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# Corrections-Based Responses to the Opioid Epidemic:

Lessons from New York State's Overdose Education and Naloxone Distribution Program

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INSTITUTE OF JUSTICE

## From the Director

The numbers behind America's current opioid crisis are grim: 60 percent of all overdose deaths in 2015 involved an opioid, and overdose deaths from opioids increased nearly threefold between 2002 and 2015. The epidemic has received attention from the highest levels of government, with the president declaring it a public health emergency. As the opioid crisis has swept the nation, New York State has been especially gripped by its devastating effects—between 2014 and 2015 the overdose death rate in the state from synthetic opioids (other than methadone) grew more than 135 percent, the largest increase in the nation.

To combat opioid overdose deaths, the federal government has called for equipping first responders with naloxone, an overdose antidote that reverses opioid overdoses and can be administered by bystanders with minimal training. Naloxone is increasingly being distributed through public health programs and more and more states and cities are providing naloxone to police officers so they can be prepared to react to overdose situations in the field. All 50 states and the District of Columbia have passed laws providing some level of protection to people who prescribe, distribute, or administer naloxone.

One population that is perhaps more vulnerable to overdose than any other—those who have been recently released from incarceration—has largely been left out of these efforts. Yet the majority of people incarcerated in our nation's jails and prisons meet the criteria for drug dependence or abuse, and research shows that newly-released people face a dramatically increased risk of death from overdose due to their lowered tolerance during their period of abstinence in prison, combined with the stressors and lack of support that too often accompany reintegration into the community.

In light of these statistics, New York State instituted a novel overdose education and naloxone distribution (OEND) program in its correctional system, training

those who are incarcerated, their family members, and corrections staff to recognize and respond to the signs of opioid overdose, and making naloxone kits available to them. This report assesses the results of these efforts, and offers insights for other correctional systems seeking to implement OEND programs.

The results are promising—people who received the training significantly increased their knowledge about opioid overdose and their confidence in their ability to respond. They also responded to messaging about saving lives and many indicated they would take a kit in order to help their communities. Not everyone who was trained took a kit, however—some cited their distrust of the justice system and concerns about the laws designed to offer legal protections for people reporting an overdose. There are thus some areas where training can be strengthened.

While the opioid crisis must be confronted on many fronts, harm reduction strategies—public health efforts to address drug use that promote health and safety without requiring abstinence—like naloxone distribution offer one promising avenue toward eliminating unnecessary deaths, while giving the formerly incarcerated the tools and agency they need to keep themselves safe during the critical post-release period. It is our hope that this report will inspire other corrections systems to integrate OEND efforts into their opioid crisis responses, so that people who are incarcerated are given every chance to succeed as they reenter their communities.



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# Introduction

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The United States continues to be in the grips of a growing opioid epidemic. In August 2017, the Centers for Disease Control and Prevention (CDC) released new data reporting that more than 64,000 Americans died of drug overdose deaths in 2016—a 21 percent increase from 2015.<sup>1</sup> The most recent estimates from 2015 show that more than 60 percent of drug overdose deaths involve an opioid (which includes illicit drugs like heroin and fentanyl and prescription pain relievers like oxycodone, hydrocodone, codeine, and morphine)—and that overdose deaths involving opioids increased nearly threefold between 2002 and 2015.<sup>2</sup> Responding to these numbers, President Trump recently declared the opioid crisis a public health emergency, and the President’s Commission on Combating Drug Addiction and the Opioid Crisis released a final report with 56 recommendations, urging Congress to act quickly to provide appropriate funding for implementation.<sup>3</sup>

Comprehensive efforts had already been underway across the country to respond to the dramatic rise in opioid-related overdose deaths. Chief among these has been the increased availability and use of naloxone, an overdose antidote that reverses the effects of an opioid overdose and can be administered by bystanders with minimal training. Naloxone has been distributed to people who use drugs through public health programs since 1996, and is now increasingly available to first responders and the public. As of July 2017, all 50 states and the District of Columbia have naloxone access laws that provide some form of protection from civil and criminal prosecution for prescribers, dispensers, and laypersons who administer naloxone.<sup>4</sup> Naloxone is also becoming more readily available by prescription at local pharmacies, and the Federal Drug Administration has publicly supported naloxone as life-saving and has pushed initiatives to make over-the-counter versions available.<sup>5</sup> Furthermore, more and more cities and states are providing first responders, including police officers, with naloxone to save lives.

Naloxone distribution is one component of a harm reduction approach to combating drug use—a philosophy and set of practical strategies that promote public health and safety without requiring abstinence, and includes such strategies as law enforcement-led diversion and needle exchanges. As public health officials, harm reduction organizations, policymakers, and

advocates call for an increased supply of accessible and affordable naloxone, a small but growing group of corrections professionals across the country has started to implement jail- or prison-based overdose education and naloxone distribution (OEND) programs to serve people who are returning to the community following a period of incarceration. People involved in the criminal justice system have high rates of substance use disorders; new data from the Bureau of Justice Statistics estimates that 58 percent of people incarcerated in state prisons and 63 percent of the sentenced population in local jails meet criteria for drug dependence or abuse.<sup>6</sup> People who are incarcerated also face dramatically increased risk of death from overdose on their release due to their recent period of abstinence and the stress and inadequate economic and social

✦ **Corrections departments are well positioned to implement interventions that curb the heightened risk of overdose-related mortality following incarceration.** ✦

support that many experience during their reintegration into the community.<sup>7</sup> A widely-cited study in Washington State found that the relative risk of death from overdose within the first two weeks after release from prison was 129 times that expected in similar demographic groups in the general state population.<sup>8</sup> More recently, the Massachusetts Department of Public Health released findings from a statewide analysis of opioid-related deaths from 2013 to 2014 and found that people released from Massachusetts prisons were 56 times more likely to die of an opioid overdose than the general public.<sup>9</sup>

Given the acute dangers associated with the early reentry period and the high rates of substance use disorders among incarcerated people, corrections departments are particularly well positioned to implement interventions that curb the heightened risk of overdose-related mortality following incarceration. This report focuses on the novel efforts of New York State to implement an OEND program in the New York State Department of Corrections and Community Supervision—a program that teaches all soon-to-be-released people in state correctional facilities about the risks of opioid use, especially after periods of confinement; trains them in the use of naloxone; and offers it to them free of charge at release. The report also highlights key considerations for other jurisdictions interested in implementing OEND in their own correctional systems.

# New York State: A case study

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New York State has been dramatically impacted by the national epidemic of drug overdose deaths. Between 2009 and 2013, the total number of drug-related deaths rose by 40 percent across the state and, from 2010 to 2015, the age-adjusted drug overdose death rate increased from 7.8 to 13.6 per 100,000 residents.<sup>10</sup> Newly-released data shows that the rate of unintentional drug overdose deaths in 2016 reached 16.7 per 100,000 residents in New York State (excluding New York City) and 19.9 per 100,000 residents in New York City.<sup>11</sup> Opioids are involved in the majority of these deaths, and synthetic opioids other than methadone—such as fentanyl—count for a rising share of deaths: between 2014 and 2015 the overdose death rate from synthetic opioids other than methadone grew more than 135 percent in New York, the largest percent increase in the country.<sup>12</sup>

In response, the state has implemented a multipronged strategy to equip first responders and others likely to witness overdoses with the knowledge and tools to recognize and respond to overdoses using naloxone. As of 2015, there were more than 225 registered overdose prevention programs across the state, which had trained 75,000 overdose responders and reversed more than 1,800 overdoses.<sup>13</sup> To increase the distribution of naloxone into high-risk communities, public health and correctional leadership in New York State recognized the potential of expanding overdose prevention and naloxone access to individuals incarcerated in state prisons. In 2015, the New York State Department of Health (DOH), the New York State Department of Corrections and Community Supervision (DOCCS), and the Harm Reduction Coalition (HRC) partnered to develop a novel opioid overdose and prevention training program in New York State prisons (see “Bringing naloxone to people incarcerated in New York State prisons” at page 7). The program targets three key audiences for OEND.

