Creating Reach Beyond the Jail Walls: An Implementation Guide for Harm Reduction Re-Entry Wrap Around Services Programs

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Table of Contents

An Introduction to Harm Reduction Re-Entry Wrap Around Services

The ongoing and intersecting social problems of the war on drugs and the overdose crisis have had severe negative impacts on public health for years. An unpredictable illicit drug supply, contaminated with fentanyl and other dangerous adulterants, has only worsened an already high risk of overdose among people who use drugs (PWUD). At even higher risk of adverse outcomes from substance use are individuals who have recently been released from incarceration. Evidence has shown that people who use opioids and are involved in the criminal justice system have a 10-40% greater risk of overdose after release from incarceration compared to the general public[1]. This heightened vulnerability is due to a decreased tolerance for opioids as a result of unexpected detoxification and imposed abstinence during incarceration, followed by a subsequent return to use in the community upon release. We can mitigate these potential harms, however, by providing access to Medication Assisted Treatment (MAT, including buprenorphine, methadone, and naltrexone), also known as Medication for Opioid Use Disorder (MOUD)[2], for incarcerated individuals with opioid use disorder (OUD), and to concrete support for safe and successful re-entry to the community provided through a harm reduction lens. This document is intended to guide community-based harm reduction organizations seeking to provide such support for incarcerated PWUD through collaboration with local correctional facilities. The information presented is based on the experience of Albany Catholic Charities Care Coordination Services (CCCCS), a harm reduction organization that has been implementing their own *Harm Reduction Re-Entry Wrap Around Services Program* since January 2019 and began formally evaluating the program in December 2019.

The provision of wrap around re-entry services to incarcerated individuals with OUD or other problematic substance use, ideally but not necessarily in combination with MOUD, can significantly reduce the individuals' risk of overdose post-release, and support their successful re-entry to the community. Providing wrap-around services means engaging individuals in client-centered case management for safety and post-release planning, as well as offering harm reduction education and support for the consistent use of strategies to reduce the risk of overdose. Services are delivered by conducting both in-reach within the jail walls while the individuals are incarcerated, and outreach to follow up in the community post-release. While in jail, clients of CCCCS' Harm Reduction Re-Entry Wrap Around Services program, for example, receive overdose education and naloxone distribution (OEND), safety planning, and release planning. Post-release, clients receive transportation to obtain MOUD prescriptions, help

[1] Substance Abuse and Mental Health Services Administration. 2019. *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*. HHS Publication No. PEP19-MATUSECJS. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf.

[2] Note that while pharmacological treatment for opioid use disorder has historically been referred to as "Medication Assisted Treatment" (MAT), there has been a more recent shift to the preferred language of "Medication for Opioid Use Disorder" (MOUD), since it precisely describes the treatment form and carries less stigma. While many valuable resources still use the term "MAT," this guide will refer to it as "MOUD" hereafter, following emerging best practice and helping to shift our language away from stigmatizing terms. Thanks to the University of Michigan Injury Prevention Center for their contribution to this valuable distinction.

applying for medical coverage and obtaining needed healthcare, assistance with enrollment in public benefit programs and finding affordable housing, support in reaching out to estranged loved ones, aid in finding a treatment program that meets their needs, as well as needed support and encouragement throughout the process. Crucially, all services are "low-threshold" and client-driven every step of the way. Providing services with a low threshold approach means removing as many potential barriers or requirements as possible in order to encourage participation in whatever way an individual is comfortable or capable.

As results from our ongoing evaluation have demonstrated over the past two years, these wrap-around services are essential to supporting successful re-entry and reducing the risk of overdose post-release. In our project's second year, self-reported overdose decreased from 41.3% at intake to 2.6% and 0.0% at 2-week and 1-month post-release follow-up periods, respectively. (Additional evaluation highlights are shared below.) We firmly believe in the value of "beyond the jail walls" coordination – that re-entry services start in the correctional facility but then must also push beyond the walls, into the community, to follow the client as needed. We know that by engaging with clients inside the jail when possible and reaching out upon and post-release, these Re-Entry services improve and save lives.

Correctional facilities alone often lack the capacity and expertise to support individuals returning to the community, missing the needed reach beyond the jail walls. In order to reduce risk of overdose post-release, it is essential to provide continuity of care for MOUD, as well as wrap-around supportive services for basic needs such as housing, medical care, transportation, employment, and more. This is in addition to release planning, sustained education on harm reduction and safer use strategies, and naloxone distribution upon release. Community-based harm reduction organizations can and should collaborate with local jails and prisons to meet this need.

