision (Banister & Strom, 2021). Without careful planning and oversight, these more supportive interventions are more likely to be accessible to White persons under supervision than to communities of color.

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Appendix. Semi-Structured Interview Guide

Thank you for agreeing to participate in this interview. The National Council for Mental Wellbeing, with support from the Centers for Disease Control and Prevention (CDC), is collecting information to better understand best and promising strategies within community corrections to prevent overdose. Understanding your experience, innovative practices, resources used, and lessons learned is valuable information. Your input will help inform the development of technical assistance tools to support the implementation of evidence-based overdose prevention strategies for those who are participating in community corrections programs.

This interview is completely voluntary and will take no more than 60 minutes to complete. To facilitate information gathering, we would like to record the interview. The recording, transcript, and notes will not be shared with anyone outside of the project team. We will seek your permission to use any direct quotes in any materials that are developed.

Do we have your permission to record the interview?

Before we get started, are there any questions you would like to ask?

1. Could you describe your current role working with/within community corrections?
 - a. Is your organization a public or private entity?
2. What types of evidence-based overdose prevention strategies are currently offered for individuals under community supervision (e.g., MAT/MOUD and naloxone)?
 - a. How are they funded?
 - i. Are any of the services provided reimbursed through health insurance (e.g., Medicaid, Medicare, commercial insurance)?
 - b. What has been the impact of COVID-19 on overdose prevention services?
3. How did the program intervention/strategies come about?
 - a. Who championed the implementation of these efforts within your organization?
 - b. How were they successful in obtaining buy-in from leadership and other key stakeholders?
 - c. What resources, tools, or technical assistance did you find helpful when starting this work?
 - d. What types of resources, tools, or technical assistance do you wish you had when you started this work?
4. What is the role of the community corrections officer in implementing the strategies?
 - a. How adequate/effective is this role?
 - b. What tasks would you add or subtract from the role to help officers be more successful?

5. What challenges and barriers do community corrections-involved individuals face when accessing overdose prevention services?
 - a. How do corrections officers help individuals to address those barriers?
6. Do you currently partner with other organizations on your overdose prevention and response efforts?
 - a. Who are the main partners (e.g., CBHO/CCBHCs, OTPs, SUD-providers, RCOs, etc.)?
 - b. How did you get everyone at the table?
 - c. How do you continue to engage and collaborate with your partners to ensure they are able to fulfill their role?
7. What types of data or metrics are you monitoring?
 - a. Do you have any published/reported results?
 - b. What health/behavioral health outcomes are measured?
 - c. What justice outcomes are measured?
8. What are the most important lessons learned?
 - a. What have been the greatest facilitators of program success?
 - b. What are the greatest challenges to implementing your overdose prevention efforts?
9. Are there other innovative and successful overdose prevention efforts within community corrections that we should be aware of?

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