- > **People who are incarcerated.** The OEND program targets all soon-to-be-released people who are incarcerated across the state’s 54 correctional facilities, training them to understand the risks of opioid use and to administer intranasal naloxone. Naloxone is offered to trained individuals when they are released from prison.

Notably, all soon-to-be-released individuals are offered the training and kits, not only those people documented to be drug-involved.

- > **Corrections staff and parole officers.** Recognizing that program success hinges partly on staff acceptance, and that substance use disorders do not exclusively impact people who are incarcerated, the state offers overdose prevention training to corrections staff and parole officers.<sup>14</sup>
  
- > **Family members of incarcerated people.** In partnership with Community Health Action of Staten Island (CHASI), a local community-based organization, Queensboro Correctional Facility offers OEND training to family members, further elevating the capacity of the community to respond to overdose. After family members are trained, they are offered naloxone.<sup>15</sup>

The training offered includes modules on a number of topics, including:

- > the risk factors for overdose, including using drugs at dosages your body may not be accustomed to following periods of sobriety and/or incarceration;
  
- > how to recognize when an overdose is occurring (for example, shallow breathing or skin discoloration);
  
- > what to do when witnessing an overdose, including calling 911, administering naloxone, and putting the person who is overdosing in a safe position;
  
- > how to assemble and use an intranasal naloxone applicator;<sup>16</sup>
  
- > an overview of legal protections for people using naloxone or summoning help when witnessing an overdose, like New York State's 911 Good Samaritan law (see "New York State's 911 Good Samaritan law" at page 20); and
  
- > a 15-minute educational video produced by HRC that reviews important lessons from the training curriculum and features DOCCS leadership endorsing naloxone.<sup>17</sup>

## Bringing naloxone to people incarcerated in New York State prisons

The development of New York State’s corrections-based OEND program was initiated by the Superintendent of Queensboro Correctional Facility, Dennis Breslin. Queensboro Correctional Facility is a minimum-security men’s prison located in Queens, New York that is primarily focused on community reentry for men who are within 90 days of release. Initially conceptualized as an effort to train corrections officers and other staff in overdose recognition and responses for use in their own lives, Superintendent Breslin quickly realized the program would also be relevant to individuals incarcerated in his facility. The program has two components.

- > **Overdose prevention training:** When the pilot program launched in February 2015, HRC conducted train-the-trainer trainings with corrections officers and program staff who were designated trainers. These trainers were certified by HRC to deliver the OEND training to their corrections peers as well as to the people who were incarcerated. As the program began to roll out across the state and, with an eye toward future sustainability, it is transitioning to a peer-to-peer model whereby incarcerated people themselves will become certified to deliver the

training and then will train their peers as a standard part of their reentry planning program.

- > **Naloxone distribution:** Since naloxone requires a doctor’s prescription, a “standing order” is necessary to legally distribute naloxone to incarcerated people within New York State prisons. A standing order is an order from a physician that can be carried out by other health care workers and, in some cases, laypersons, when predetermined conditions have been met.<sup>a</sup> By issuing a standing order in collaboration with DOH, the medical director of DOCCS was able to designate individuals—here, the corrections staff—who could distribute naloxone to incarcerated people who had received the OEND training.<sup>b</sup>

Since the program’s inception, more than 6,000 formerly incarcerated people have received kits. Furthermore, there have been 14 incidents of naloxone administration by formerly incarcerated people in the community using kits distributed to them on release. The popularity of the pilot led the state to expand the program statewide. As of June 2017, the OEND training was available at all 54 prisons located throughout New York State.<sup>c</sup>

<sup>a</sup> For non-patient specific prescribing and dispensing specifics of the law, see New York State Consolidated Laws, Public Health Law – PBH §3309 (opioid overdose prevention), <https://perma.cc/27D4-NH93>.

<sup>b</sup> The standing order also enables DOCCS nursing staff to administer naloxone by injection to any incarcerated person, staff member, or visitor suspected of an overdose without first obtaining a physician order. See Howard Zucker, Anthony J. Annucci, Sharon Stancliff, and Holly Catania, “Overdose Prevention for Prisoners in New York: A Novel Program and Collaboration,” *Harm Reduction Journal* 12, no. 1 (2015), 51-52, <https://perma.cc/YE4J-K9RS>.

<sup>c</sup> Data provided by NYS DOCCS, February 2018.

In 2016, the Vera Institute of Justice (Vera) partnered with the New York State DOH, DOCCS, and HRC to conduct a process evaluation of the state’s corrections-based OEND program. Vera’s six-month evaluation had three primary goals:

- > to understand the development and implementation of the OEND program as it began scaling across the state;
- > to describe early program results, measuring changes in knowledge and attitudes among corrections staff and incarcerated people; and
- > to provide suggestions for program improvement based on perceptions of key stakeholders and analysis of data showing people who do or do not take the kit when they leave custody.



## Methods and limitations

Vera's evaluation design relied on a mixed-methods approach, using both qualitative and quantitative data to answer the research questions. Data collection occurred between November 2016 and April 2017 and focused on two correctional facilities—Queensboro Correctional Facility and Wallkill Correctional Facility. Research activities included:

- > interviews with DOCCS, DOH, and HRC leadership, as well as with DOCCS staff who were integral to launching and expanding the program (n=19);
- > focus groups with incarcerated people who had received the training (n=5);
- > observations of family trainings (n=1) and trainings of incarcerated people (n=5);
- > anonymous pre- and post-training tests of incarcerated people (n=69); and
- > administrative data analysis on naloxone kit uptake among individuals leaving Queensboro and Wallkill Correctional Facilities.

For analysis of the qualitative data, the research team used Dedoose, an application that allows researchers to organize and analyze qualitative data, to identify major themes. All researchers on the team independently read through all the qualitative data collected (such as observation, interview, and focus group notes) and generated a list of main themes. The team used these themes to define codes related to impressions of the training, relevance to incarcerated people, and suggestions for improvement. Codes were refined in regular research team meetings and, after a complete code list was developed, two researchers independently coded the qualitative data. This process allowed Vera to understand how frequently themes arose, the relevance of particular topics, and the diverse perspectives of leadership, corrections and program staff, and incarcerated people who received the training.

For the administrative data, the research team provided DOCCS with data on all individuals from Queensboro and Wallkill Correctional Facilities who had taken a kit on release, including their names. DOCCS research staff then added to this file information on individuals who were released but did not take a kit. Next, demographic and other key variables such as length of stay, criminal offense, and release type were appended for both groups. Finally, DOCCS stripped identifying information from the data before returning a de-identified (anonymous) file to Vera. Vera researchers analyzed the de-identified administrative data to examine potential differences between those who took kits and those who did not.

Data collection was limited in a few ways. First, due to the short evaluation period, Vera researchers were only able to collect data from two DOCCS facilities, which were selected in collaboration with project partners. The limited geographic scope of the research may limit the applicability of findings across other prisons in the state. Second, analysis of administrative data on the number of individuals taking naloxone kits on release from custody was complicated by inconsistencies in the way facilities throughout the state tracked kit uptake (for example, only tracking the aggregate number of kits given out each month). This made it difficult to draw broader conclusions about whether any factors linked to individuals may be associated with kit uptake, such as the charges for which a person was sentenced. Finally, although Vera had originally intended to have DOCCS administer a brief, confidential paper-and-pencil survey to people leaving custody to better understand why people do or do not take naloxone when they are released, this data collection activity was stopped after it was reported by DOCCS that the surveys were discouraging people from taking the kits. The evaluation results do not include any analysis of the surveys that were collected prior to cessation of this activity.

Despite these limitations, the regularity with which core themes appeared and their overlap with some of the existing—albeit limited—literature on corrections-based OEND programs suggest that there are lessons from New York that can guide the expansion of these programs nationally.<sup>18</sup>

## Major themes and findings

Vera's evaluation uncovered five major themes.