Re-Entry Services by Albany Catholic Charities Care Coordination Services

New York State (NYS) has long been at the forefront of innovative interventions that build the evidence base for public health programs. As early as 1992, emergency regulations and NYS Public Health Law created Syringe Exchange Programs (SEPs) to provide sterile syringes and harm reduction supplies to people who inject drugs (PWID) to avoid the transmission and/or acquisition of Human Immunodeficiency Virus (HIV). Since 2009, Albany Catholic Charities Care Coordination Services (CCCCS) has served the Capital Region of NYS as the area's NYS-Authorized SEP, and later as a NYS Department of Health (NYSDOH) Drug User Health Hub. More recently, CCCCS has broadened its work with people involved in the criminal justice system (CJS) through innovative programming to expand public health impacts beyond the provision of naloxone kits upon release. These efforts include a partnership with the Albany County Corrections and Rehabilitative Services Center's (ACCRCS, formerly Albany County Correctional Facility, ACCF), which began with a three-phase MOUD program for inmates, rolled out in collaboration with the NYSDOH starting in January 2019. Phase 1 continued MOUD for

individuals who entered the facility with existing prescriptions; Phase 2 prescribed and induced MOUD for inmates with OUD and upcoming release dates. Phase 3 assures the continuation of or induction on MOUD for all individuals with a diagnosis of OUD who wish to participate.

Since the initiation of the MOUD program and CCCCS' Harm Reduction Re-Entry Wrap Around Services Program within ACCRCS, CCCCS has engaged with and provided wrap-around Harm Reduction Re-Entry services to over 200 clients, despite steep challenges presented by the global COVID-19 pandemic and complications of state-wide bail reform. Through its experience with harm reduction service delivery in both community and correctional settings, CCCCS has learned the critical importance of having to reach beyond the jail walls in order to provide the various transitional supports needed by PWUD upon release from jail. This implementation guide will describe the need and evidence base for this approach, explain CCCCS's Harm Reduction Re-Entry Wrap Around Services Program, and detail the steps and resources needed to replicate the program in your community. Evaluation results are also summarized to demonstrate the growing evidence in support of this approach.

Program Development

This section will describe what organizations need to begin designing their own Harm Reduction Re-Entry Wrap Around Services Program in local correctional settings. Here, we share our experience and discuss how to prepare your organization to undertake this endeavor, assess local need, identify and engage with local partners, share harm reduction perspectives with potential partners, identify necessary funding and other resources, and build staff capability.

Community-based Harm Reduction

As a long-standing harm reduction provider in our community, we strongly believe that these services must be delivered by community-based harm reduction organizations, as strong community trust is important to developing the relationships necessary to identifying and meeting clients' needs. Through our experience working in the community over the years, we have learned first-hand how essential it is to build trusting relationships with the people we serve, including in our Harm Reduction Re-Entry Wrap Around Services Program. Most services needed by our Re-Entry clients are possible to meet through the CCCCS umbrella, including a NYS-authorized SEP and a NYSDOH-supported Drug User Health Hub which provides connection to services for primary health care needs. CCCCS also maintains relationships with other community agencies and providers, within their catchment area and beyond, to ensure the ability to make warm hand-offs and linkages to care when needed. This enables our Case Managers to make appropriate referrals to meet identified needs that are beyond the scope or capacity of CCCCS' array of services. Regardless of internal capacity, organizations implementing a similar program should endeavor to engage the community from the start, identifying trusted and supportive partners along the way.

Local Needs Assessment

An important step for any harm reduction organization seeking to implement a Re-Entry Wrap Around Services Program is to gather and understand information related to the particular needs of the population you aim to serve. This includes gathering data regarding local overdoses (non-fatal and fatal), recidivism rates, and jail population data such as race/ethnicity and other demographic information, as well as the percentage of those incarcerated with diagnosed substance use disorder (SUD) or OUD. In addition, this assessment should include the gathering of information regarding what resources and referral workflows are already in place at the jail, and exploring what other needs and services are necessary to support successful re-entry (housing, food, medical care, etc.). Once this assessment has been completed, programs should work to shape their services to fit the needs of the community they will be serving and commit to building their own resource network, inclusive of treatment programs, emergency housing programs, social service resources, entitlement programs, primary and mental health resources, and other vital services.

Identifying and Engaging with Correctional Settings

Given the high risk of overdose for people with OUD upon release from incarceration, it is of the utmost importance that we expand our reach – both inside the jail for safety and re-entry planning, as well as outside the jail for transitional support and linkages to community-based services. For this to take place, correctional settings must also acknowledge the need to reach beyond the jail walls in order to reduce recidivism and risk of overdose among releasees. Jails and prisons that acknowledge this need should seek to make referrals to a collaborating harm reduction organization, allow that organization access to inmates inside the jail, and coordinate and communicate about releases for the purpose of providing transitional services, including meaningful linkages to community MOUD providers and other services.

Identifying such a correctional setting may prove challenging, depending on your local environment. Engaging or allowing state, county, and local leadership (e.g., state department of health, county executive, town councils) and other stakeholders including public safety partners (e.g., sheriff's office, local Overdose Response Strategy (ORS) partners) to take the lead in gaining buy-in and building momentum for program development can be more effective than trying to do so on your own. Utilize existing coalitions, identify local champions, and leverage existing or developing MOUD programs as opportunities to get traction on adding a re-entry program component in partnership with your harm reduction organization.

It is helpful to bear in mind that, generally speaking, harm reduction organizations and correctional settings are coming from very different perspectives and cultures. Bringing them together in true collaboration can be hard work and requires commitment from all sides. When coming across an individual or institution opposed to a harm reduction approach, it is a good idea to approach the situation carefully, remembering that your goal is to be able to provide needed services for PWUD who are incarcerated. In your communications with correctional leadership and staff, identifying common goals (e.g., reducing overdose) can help to overcome

these challenges. Another helpful strategy is to ask questions about how things operate in the jail or prison, and why they are done that way. That can open up discussion and help to identify areas where change can be implemented to support harm reduction programming and perspectives. Identify your champions and be mindful of maintaining your access along the way – always try to keep the "door" open for further discussion, planning, and implementation.

Changing Hearts and Minds

Offering formal and informal education to correctional facility leadership and staff about the evidence-based successes of harm reduction programs is one effective strategy to help foster successful partnerships. Harm reduction organizations can offer education and training to help address stigma and build trust among correctional and medical staff, incarcerated individuals, and community members. CCCCS has found that this work of "changing hearts and minds" helps correctional leadership and staff recognize the value of harm reduction services and gains buy-in from key stakeholders. We have found it very helpful to engage all jail personnel in harm reduction training, particularly OEND. We also regularly conduct OEND trainings for inmates, as well as their loved ones. Distribution of naloxone, especially to inmates, is strongly encouraged both as an engagement tool and to lower risk of overdose. Our corrections partners have allowed us to provide a naloxone kit to inmates by including it with their personal belongings so that they will receive it immediately upon release.

It is also important to facilitate familiarity with MOUD among jail leadership and staff, especially buprenorphine prescribing requirements and dispensing protocols. If the medical provider for the facility is familiar with buprenorphine and/or is providing the medication in another facility, that may increase the likelihood of implementing MOUD in the facility with which you aim to work. Toward supporting the provision of all forms of MOUD approved by the Federal Drug Administration (FDA), you may ask if the facility is an Opioid Treatment Provider (OTP) or has a relationship with one in the area. If not, you might make an introduction to an existing program or suggest the facility consider becoming certified themselves.

Our experience has been that this implementation process is often easier if the jail's medical provider or contractor has experience and comfort with providing MOUD, but don't be discouraged if this isn't the case in your area. The most important thing is that the prescriber recognizes the value of MOUD in reducing risk of overdose and in supporting people re-entering the community. If MOUD provision is not supported in a facility, consider offering re-entry services there anyway. While we have not yet evaluated this approach, we think it is likely valuable to provide re-entry services to incarcerated PWUD (i.e., OEND, post-release and safety planning), even without an MOUD program in place.

Needed Resources

Undeniably, dedicated funding is necessary for program implementation and sustainability. Without sufficient funding, programs will find it difficult to dedicate the time and effort required to develop relationships with partners, conduct in-depth community needs

assessments, implement a structured program, and provide comprehensive service delivery. Having the capacity to invest the required time and effort to develop, implement, and facilitate services allows programs to commit to building buy-in from corrections partners by offering up opportunities to build programs that don't ask too much them. At CCCCS we have found this "let us do all the work" approach often supports jails and other partners in engaging in collaborative efforts, and has resulted in the development of simplified workflows and protocols that not only make it easy for jail staff to refer, but have fostered a low threshold approach that goes hand in hand with a low threshold MOUD program model. A simple example of this is clearly reflected in the way referrals are initiated into CCCCS Re-Entry services: once an individual has been identified as eligible for the MOUD program at the jail, the program coordinator generates an email to all relevant jail and CCCCS program staff to inform of the date of initiation. This single email prompts all involved (including jail staff, medical staff, and community-based staff) to initiate the particular processes each are responsible for. Upon receiving this email, our staff work to schedule their first in-reach visit to meet the individual and complete an assessment. Our program workflow is included in Appendix A, for reference.

In addition to establishing simplified workflows, the program development process should include opportunities to meet with jail medical staff to learn and understand how they (will) identify candidates for MOUD and what, if any screening tools are/will be used. It is during these discussions that a collaborative model is built. Identifying points of integration for Re-Entry staff into the established jail intake workflow offers opportunities for the jail to adopt other policies, protocols, and workflows that emphasize the harm reduction principles of risk reduction and safety. Once the collaborative workflow has been developed, programs should establish frequent points of communication with the jail around program updates, client-specific case conferencing, concerns, challenges, and successes. These points of communication can and should take varied forms, including monthly stakeholder meetings, weekly release and case conferencing meetings, and emails as needed.