- > People in all positions found the program to be relevant and empowering.
- > The training increased peoples' knowledge about overdose and confidence in administering naloxone.
- > Charge type (top charge in an individual's conviction) and release type (whether the person was released on parole, conditional release, or reached the maximum expiration date of their sentences) were significant predictors of whether someone took a naloxone kit at release.
- > Incarcerated people who said they would take the kit when released felt the potential to save a life and contribute to the public good trumped their fears of consequences for having the kit (for example, being in a situation while using the kit that might lead to a parole violation).
- > Trainees who said they would not take the kit cited their distrust of the justice system and concerns about the laws designed to offer legal protections for people reporting an overdose.

These themes and findings are discussed in detail below.

### Program relevance

The overwhelming theme that emerged in interviews, focus groups, and observations was that New York State's corrections-based OEND program is both relevant and empowering to people who work within DOCCS, as well as those who are incarcerated in the state's prison system. Conversations with leadership at DOCCS, DOH, and HRC emphasized the importance of this intervention as a public health response to a worsening opioid crisis, frequently referring to their own communities and the experiences people in custody have when they are released. Some DOCCS staff did cite concerns that distributing naloxone might encourage drug use on release. The available literature on prison-based take-home

naloxone programs indicates that these perceptions are not unique to New York State.<sup>19</sup> However, there is no data to suggest that the potential lack of negative consequences from drug use that naloxone affords encourages the misuse of opioids.

Even with this concern, most staff interviewed were supportive of the program. As one interviewee stated, “drug problems are an issue for everyone, not just people that are in prison,” while also highlighting that training people and equipping them to save a life with naloxone is one way to empower incarcerated individuals as they transition back to their communities. As one corrections officer said, “The value of [the program] is to put the power back into someone who does not have power—to save someone’s life who does not have power.... We are empowering people who otherwise wouldn’t be allowed to be empowered to do anything.”

People who were incarcerated expressed almost uniformly favorable views of the OEND program, a finding that echoes a recent summary of the available literature on this topic that those who participate in jail- and prison-based training programs have overall positive impressions of take-home naloxone programs.<sup>20</sup> Training participants emphasized the relevance of the training to their lives as people who come from neighborhoods and communities where drug use and overdose is common. Indeed, more than one-third of the 69 people who filled out the pre-test administered by Vera reported having witnessed an overdose in the past, and 9 percent of those individuals reported having used naloxone before. People also talked about having family members or friends who had overdosed, with one person saying, “It’s a terrible thing to lose someone to overdose. I saw my best friend die.” Such experiences provided the backdrop against which many focus group participants reflected on how meaningful it was to receive training that would equip them to save a life in the future. One person commented, “I know there’s active use in my family since I’ve been incarcerated, so I try to get in as much as I can from the training today. I know I’m gonna be around that, around the holidays. I don’t use myself. But if they’re using, I want to be able to save their life if I can.”

## Increased knowledge and confidence about responding to drug overdoses

Vera administered tests before and after naloxone training to 69 training participants to better understand whether the OEND program increased participant knowledge and confidence about responding to drug overdoses. Questions were designed to assess changes in knowledge around key topic areas covered in the training, such as how naloxone works and the steps one should take in the event of witnessing an overdose. Vera researchers found that the training program increased participants' understanding of overdose, naloxone, and legal protections available in New York State. Although only 13 percent of respondents answered more than half of questions correctly prior to receiving training, 73 percent were able to do so after the training. After receiving training, 94 percent of all respondents correctly identified the function of naloxone as stopping an opioid overdose (compared to 50 percent prior to the training), and 93 percent

✂ Vera researchers found that the training program increased participants' understanding of overdose, naloxone, and legal protections available in New York State. ✂

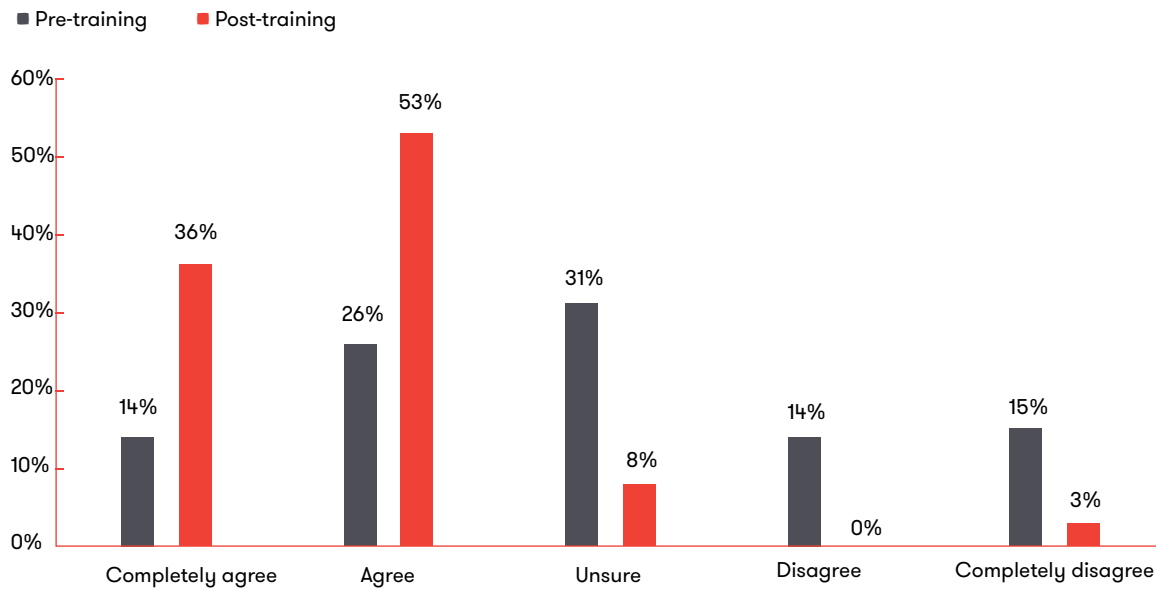
correctly identified that people leaving prison are at increased risk of overdose (compared to 51 percent before the training).

Furthermore, as shown in Figure 1, while before the training the majority of respondents reported a lack of confidence in their ability to assist in the case of an overdose, after receiving the training 89 percent responded that they either agreed or strongly agreed with the statement "I know how to help someone during an opioid overdose."



Figure 1

**Increase in opioid overdose knowledge after training:  
“I know how to help someone who is overdosing from an opioid.”**



### Kit uptake at release

Vera’s administrative data analysis revealed that more than two-thirds (68 percent) of incarcerated people who were trained in overdose prevention at Queensboro and Wallkill took a naloxone kit on release. Notably, Queensboro and Wallkill had different distribution strategies for naloxone kits, with Queensboro having people affirmatively opt in to take a kit at release and Wallkill placing the naloxone kit in the materials given to all releases and having people opt out of taking the kit if desired. This resulted in 59 percent of people taking kits at Queensboro and 88 percent of people taking kits at Wallkill.<sup>21</sup>

Vera also used the administrative data for people released from Queensboro between December 2016 and March 2017 to examine differences between people who took the kit and those who did not.<sup>22</sup> Table 1 describes demographic characteristics and other key factors for “kit takers” and “kit leavers.” The race-ethnic distribution within each group was similar, with more than half identifying as black, more than one-third as Hispanic, and less than 10 percent as white. Similarly among both kit takers and kit leavers, about 13 percent were under 25 years of age while almost one quarter were over 50. Just over one-third of kit takers, but fully one-half of kit leavers, had a length of stay of less than one year. The proportion of those convicted of drug selling was twice as high for kit leavers versus kit takers.

Table 1

### Characteristics of naloxone “kit takers” and “kit leavers” released between December 2016 and March 2017 from Queensboro Correctional Facility<sup>1</sup>

	Kit takers		Kit leavers		Significant differences <sup>2</sup> p value
	%	n	%	n	
<b>Race-ethnicity<sup>3</sup></b>					.72
White	5.9	14	8.6	14	
Black	55.3	131	51.9	84	
Hispanic	35.9	85	37.0	60	
Other	2.9	7	2.5	4	
	100.0	237	100.0	162	
<b>Age (years)</b>					.77
18-24	13.5	32	12.8	21	
25-34	28.7	68	30.5	50	
35-49	36.7	87	32.3	53	
50+	21.1	50	24.4	40	
	100.0	237	100.0	164	
<b>Offense category</b>					.02 **
Violent	38.4	91	31.7	52	
Other coercive	15.6	37	9.2	15	
Drug sales	11.4	27	21.3	35	
Property and other	24.5	58	26.8	44	
Youthful offense	0.8	2	0.0	0	
Juvenile offense	0.8	2	0.0	0	
Drug possession	8.4	20	11.0	18	
	100.0	237	100.0	164	
<b>Length of stay</b>					.03 **
< 1 yr	37.1	88	50.6	83	
1 - 2 yrs	37.6	89	30.5	50	
3 + yrs	25.3	60	18.9	31	
	100.0	237	100.0	164	
<b>Release type</b>					.01 **
Parole	31.7	75	45.7	75	
Conditional release	62.9	149	48.2	79	
Maximum expiration	3.8	9	6.1	10	
Other	1.7	4	0.0	0	
	100.0	237	100.0	164	

<sup>1</sup> Twenty-five people who took kits were excluded from this analysis because their ID numbers could not be linked to demographic and administrative data.

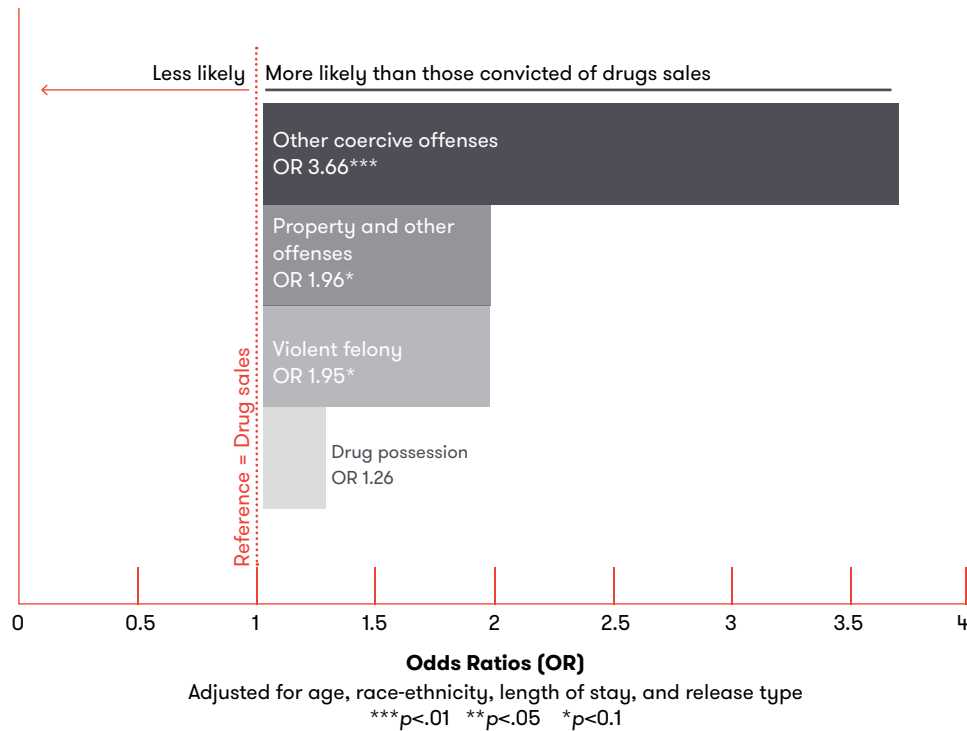
<sup>2</sup> Tests were conducted to determine whether there were statistically significant differences between takers and leavers. \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.10$ .

<sup>3</sup> Two people who did not take kits had missing values for race and were excluded from the race panel above.

Figure 2

### Association between offense type and kit taking

Those convicted of other offenses are more likely than those convicted of drug sales to take naloxone kits.



Further analysis was conducted using logistic regression to determine if length of stay, offense type, or release type were associated with the likelihood of taking a kit upon release when controlling for race-ethnicity and age.<sup>23</sup> Vera researchers calculated odds ratios (OR) to assess the strength of association between kit taking and variables such as length of stay, offense type, and release type.<sup>24</sup> Length of stay was not statistically significantly associated with kit taking. However, two other significant predictors emerged.

Figure 2 displays the associations between offense type and kit taking. Using drug sale offenses as a reference group, Vera researchers assessed whether people convicted of other offense types were more or less likely to take a naloxone kit upon release. Figure 2 shows that those convicted of other coercive offenses were statistically significantly more likely to take kits than those convicted of drug sales—in other words, the odds are more than three-and-one-half times greater (OR 3.66,  $p < .001$ ). Although not statistically significant, there was a similar trend among those convicted of property and other offenses (OR 1.96,  $p < 0.1$ ) and violent felony convictions (OR 1.95,  $p < 0.1$ ). The relative reluctance of those convicted of drug sales to take kits may be partially explained by the fear of future law enforcement contact and mistrust of the legal protections. (See “Reasons for refusing the naloxone kit at release” on page 18.)

Figure 3

### Association between release type and kit taking

Those released on conditional release were more likely than those released on parole to take naloxone kits.

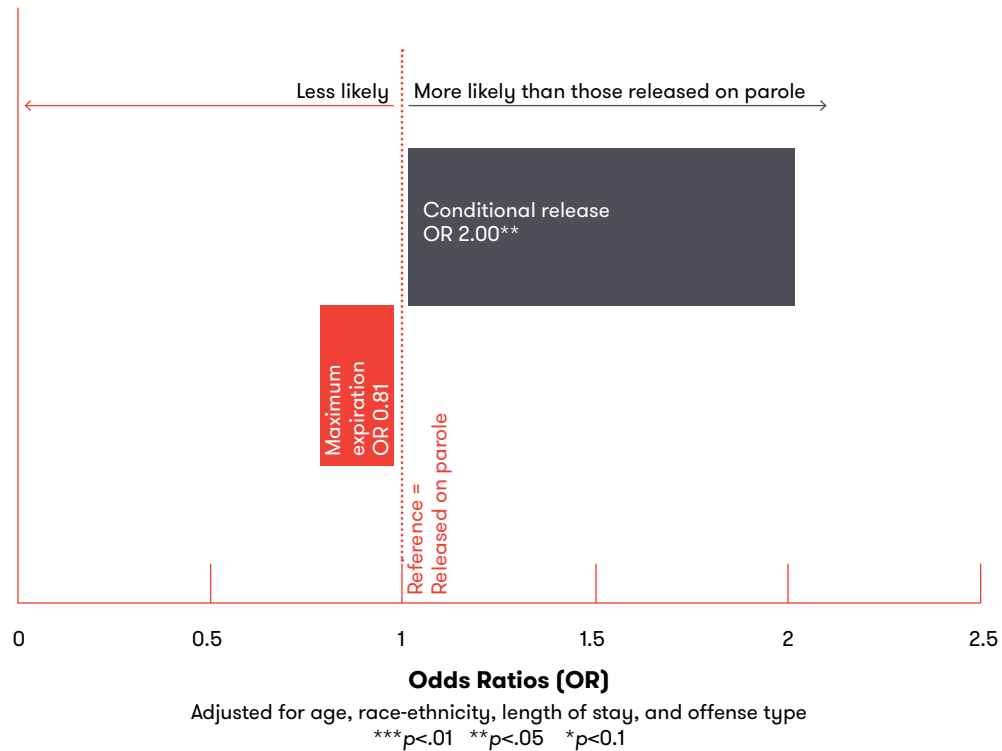


Figure 3 shows the associations between release type and kit taking. Using parole as a reference group, Vera researchers assessed whether people with other types of releases were more or less likely to take a naloxone kit. The results indicate that people released to the community through conditional release were statistically significantly more likely than those released on parole to take kits (OR 2.00,  $p < .05$ ). The result was not statistically significant for those released through maximum expiration of their sentences.