Re-Entry Program Staffing

Staff members recruited for this type of program must include individuals that understand harm reduction, are comfortable with conducting street level outreach, have case management and advocacy skills, and can pivot on tasks in response to urgent needs. Many of these skills are learnable and can be fostered through formal and informal supervision, trainings, and mentoring. However, programs should note that the investment in staffing must include a commitment to ensuring that the service delivery is faithful and consistent with the principles of harm reduction. This is accomplished by committing to providing harm reduction trainings that help inform, build, and reinforce staffs' skill sets and orientation towards harm reduction perspective and practice. In addition, providing staff with trainings on motivational interviewing, trauma-informed care, and case management assessment can further support skill development and professional growth.

Programs should ensure that the appropriate level of supervision and staff supports are in place so that policies are clear and faithfully followed, protocols exist and are appropriately carried out, collaborations are well established and fostered, and case-specific supervision is available to address difficult and unexpected client concerns.

Program Implementation

This section will describe how organizations can take steps toward implementing their own Harm Reduction Re-Entry Program. Here again, we share our experience and describe how to identify and engage with clients while in the jail or prison, assess client needs, and provide in-facility services and follow-up post-release.

Identifying and Engaging Clients

Programs should work closely with jail staff to collaboratively establish a referral process that will be easy for the jail to incorporate into their existing workflow and ensure that any eligible individual entering the facility has the opportunity to be screened and enrolled in the program. This includes identifying points of referral for those individuals that might not be eligible for the jail's MOUD program, but would benefit from engaging with the Harm Reduction Wrap Around Re-Entry services. For this reason and others, the jail's referral process should ideally include protocols that apply a standard diagnostic criteria for identifying individuals with SUD (e.g., DAST-10) and processes for referring individuals to the appropriate level of service.

The capacity to initiate service delivery within the correctional facility through in-reach efforts is crucial to engaging referred clients into Re-Entry services. Thus, having an established mechanism to schedule time with new and/or enrolled clients while they are still incarcerated is a vital component of the program, and one that must be well established and supported by corrections staff. Access into the facility must be seamless and available without any barriers to ensure that program staff have the opportunity to facilitate in-reach meetings to assess client needs, build rapport with clients, and prioritize post-release needs to ensure seamless transitions from in-facility care to community-based care. It is during this in-reach that program staff should employ interventions to reinforce harm reduction strategies and safety planning, including opioid overdose prevention training with naloxone distribution upon release. Our Re-Entry staff have found that in addition to in-reach efforts being invaluable to engaging clients into services and supporting the release process, these activities also serve as mechanisms to advocate for a harm reduction perspective and against stigma within the correctional setting in a broader sense. This macro-level effect can have lasting positive impact.

In our program workflow, eligible and interested inmates are referred to the CCCCS Harm Reduction Case Manager by the jail medical team after initial screening. Inmates with OUD are also initiated into the MOUD program. The Harm Reduction Case Manager visits the inmate, typically within 24 hours, to complete a needs assessment to prepare the client for smooth and safe re-entry into their community. This is achieved by: linking to a MOUD/SUD treatment provider for after release; providing overdose trainings with access to naloxone upon release;

making linkages and referrals to housing resources; peer recovery services; and warm referrals to other vital health care services. The CCCCS Harm Reduction Case Manager meets with each client as needed – typically, two to three times prior to release, at the time of release, and again every two weeks, for up to 6 months post-release. Frequency of contact is client-driven and can be reinitiated by the client at any time, even after a period of disengagement.

Assessing Client Needs

Clients referred for Re-Entry services should receive a brief but thorough assessment in order to understand their individual needs and provide adequate support for their successful transition from incarceration back into the community. For consistency, programs should consider developing or adopting an assessment tool that gathers information that will help inform and guide the service delivery. It is recommended that the initial assessment tool include questions that seek to support the development of a client-driven re-entry plan, including goals aimed at mitigating risks associated with substance use. Program staff should work closely with clients through this process to assess their engagement level and personal capacities, strengths, and challenges, as well as to support their self-identified priorities. Because needs can change frequently, it is recommended that this assessment and subsequent service plan be considered "living" documents. While certain core data elements should remain consistent to the extent possible for ongoing evaluation or other tracking and reporting purposes, we suggest allowing for occasional updates to the assessments in order to reflect changing environments and needs. Changes to individual service plans must also be permissible to adapt the course of care as various changes take place in clients' lives.

Providing Services

In order to enable effective service provision, it is critically important that trust is built between clients and program staff. To that end, sometimes just being there to listen to a client talk about the barriers they are facing is an important service in itself, and we consider this provision of social support as part of our client engagement and service delivery. Specific types of community-based follow-up provided can vary greatly, depending on the individuals' immediate and changing needs. For some, it includes the delivery of harm reduction supplies and linkage to a SEP for ongoing services. For others, it includes linkage to in-patient or out-patient treatment. Many need connections to healthcare, such as for primary care or for Hepatitis C (HCV) treatment and care navigation. In our program, for instance, testing for HIV and HCV are available in-house, and linkages to follow-up care are made as needed. Transportation to and from Department of Social Services appointments, treatment providers, healthcare providers, and pharmacies, among other destinations, is a vital service for many. Advocacy is conducted as needed with parole, probation, treatment, housing, healthcare systems, insurance, benefit programs, and pharmacies creating barriers to obtaining MOUD.