In New York State, the difference between “parole” and “conditional release” types is determined by whether the parole board is involved in the decision to release an individual.<sup>25</sup> In both cases, the individual is released to community supervision. However, while a release type of parole means that there was a parole board interview or hearing resulting in an individual's release, a release type of conditional release is based primarily on the individual's conditional release date calculation (typically two-thirds of the maximum expiration sentence for those who received indeterminate sentences). Although the results of the kit uptake analysis are preliminary, they suggest that some groups may be more likely to take kits than others. This points to the need for further research to help inform program design and improve uptake among target groups.

## Reasons for accepting the naloxone kit at release

Even with fears about potential legal consequences of using naloxone, the relatively high kit uptake rates suggest that many people are still willing to use naloxone on someone who is overdosing. Focus groups with OEND trainees and interviews with staff revealed that this willingness to accept a kit at release centered on the theme of “saving a life.” Some participants spoke of the potential, in the case of an overdose, to save the lives of family members who use opioids, while others referenced their own past history of either using or selling drugs. Even respondents who had used drugs in the past and did not plan to use after release voiced their intention to be prepared and the responsibility they felt to help members of their communities. One person reflected on this, saying, “I would feel less than a man knowing that I had an opportunity to be able to do something constructive and not take the chance. Nah, I can’t see [myself] doing that. Plus, me, I’m just different now.”

Vera also observed trainers talking about how saving a life was an opportunity for people to do good in their communities, especially as a

✂ **People released to the community through conditional release were statistically significantly more likely than those released on parole to take kits** ✂

tactic to refocus the training if participants were fixated on their fears and the intricate details of the 911 Good Samaritan law (see “New York State’s 911 Good Samaritan law” at page 20). Similarly, in focus groups and observations, Vera researchers heard people who were incarcerated use language around “saving a life” to talk to their peers about the benefits of taking the naloxone kit. One person said, “If you’re in a situation to save a life, to hell with it. Even if you will get in trouble, I’m not gonna walk by somebody dying and not do something if I can.” The emphasis on this from program participants suggests messages conveyed in training about saving lives and providing a public good are heard and internalized; people who are incarcerated and receive the OEND training overwhelmingly see naloxone as something that can benefit their communities at large, allow them to be valuable members of their communities, and be worth using even if it saves just one life.



## Reasons for refusing the naloxone kit at release

Focus groups with people who are incarcerated and observations of trainings also offered insights into why some people were reluctant to take the naloxone kit at release. Although a small number of people expressed they did not anticipate taking the kit because they did not use drugs or spend time with people who use drugs, most people talked about their fears of further involvement with the legal system. Two categories emerged.

- > **Law enforcement, parole, and probation.** People who were incarcerated talked frequently about their previous contact with police, parole, and probation officers—three categories of people who have the ability to arrest and detain individuals. While not every encounter with these justice system actors is negative, many people voiced a deep mistrust of these agencies and recalled personal experiences where they felt they were treated unfairly. These past experiences contributed to skepticism about the advisability of carrying the kit in the community, despite reassurances from trainers that police and parole officers know about naloxone and frequently carry the kit themselves, and that all parole officers are receiving the same OEND training through the Department of Corrections and Community Supervision (DOCCS). For example, one trainee talked about how he suspected that merely being in possession of the kit would give police officers more reason to search them for drugs, saying “... now you’re profiled; carrying that big, bulky, ugly bag in your pocket.” Others feared the possibility of receiving a parole violation—even though having or using the kit is not a parole violation in and of itself. As one training participant reflected, “They takin’ you to the station for more questioning. I’m [going to] leave the kit right here; I’m done. I seen data and people get violated for less.”
- > **Good Samaritan laws.** In addition to distrust of individual system actors, people who were incarcerated also described mistrust of the legal protections—known as Good Samaritan laws—that are designed to minimize fear of arrest and encourage people to call 911 when someone is having a drug or alcohol overdose. (See “New York State’s 911 Good Samaritan law” on page 20.) The feeling among many focus group respondents was that individuals on

parole are “not regular citizens” and are therefore not afforded the same protections as other people under the law. One person remarked:

The Good Samaritan law, they say they won't violate you, but who's to know that particular parole officer is in the loop? Now you gotta fight to get out of it even though there is the Good Samaritan law. How are they gonna apply it? If it's being used the same way courts use regular criminal activity, then I don't trust it. It might as well not exist. They can interpret it the way they want.... If you're the felon you don't ever get the benefit of the doubt. You can't sit there and tell the cop at the scene that you're claiming Good Samaritan. You have to wait and tell your PO, meanwhile you're sitting on Rikers Island waiting, and you might've had a job. It can get a little hairy in that situation.

Interviews with staff and leadership further revealed that trainers struggled to determine what to convey about the 911 Good Samaritan law and interactions with parole. Some trainers distributed detailed handouts that describe what the 911 Good Samaritan law covers in New York, while others talked about the law and its interactions with parole in more general terms, telling trainees that they would not receive a parole violation for drug possession, but could expect to be violated for things like being in possession of a gun or being out past curfew. The ambiguity of what the law does and doesn't cover, and how it protects or doesn't protect people with criminal records who are on parole, led some trainers to caveat the information they conveyed to trainees. For example, in one of the trainings Vera observed, a trainer said, “In all honesty, they say it [the 911 Good Samaritan law] will help you. You can believe it or not, it's up to you.”

## New York State's 911 Good Samaritan law

Signed into law by Governor Andrew Cuomo in 2011, New York's 911 Good Samaritan law offers New Yorkers criminal immunity from charge or prosecution for certain offenses if they witness or are a victim of a life threatening medical emergency and seek medical attention.<sup>a</sup> In limited circumstances, the law also protects against arrest for very small or residual amounts of controlled substances.<sup>b</sup> New York's law is broader than most other Good Samaritan laws because, in addition to applying to people who witness or are a victim of a drug or alcohol overdose, the law protects people who seek medical services for life threatening emergencies that are not drug- or alcohol-related.

Immunity is only applied to certain criminal offenses directly resulting from the individual seeking medical care. The offenses covered under the law include:

- > possessing controlled substances (anything under eight ounces);
- > possessing alcohol, where underage drinking is involved;

- > possessing marijuana (any quantity);
- > possessing drug paraphernalia; and
- > sharing drugs.

The law does not protect individuals from the following:

- > felony possession of a controlled substance (eight ounces or more);
- > sale or intent to sell controlled substances;
- > open warrants for one's arrest; and
- > violation of probation or parole.

The law also provides for an "affirmative defense"—or a defense which, if proven by the defendant, defeats or mitigates negative legal consequences—for criminal sale of controlled substance offenses. The affirmative defense protection does not apply to defendants who have prior Class A 1st or 2nd degree felonies or any Class B felony convictions.

<sup>a</sup>For the provisions of the law, see New York S04454 (2011), <https://perma.cc/G4FY-ZLRZ>.

<sup>b</sup>New York State Department of Health, *New York State's 911 Good Samaritan law Protects YOU* (Albany, NY: New York State Department of Health, 2016), <https://perma.cc/VV9L-LP6B>.

# Implementing corrections-based strategies

New York State's prison-based OEND program offers a number of lessons for other jurisdictions that are looking to implement similar corrections-based strategies to reduce opioid-related mortality for people leaving custody and promote multipronged approaches to the opioid epidemic. Key considerations center on program development and programmatic components.

## Program development

To develop a successful OEND program, a number of factors are important to address from the outset to avoid pushback from correctional leadership and staff, as well as the community at large. In interviews with leadership, DOCCS largely attributed programmatic success to three key factors: (1) having a

strong champion for the program; (2) focusing on staff buy-in at inception; and (3) forming key partnerships with community-based organizations.

## Identifying a champion

The New York State program required strong leadership from the beginning to ensure successful implementation and expansion. Administrators across DOCCS recognized the importance of this leadership, identifying the superintendent of Queensboro Correctional Facility as “a major driving force” in both getting the pilot off the ground and expanding the program statewide. Jurisdictions looking to pilot similar programs should identify a champion who:

- > understands the value of the program and can convincingly communicate its importance to stakeholders;
- > tackles obstacles with tenacity and creatively solves problems; and
- > has the respect of line staff, mid-level management, and agency administrators.