Since this Re-Entry Program model is based on a harm reduction service delivery approach, service delivery activities should always aim to include a re-assessment of client safety, which includes the offering and re-offering of harm reduction education and services, regardless of

post-release plan and client goals. This focus on safety as an integral part of service delivery is an on-going and primary activity, regardless of the level of engagement of the client being served. This also ensures that the provision of services remains low threshold and isn't predicated on an individual's continuation of MOUD or other substance use treatment services.

Post-release Follow-up

Although the initial engagement and enrollment into Re-Entry services occurs within the correctional facility, the Re-Entry Program should be designed and implemented as a community-based program that aims to guide and support clients' successful and safe transition back into the community. Building out a program that extends beyond the walls of the facility requires a cooperative, collaborative, and planned approach that acknowledges that each entity relies on each other to provide the services that set clients up for success. This includes the mutual understanding that the release process includes participation from both jail and program staff to ensure that clients are seamlessly guided back into the community.

For those clients engaged with the MOUD program, this release process should include access to a "bridge prescription" (or "script") to ensure the client does not experience any lapse in their medication until the linkage to a community provider can occur. In some instances, facilities are committed to providing a bridge script that is covered under the facility's medical services, thus mitigating any risk for an individual to lack the means to pay for their medication. In the instance that a facility is not able to provide payment for a script, access to community resources and/or a provider that is willing to see clients on the day of release is crucial. Furthermore, corrections and program staff should work closely to plan and coordinate a client's release, including transportation to a pharmacy, safe housing, and/or MOUD provider.

The capacity for seamless collaboration and coordination with corrections staff, particularly with regard to an individual's release, can directly impact an individual's continued engagement in treatment and/or with wrap-around services. Because of the often-unpredictable nature of releases from jails, however, this element of post-release planning is sometimes not feasible. As such, communication safeguards should be in place among corrections and program staff, and release coordination efforts should be developed. This can include limiting releases to only daytime hours to ensure program staff can be available to support clients, and the collection of updated contact information by corrections staff from clients with whom Re-Entry Program staff were unable to connect with prior to their release.

Whenever possible, Re-Entry Program staff should establish detailed case management/service delivery plans with clients regarding the degree of support and follow up they will need once they have been released. This should include a post-release follow-up meeting that allows for Re-Entry Program staff to review safety protocols, re-assess client needs, and implement case management interventions. In the event Re-Entry Program staff are unable to develop a personalized plan prior to release, or meet clients upon release, staff should plan to quickly connect with these clients by conducting outreach and home visits in the community. On-going

outreach efforts for a minimum period of one-month post-release should be facilitated for those clients who have not been able to be contacted. This can allow for an opportunity to re-engage and potentially meet newly identified needs.

After the initial post-release follow-up, Re-Entry Program staff should work with each client to determine the intensity and level of support needed thereafter, ensuring that harm reduction and safety principles guide each interaction. As clients settle back into the community, program staff should frequently re-assess their risk, safety, and any newly emerging issues in order to support and foster the opportunity to assist with linkages to services and resources that best meet identified needs. Both in the jail and in the community, program staff may meet with individuals as much or as little as is needed, as frequency of contact is client-driven and can be reinitiated by the client at any time, even after a period of disengagement. Above all, program service delivery should be client-centered and reflective of clients' identified needs and desired levels of engagement.

Challenges

We learned a lot while implementing and evaluating our program model over about two years, and hope that our "lessons learned" can provide helpful insights to those attempting to replicate this model.

In-jail Engagement

It is important to acknowledge that, despite their willingness to collaborate and partner with harm reduction programs, jails and prisons may still be reluctant to embrace aspects of a harm reduction approach to treating individuals with OUD. The culture of correctional facilities is guided by different principles and can take time to change. This can directly impact the implementation of workflows that are collaborative and integrative of harm reduction practices, but it is possible to come together and create a successful program with commitment and communication. This deep-rooted culture often includes jail policies, protocols, and staff attitudes that not only uphold stigma and punitive approaches, but actively promote them. This is especially pronounced when confronted with the issue of "diversion", instances when incarcerated individuals do not take their medication as prescribed and instead save and later use or redistribute doses to others. Correctional facilities typically respond punitively to diversion, restricting or removing access to MOUD, which can do more harm to the individual. Harm reduction-focused ways of mitigating the incidence of buprenorphine and other medication diversion in correctional settings include carefully monitoring medication dispensing, ensuring that adequate doses are prescribed to meet individual needs, and that MOUD is made available to all who meet the minimum criteria for participation to mitigate in-facility demand. Encouraging jails to implement such strategies is challenging but critical for not only the success of programs, but also the safety of clients.