## Generating staff buy-in

Leadership in New York State emphasized the importance of having staff at all levels on board with the program, which was achieved by initially training staff on overdose prevention and distributing naloxone to them for personal use.<sup>26</sup> This approach to generating buy-in accomplished three goals.

- > **It brought agency leadership on board by centrally focusing the program on staff wellness.** In conducting overdose education training and distributing naloxone among corrections officers and other staff who work in facilities, DOCCS demonstrated its commitment to ensuring staff have the tools they need to lead healthy lives and promote wellbeing in their communities. This focus on staff wellness was appealing to agency leadership as well as to facility leadership, like prison superintendents, who live and work in communities throughout the state that are deeply impacted by the opioid crisis. Offering these managers tools to address the needs of their staffs and their communities was essential to generating excitement for the program, especially as the pilot expanded statewide.

> **It introduced important harm reduction concepts to staff.** Justice systems—and particularly correctional facilities—have historically responded to substance use disorders by relying on abstinence-based treatment options that require the cessation of all drugs in order to achieve recovery. In contrast, harm reduction hinges on the understanding that drug use is complex and encompasses a continuum of behaviors, that there are some ways of using drugs that are safer than others, and that negative consequences—like overdose death—can be reduced.<sup>27</sup> While many people interviewed continued to emphasize the importance of abstinence, staff also discussed their shifting attitudes regarding drug use. One corrections officer emphasized the need to equip incarcerated people with practical information, commenting, “There’s no point of telling them no, they can’t do it, it’s illegal. So let’s look at it with another aspect . . . let’s give you information and education on doing it safely . . . it’s hard to get them off [drugs] but maybe we can inform them to where they make proper decisions about what they do.” A different officer reflected on the need to separate substance use from a person’s worth. “You don’t need to be a good or bad person to overdose,” he reflected. Exposure to harm reduction principles through staff training allowed staff to see drug use not as a moral issue, but as one that requires a holistic approach to treatment and recovery.

> **It limited “us” versus “them” dynamics between corrections officers and incarcerated people within the facilities.**

In addition to engendering support for the program among correctional leadership, staff training also offered additional opportunities to build support with officers. In correctional settings, where resources are frequently devoted to programming for people who are incarcerated and where staff often work long hours, it is not uncommon for staff to feel as if their needs are not the priority of department leadership. In providing the same training to corrections officers and people who are incarcerated, DOCCS signaled to staff that their needs were equally as important as the needs of the incarcerated population. Furthermore, staff frequently addressed skepticism from incarcerated people toward naloxone in training settings, citing their own training and emphasizing the legitimacy of the training they were receiving.



## Partnering with community-based organizations

Community partnerships with the Harm Reduction Coalition (HRC) and Community Health Action of Staten Island (CHASI) were essential for launching and sustaining the New York State program. HRC provided train-the-trainer trainings to DOCCS trainers and created supplemental training resources, like the production of a video that is shown during trainings; and they continue to be instrumental partners as the program expands statewide. CHASI, on the other hand, conducts training for the family members of incarcerated people at Queensboro Correctional Facility. For jurisdictions looking to pilot similar programs, building strong partnerships with community-based harm reduction and public health organizations, as well as primary care providers, is an important first step in constructing the training curriculum, solving challenges unique to each agency and community, and developing sustainability mechanisms.

## Programmatic components

Beyond the design of the program, jurisdictions implementing corrections-based programs should consider a number of logistical factors that can contribute significantly to programmatic successes and failures. Focus groups with incarcerated people in New York State cited a number of elements of the OEND training that either served to facilitate the training lessons or created barriers to learning.

### Training delivery

Observations of trainings for incarcerated people and family members, as well as focus groups with people who were incarcerated, indicated that the method of training delivery was an important factor in its success. Jurisdictions seeking to implement similar programs should:

- > **Emphasize discussion.** Observations of trainings revealed that some instructors delivered the training in a rigid format, sometimes reading off a script or addressing bullet points, which limited opportunities for discussion. In contrast, other trainers were more comfortable with a flexible approach to communicating training materials, frequently asking trainees to discuss their personal experiences with the subject matter and allowing enough time for questions and dialogue. Focus groups suggested

discussion-based formats may be more successful; and multiple people talked about how having an “open conversation” would be more productive.

- > **Find credible messengers.** Another important consideration for jurisdictions is the credibility of the individual delivering the training. With the exception of one observation of a peer-led training at Wallkill, all trainings Vera observed were led by program and security staff. Focus group respondents cited tensions between security staff and incarcerated people as being counterproductive to the training’s effectiveness, saying that their distrust of security staff made them have a difficult time believing staff were invested in their success. Furthermore, incarcerated people questioned the credibility of DOCCS-sponsored information, believing that the information may be out of date and that security staff were communicating information that was beyond their areas of expertise. Both staff and incarcerated people suggested that the most effective trainers would be those with some experience of addiction, overdose, or naloxone. One focus group participant, when discussing the prospect of having someone who is incarcerated conduct the training instead of DOCCS staff, said, “I think they can reach and communicate better. They feel our pain. And they can get the message across.” Finding credible messengers has the added benefit of mitigating any fears of taking the naloxone kit; by ensuring the training is delivered by someone incarcerated who people trust and respect, jurisdictions can address fears proactively. If a jurisdiction includes information regarding Good Samaritan laws in the training, instructors should be well-trained on the law, should have access to supplemental materials (such as handouts and FAQs) that can be shared with trainees, and should be prepared to facilitate discussions about what the law does and doesn’t protect.

## Timing and location of the training

To ensure information presented is retained, feedback gathered in focus groups indicates that training should be conducted at a time when people are not otherwise unsettled. For example, given the short lengths of stay for many of the people who are incarcerated at Queensboro Correctional Facility, the OEND training is provided at intake orientation. While this method ensures that all people in the facility receive the training before they

are released, it is also a time that can be hectic and stressful. Indeed, Vera heard from some people that they did not remember the OEND training conducted during intake orientation at all until they were reminded by their peers. If—due to administrative and logistical reasons—it is not possible to avoid conducting trainings during an otherwise chaotic time period, jurisdictions should consider strategies to mitigate those factors, such as supplemental trainings or reminder notifications prior to release.

## Reinforcing lessons

Finding ways to reinforce training materials is an important consideration for jurisdictions implementing corrections-based OEND trainings, and methods should be employed with fidelity. Interviews and focus groups in New York State revealed people appreciate opportunities to reinforce the information provided during trainings. The New York State program accomplished this in two ways.

- > **Hands-on training.** Having the ability to practice assembling the naloxone kits as part of the training, rather than only observing a demonstration of it, was widely cited—by staff, leadership, and people who are incarcerated—as the most important training component. Some people talked about how having the opportunity to put the kit together helped give them “confidence” they could do it on their own, without having to read the instructions, when an emergency was occurring. Other people talked about how many “people learn better hands on.” In addition to being able to practice assembling the kits, people also recommended incorporating other props, like rescue dolls, to better demonstrate key concepts such as rubbing the sternum with the knuckles to stimulate an overdosing person, the recovery position, rescue breathing, and chest compressions.<sup>28</sup>
  
- > **“Staying Alive on the Outside (New York State)” (<https://vimeo.com/164337787>) training video.** The inclusion of a brief video in trainings allowed DOCCS to include perspectives on naloxone and overdose prevention from people who would not be able to present at every training, like a person who used naloxone to save someone’s life while they were on parole. Focus group participants said they responded well to hearing from people they could relate to:  

The video was good. It was people from our neighborhoods, you could just see. Not some

doctors sitting there. A lot of time that creates a wall; using words we don't know. It had people just like us—ex-prisoners, ex-cons, people in the community that might never been arrested but in the cycle of drug addiction.