As harm reduction organizations work to structure their programs and build out their networks, it is essential that they do so in a way that ensures they are distinct as a service provider,

separate from the correctional facility/ies they are partnered with. We have found that it is important to differentiate the in-facility services provided by CCCCS from the jail's own staff and programming. Responses from client interviews conducted during our initial evaluation study showed that there was sometimes confusion about the separation of the MOUD and Re-Entry Wrap Around Services programs – the former is operated directly by the jail, while the latter is run solely by CCCCS. This seemed to impact people's willingness to engage with the program. We are working to communicate about our Re-Entry Program more effectively to existing and potential clients to help clarify the separation and hopefully encourage more enrollment among eligible individuals. This separation as a third-party, standalone entity is also important to ensuring that the program's harm reduction philosophy informs the services offered in the jail, and seamlessly carries engagement and service delivery into the community.

Overall, our experience has demonstrated that the presence of a harm reduction organization inside the correctional facility can positively impact attitudes among jail staff about harm reduction, including MOUD and OEND, and even PWUD. There is still more work to be done, but with our approach of consistency and communication, things keep moving forward. Even in the case of diversion, for which the jail and the medical teams have consistently gravitated to implementing punitive and tighter protocols out of line with the recommended low threshold model, the jail has more recently asked CCCCS for our opinions and been more open to exploring alternative ways to address these concerns. Although this inclusion hasn't always resulted in perfect alignment with harm reduction principles, their willingness to involve us in the discussion speaks to their commitment to our partnership and collaboration. Further, it points to the value of continuously fostering relationships with corrections stakeholders to further educate about, and highlight the value of, a comprehensive harm reduction approach.

Impacts of COVID-19

This section is included to provide specific guidance around program implementation and delivery under the challenges of an ongoing global pandemic. We hope that this section quickly becomes obsolete, but feel the lessons learned and mitigation strategies developed in response warrant sharing, in the event they can be helpful to new programs facing similar challenges.

In mid-March 2020, NYS became an epicenter of the COVID-19 pandemic in the United States, and a strict stay-at-home Executive Order was put in place by the Governor. The declared State of Emergency was ended on June 23, 2021, but the pandemic continues on, mitigated somewhat by available vaccines. Due to restrictions related to COVID-19, Re-Entry Program staff were unable to access the jail for months at a time, hindering engagement with clients prior to release and in the community. When the facility finally permitted the return of the Harm Reduction Case Managers for in-person engagement, the program observed substantial increases in new and existing client engagement. These restrictions meant missed engagement with some potential clients, as some people were referred but released before the Case Manager could make contact. Furthermore, during the COVID-19 pandemic, all new inmates have had to quarantine for two weeks upon arrival at the jail, limiting access to referred clients

for Re-Entry Program staff even when the jail has been open to visitation.

Added restrictions related to medication dispensing were also implemented in response to impacts of COVID-19, which slowed the pace of distribution and created some additional stigma for clients receiving MOUD. This also slowed new MOUD inductions, as less OUD screening was happening because the jail's medical resources were being used for medication dispensing across the general population. Another key impact of COVID-19 was that people were detained in the jail for longer periods of time awaiting determinations about their status, as a result of courts being shut down or operating with diminished capacities during the pandemic. Anecdotally, Re-Entry Program staff encountered understandable client frustration related to these due to uncertain timeframes, and negative impacts on their mental health. In addition, at two different points in time during jail access, CCCCS program staff were exposed to an individual who tested positive for COVID-19, resulting in two-week quarantines for those staff members. Though precautions were taken in accordance with expert recommendations, these exposures underscore the need for adequate supplies of personal protective equipment (PPE) for in-person interactions, when possible, including masks and hand sanitizer for all present.

Although these impacts of COVID-19 made it harder to coordinate with and advocate for clients, CCCCS continued to engage clients during jail facility closures via (monitored) telephone conferences, and participated in regular case conferencing with the jail's Credentialed Alcoholism and Substance Abuse Counselor (CASAC) team, who were still able to see clients face-to-face at the time. CCCCS staff also made use of 'no-contact visits', tele-visits, and tablet devices made available through the jail to mitigate impact on outreach and engagement capacity. Despite all of these obstacles, the program continued delivering crucial services.

Evidence for Re-Entry Wrap Around Services

From December 2019 through July 2021, our Harm Reduction Re-Entry Wrap Around Services Program was evaluated in partnership with the University at Albany School of Public Health. This project was funded through two grants, ORS Pilot Project Implementation (2019-20) and Continuing (2020-21) Awards, and included evaluation of process and outcome components; this ORS funding also supported program staff and some overhead. Our professional evaluation team collected data from intake and subsequent follow-up surveys administered by Harm Reduction Case Managers during their interactions with program clients. There were also open-ended interviews conducted with program staff, jail staff, and program clients, as well as a self-administered client survey. Agencies aiming to evaluate their own programs should carefully assess available resources (funding, staff, etc.) and consider partnering with a local academic institution, if possible. An overview of our evaluation results is provided below; the complete final report is available upon request. These findings provide considerable support for the positive impact of the CCCCS Harm Reduction Re-Entry Wrap Around Services Program for reducing the risk of drug overdose among individuals recently released from incarceration.

Reduced Risk

Our data show that the CCCCS Re-Entry Program has had a positive impact in reducing risk for drug overdose, especially in light of some studies that demonstrate 1-2 weeks after re-entry into a community is the most hazardous time to die from drug overdose[3]. Consistent across both years of data collection, a majority of clients reported that they were currently carrying naloxone at their 2-week and 1-month follow-ups (76.9% and 83.9%, respectively). Also consistent throughout the evaluation period, an increased proportion of clients reported using key strategies to reduce risk for fatal overdose at follow-up assessments, relative to upon intake. At 2-week and 1-month follow-up surveys, clients were more likely to report "sometimes", "often", or "always" for overdose risk reduction strategies such as using drugs with others, carrying naloxone, using clean needles, and using fentanyl test strips, compared to responses at intake. Clients were also more likely to report "never" or "rarely" for sharing needles and other equipment at follow-up. These results reflect desired behavior changes in line with harm reduction strategies taught by Case Managers. However, a common finding across the different strategies is that most clients did not use these harm reduction strategies *consistently*, indicating need for continued education and training with incarcerated individuals, both within the jail walls and beyond, to prevent overdose and other drug-related harms.

MOUD Induction and Continuation

Among clients for whom data was available, all but one individual with OUD accepted the offer to enroll into the jail MOUD program. Upon intake, 58.0% of inmates responded that they were being prescribed MOUD for OUD at the time of arrest, 82.5% of which were being prescribed buprenorphine. Most of the remainder of clients were newly induced on buprenorphine in the jail. Among clients with available data, the majority (81.3%) reported having maintained their MOUD at the 1-month follow-up. Notable increases in engagement with professional counselling, support groups, and peer recovery support services were observed at 2-week and 1-month follow-ups, relative to initial assessments.

Clients reported feeling that the Re-Entry program helped to address their needs during and after incarceration by offering consistent support, providing harm reduction supplies and alternatives to substance use, and helping with the challenges associated with acquiring necessities in the community. An overwhelming majority of clients continued MOUD following their release from the jail; however, there were several clients who reported temporary relapses or discontinuation of their medication altogether. It is important to note that (dis)continuation of MOUD did not impact the services delivered by the CCCCS Harm Reduction Case Managers in any way, as it is crucial that MOUD participation and other decisions and delivered services be client-driven. Those who discontinued their MOUD post-release reported challenges to maintaining their medication for OUD, including side effects, dosing issues,

[3] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. *New England Journal of Medicine*, *356*(2), 157-165. https://www.nejm.org/doi/full/10.1056/nejmsa064115.

prescription issues, and transportation issues. Overall, clients regarded their access to MOUD during their incarceration as "life-changing" and were "extremely grateful".

Client Challenges

When someone is released from jail, the scope of need and the accessibility of services and resources to meet those needs are compounded by the severity of the need(s) present (i.e., unstable housing versus homeless on street). This further challenges a client's capacity to engage in treatment or make sustained behavior changes. This is complicated even more for those individuals released from incarceration who are not provided any opportunity to receive wrap-around services. The most commonly reported client challenges during incarceration were related to the difficult social and environmental conditions of jail, the availability of illicit, non-prescription drugs in jail, and the period of withdrawal upon entering jail. Outside of jail, clients faced challenges related to social and environmental triggers, basic needs (money, employment, housing, etc.), and finding personal support.

Food insecurity is an especially important need. Program staff often link clients to food pantries, food programs, SNAP benefits, and food gift cards. This food insecurity is further complicated by an individual's access to stable housing, local food pantries, transportation, and refrigeration. Our program staff anecdotally found that the COVID-19 pandemic often created additional barriers to these types of access, intensifying the need, which is consistent with reports on the general population[4,5]. Linkages to primary care and mental health treatment access continue to be challenging due to lack of capacity and long waiting periods. Particularly for those with a history of SUD and/or medication diversion, associated stigma and fear of discrimination reduce the clients' willingness to seek appropriate care.