If a video is used in conjunction with the training curriculum, jurisdictions should ensure that trainers are equipped with the appropriate technology, and trainers should do their best to create an environment conducive to watching the video (by, for example, making sure the volume is at an audible level, pulling the television close enough to be seen, and darkening the room if needed).

## Family involvement

As with many aspects of reentry, family involvement is an important component of success when people are released from custody.<sup>29</sup> Studies indicate family engagement is critical for ensuring people have access to housing, social, and financial support—important ingredients for success for everyone, including those who are reentering the community after a period of incarceration and people who have a substance use disorder.<sup>30</sup> Offering family members training provided a number of benefits in New York, including:

- > **Incentivizing training.** At Queensboro Correctional Facility, the opportunity for a visit with family is the primary way in which this training is marketed, and it appears to be a successful technique. Queensboro Correctional Facility reported that as of February 2017, approximately 169 visitors had been trained on overdose prevention.
- > **Encouraging larger conversations about drug use.** Vera staff observed family members encouraging people who are incarcerated to take the naloxone kit when they are offered it at release.
- > **Increasing the number of kits in the community.** The family trainings had high rates of kit uptake. Of the 169 visitors that Queensboro Correctional Facility reported had received training on overdose prevention, approximately 152 kits had been taken. During Vera's observations of the family trainings, some family members took more than one kit in order to have additional kits in their home

When implementing family trainings, jurisdictions should consider the proximity of correctional facilities to the communities where the incarcerated population is returning. Investing resources into developing a family training when the incarcerated population cannot easily have visitors due to distance or travel costs is not likely to be worthwhile, though those facilities may consider offering trainings when families are more likely to visit (for example, on holidays). For jurisdictions that are proximate to reentry communities, family trainings should be offered at times that are convenient for family members in order to optimize participation. Additionally, jurisdictions should consider sustainability mechanisms, including budgeting staff time to scheduling trainings and forming partnerships with community-based organizations.

## Distribution methods

Unlike community-based initiatives, where naloxone kits are typically distributed directly following the training, corrections-based settings require a delay between the initial training and the actual distribution of naloxone, since naloxone is distributed at the time of release from custody and trainings are conducted while people are still incarcerated. Distribution mechanisms influence the rate of kit uptake, and jurisdictions should consider the goals of their program when determining which mechanism makes the most sense for them. Depending on the facility, DOCCS uses both an opt-in system, where people leaving custody are offered the kit at the time of release and individuals may choose to either take or leave the kit; and an opt-out system, where kits are included in a person's belongings and an individual has to ask to have it removed. Both systems have their advantages and their disadvantages: the opt-in system allows people who feel like the kit will be most relevant to them to take it, while people who don't think the kit will be useful can leave it behind, thus conserving available kits; the opt-out system allows wider distribution, even if some people taking the kit are unlikely to ever encounter a situation where it would need to be used. If a jurisdiction has a limited supply of kits, the opt-in system may be helpful in reserving kits for those who are most likely to use them. If naloxone kit availability is not a concern, the opt-out system is likely the most effective option for wide distribution.<sup>31</sup>

## Helpful resources for jurisdictions implementing corrections-based naloxone distribution programs

The following resources provide useful information and programmatic tools for jurisdictions seeking to implement naloxone distribution programs through their correctional systems:

- > **“Staying Alive on the Outside (New York State).”** (<https://vimeo.com/164337787>) This video can be used as part of a corrections-based naloxone distribution training program. It explains the risk of post-release overdose and teaches viewers to recognize and prevent opioid overdoses.
- > **New York State’s opioid overdose prevention program.** (<https://perma.cc/9FQP-F6X9>) This website from the New York State Department of Health provides resources for the public and providers on naloxone distribution and opioid overdose prevention.
- > **Harm Reduction Coalition’s overdose prevention website.** (<https://perma.cc/5WS3-GDJK>) This clearinghouse provides information about preventing drug overdose, including tools and best practices related to naloxone and opioid overdose.
- > **New York State’s 911 Good Samaritan law fact sheet.** (<https://perma.cc/VV9L-LP6B>) This single-page handout from the New York State Department of Health explains in lay terms the legal protections provided to individuals who call 911 if they are either experiencing an overdose or witnessing someone overdosing and require emergency medical care.
- > **State-by-state guide on naloxone access laws and Good Samaritan laws.** (<http://www.pdaps.org/>) The Prescription Drug Abuse Policy System is funded by the National Institute on Drug Abuse to track key state laws related to prescription drug abuse. Users can navigate the interactive website to see whether their jurisdiction has naloxone access laws and Good Samaritan laws.

## Conclusion

Expanding access to naloxone is widely recognized as a critical strategy for tackling the opioid epidemic. The President’s Commission on Combating Drug Addiction and the Opioid Crisis recently recommended that naloxone be made as widely accessible as possible, urging the president to issue a federal mandate that all law enforcement officers carry it and to empower the Health and Human Services Secretary to negotiate reduced pricing for governmental units.<sup>32</sup> While these recommendations should undoubtedly be implemented, ensuring that naloxone is available where there is the greatest chance for an overdose also requires more focused attention on distribution to populations that have increased risk of overdose mortality. To achieve this will require closer attention to incarcerated populations and a broader commitment to ensuring that people who are incarcerated have naloxone on hand when they return to the community. The evidence is too extensive—and the consequences too great—to ignore the needs of incarcerated individuals during such a critical period of transition.

The New York State OEND program is a milestone collaboration between a state's correctional system, its public health department, and community-based harm reduction programs. It is the first state correctional system in the country to implement such a comprehensive approach throughout its facilities, and it joins only a handful of jail-based programs to make naloxone accessible to individuals as they return to the community following a period of incarceration. Importantly, this process evaluation has demonstrated that a corrections-based OEND program is acceptable to a wide range of stakeholders and feasible within the correctional environment. Vera's evaluation found that people in all positions found the program to be relevant and empowering, and that incarcerated people who received training increased their knowledge and confidence about overdose and administering naloxone. Furthermore, the palpable ideal of saving a life led almost all incarcerated people Vera staff spoke with to anticipate taking a naloxone kit on their release.

Increasing the number of corrections-based OEND programs is a critical strategy for combating the opioid epidemic and can save the lives of formerly incarcerated people as well as members of their families and communities. But there is work to be done. Capitalizing on the increased need to develop viable strategies that will stem the rising opioid-related death toll, criminal justice stakeholders should push for developing OEND programs in their correctional facilities that can impact public health and safety. At the same time, concrete guidance is needed for those jurisdictions that can develop the support for such programs—guidance on topics ranging from how to partner with public health departments and community-based harm reduction organizations, to how to develop standing orders for naloxone distribution, to how to best share information about Good Samaritan laws so that formerly incarcerated people have a realistic sense of the legal protections afforded to them. The experience of New York State demonstrates that, with additional guidance, many other states can develop OEND programs within their correctional systems and contribute to a comprehensive response to the opioid epidemic in this country.



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## Endnotes

- 1 Centers for Disease Control and Prevention, *Provisional Counts of Drug Overdose Deaths, as of 8/6/2017*, <https://perma.cc/JX4K-BT53>.
- 2 Rose H. Rudd, Puja Seth, Felicita David, and Lawrence Scholl, “Increases in Drug and Opioid-Involved Overdose Deaths—United States, 2010-2015,” *Morbidity and Mortality Weekly Report* 65, no. 50-51 (2016), 1445-52, <https://perma.cc/GMP6-CLDS>.
- 3 The White House, “President Donald J. Trump is Taking Action on Drug Addiction and the Opioid Crisis,” press release (Washington, DC: The White House, October 26, 2017), <https://perma.cc/MW53-FLSM>; and The President’s Commission on Combating Drug Addiction and the Opioid Crisis (President’s Opioid Commission), *The President’s Commission on Combating Drug Addiction and the Opioid Crisis: Final Report Draft* (Washington, DC: President’s Opioid Commission, 2017), <https://perma.cc/68JV-H6D6>.
- 4 The Network for Public Health Law, *Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan laws* (Edina, MN: Network for Public Health Law, 2017), <https://perma.cc/4MWL-4SXX>
- 5 Karen Mahoney, “FDA Supports Greater Access to Naloxone to Help Reduce Opioid Overdose Deaths,” *FDA Voice*, August 10, 2016, <https://perma.cc/5YAT-X7FS>.
- 6 Jennifer Bronson, Jessica Stroop, Stephanie Zimmer, and Marcus Berzofsky, *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009* (Washington, DC: Bureau of Justice Statistics, 2017), <https://perma.cc/4CQ7-JEVV>.
- 7 Sarah E. Wakeman, Sarah E. Bowman, Michelle McKenzie, et al., “Preventing Death Among the Recently Incarcerated: An Argument for Naloxone Prescription Before Release,” *Journal of Addictive Diseases* 28, no. 2 (2009), 124-29.
- 8 Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, et al., “Release from Prison—A High Risk of Death for Former Inmates,” *New England Journal of Medicine* 356 no. 2 (2007), 157-65, <https://perma.cc/7QPN-7TGO>.
- 9 Massachusetts Department of Public Health, *Data Brief: An Assessment of Opioid-Related Deaths in Massachusetts 2013-2014* (Springfield, MA: Massachusetts Department of Public Health, 2016), 6, <https://perma.cc/2MMM-B25A>.
- 10 For the increase in the number of drug-related deaths, see New York State Department of Health AIDS Institute, *Opioid Poisoning, Overdose and Prevention: 2015 Report to the Governor and NYS Legislature* (New York: New York State Department of Health, 2015), 1, <https://perma.cc/785F-J4GQ>. For the increase in the age-adjusted drug overdose death rate, see Centers for Disease Control, National Vital Statistics System, *Mortality*. CDC WONDER. (Atlanta, GA: US Department of Health and Human Services, CDC; 2016), <https://perma.cc/4D4U-WJKA>.
- 11 For the drug overdose death rate in New York State, see New York State Department of Health, *New York State – County Opioid Quarterly Report* (Albany, NY: New York State Department of Health, 2017), 8, <https://perma.cc/S5XW-LPQC>. For the rate in New York City, see New York City Department of Health and Mental Hygiene, “Unintentional Drug Poisoning (Overdose) Deaths in New York City, 2000 to 2016,” *Epi Data Brief*, June 2017, no. 89 (2017), <https://perma.cc/6F4A-J3GZ>.
- 12 Rudd et al., 2016. Also see New York State Department of Health AIDS Institute, *Opioid Poisoning, Overdose and Prevention: 2015 Report to the Governor and NYS Legislature* (New York: New York State Department of Health, 2015).
- 13 Howard Zucker, Anthony J. Annucci, Sharon Stancliff, and Holly Catania, “Overdose Prevention for Prisoners in New York: A Novel Program and Collaboration,” *Harm Reduction Journal* 12, no. 1 (2015), 51-52, <https://perma.cc/5MJX-Z5NE>.
- 14 For the training of corrections officers, the focus was on potential naloxone kit use in their personal lives, not on training them to use naloxone within the prison environment if witnessing an overdose by an incarcerated person.
- 15 As of the time of this writing, family training is only offered at Queensboro Correctional Facility. The partnership with CHASI provides for CHASI staff to run the trainings and administer naloxone directly to family members. This is critical since the standing order passed by DOCCS only covers incarcerated people—not their family members. See “Bringing naloxone to people incarcerated in New York State prisons” on page 7 for additional information on the standing order.
- 16 Naloxone can be administered either through the nose, using a nasal spray (intranasal naloxone), or by injecting the naloxone into a muscle, using a syringe. In New York



- State, intranasal naloxone is distributed to people leaving DOCCS custody.
- 17 The video, “Staying Alive on the Outside (New York State),” covers the same topics as the training curriculum. It features the Acting Commissioner of DOCCS, a regional director of community supervision, peer educators, and a person who used naloxone to save someone’s life while they were on parole. It can be viewed at <https://vimeo.com/164337787>.
  - 18 For a comprehensive review of take-home naloxone programs in correctional settings, see Meredith Horton, Rebecca McDonald, Traci C. Green, et al., “A Mapping Review of Take-home Naloxone for People Released from Correctional Settings,” *International Journal of Drug Policy* 46, no. 1 (2017), 7-16.
  - 19 See Arun Sondhi, George Ryan, and Ed Day, “Stakeholder Perceptions and Operational Barriers in the Training and Distribution of Take-home Naloxone within Prisons in England,” *Harm Reduction Journal* 13, no. 1 (2016), 5-12; and Alexander R. Bazazi, Nickolas D. Zaller, Jeannia Jiani Fu, and Josiah D. Rich, “Preventing Opiate Overdose Deaths: Examining Objections to Take-home Naloxone,” *Journal of Health Care for the Poor and Underserved* 21, no. 4 (2010), 1108-13.
  - 20 Horton et al. (2017).
  - 21 Vera worked with leadership at Queensboro and Wallkill DOCCS facilities to gather administrative data related to kit uptake and people released. The administrative data available for each facility was different due to differences in data collection. At Queensboro, data were analyzed for the period December 2016 to March 2017 and revealed that 59 percent of 401 people released took a kit. At Wallkill, data was analyzed for the period February 29, 2016 to March 30, 2017 and showed that 88 percent of 177 people released during this period took a kit. (Wallkill data did not include people released in January 2017; no kit distribution occurred during this month due to a recall on naloxone).
  - 22 Due to the opt-out system of kit distribution at Wallkill Correctional Facility, which resulted in much higher kit acceptance rates than the opt-in approach, Vera researchers only analyzed the demographics of kit takers and non-kit takers at Queensboro Correctional Facility.
  - 23 Logistic regression is a statistical method that tests whether the factor of interest (such as release type) predicts successful kit taking, while controlling for the influence of additional factors (such as age) that may also affect kit taking.
  - 24 Odds ratios are used to assess the relative strength of associations. An odds ratio greater than one indicates higher odds of kit taking.
  - 25 New York State Department of Corrections and Community Supervision (DOCCS), “New York State Parole Handbook,” <https://perma.cc/8HCR-N3WW>.
  - 26 The importance of staff engagement and support also emerged as a critical factor for program success in a recent study of a take-home naloxone program in 10 prisons in the United Kingdom. See Sondhi, Ryan, and Day (2016).
  - 27 Jim Parsons and Scarlet Neath, *Minimizing Harm: Public Health and Justice System Responses to Drug Use and the Opioid Crisis* (New York: Vera Institute of Justice, 2017), 5, <https://perma.cc/8AGG-NJQQ>.
  - 28 New York State’s training program does not currently use props other than the naloxone kit. When asked about how they would improve the training, a number of people who are incarcerated suggested incorporating other props.
  - 29 Rebecca L. Naser and Nancy G. La Vigne, “Family Support in the Prisoner Reentry Process: Expectations and Realities,” *Journal of Offender Rehabilitation* 43, no. 1 (2006), 93-106.
  - 30 See Marta Nelson, Perry Deess, and Charlotte Allen, *The First Month Out: Post-Incarceration Experiences in New York City* (New York: Vera Institute of Justice, 1999), <https://perma.cc/8CGP-KJG9>; and Alicia S. Ventura and Sarah M. Bagley, “To Improve Substance Use Disorder Prevention, Treatment and Recovery: Engage the Family,” *Journal of Addiction Medicine* 11, no. 5 (2017), 339-41.
  - 31 There is emerging literature on opt-in versus opt-out strategies for providing naloxone kits, with recent research about pharmacy-distributed naloxone finding that an opt-out strategy can improve naloxone provision and reduce stigma. See Traci C. Green, Patricia Case, Haley Fiske, et al., “Perpetuating Stigma or Reducing Risk? Perspectives from Naloxone Consumers and Pharmacists on Pharmacy-Based Naloxone in 2 States,” *Journal of the American Pharmacists Association* 57, no. 2 (2017), S19-S27.
  - 32 The President’s Commission on Combating Drug Addiction and the Opioid Crisis, *Final Report Draft* (2017).



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