Evaluation Highlights Summary

Despite the challenges faced, CCCCS was able to continue offering services throughout the majority of the project period, with overwhelmingly positive feedback from clients. This was possible largely through dedication to the collaboration between CCCCS and the partner jail. The capacity for seamless collaboration and coordination with jail staff, particularly with regard to an individual's release, directly impacts an individual's continued engagement in treatment and/or with wrap-around services. This close collaboration and diligence of CCCCS in maintaining program integrity resulted in expanded capacity for release planning "beyond the jail walls". This translates to more successful transitions to the community for incarcerated

[4] Ohri-Vachaspati P, Acciai F, DeWeese RS. SNAP participation among low-income US households stays stagnant while food insecurity escalates in the months following the COVID-19 pandemic. Prev Med Rep. 2021 Sep 14:101555. doi: 10.1016/j.pmedr.2021.101555. https://pubmed.ncbi.nlm.nih.gov/34540570/.

[5] Dubowitz T., Dastidar M.G., Troxel W.M., Beckman R., Nugroho A., Siddiqi S., Cantor J., Baird M., Richardson A.S., Hunter G.P., Mendoza-Graf A., Collins R.L. Food insecurity in a low-income, predominantly African American cohort following the COVID-19 pandemic. Am J Public Health. 2021;111(3):494–497. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2020.306041.

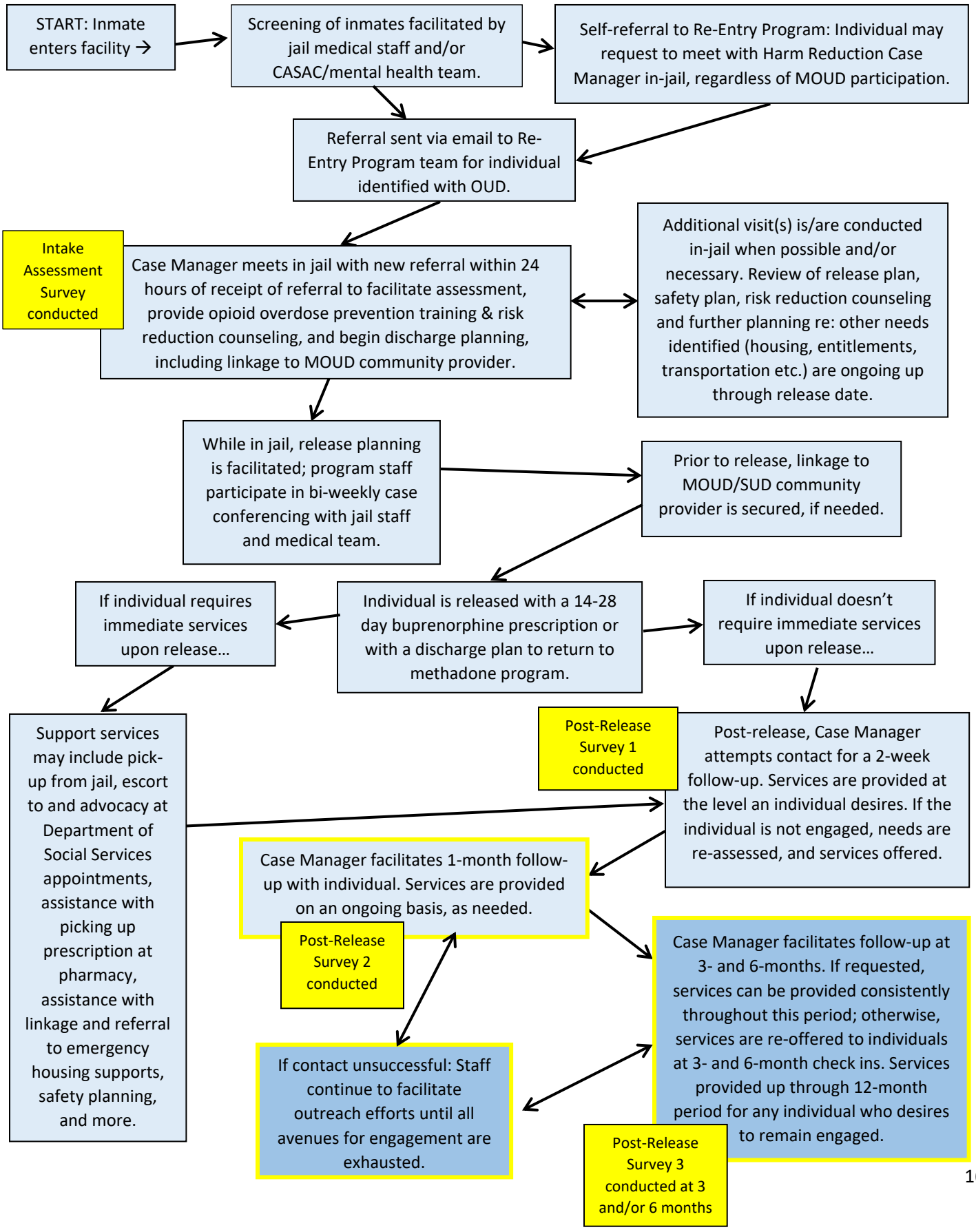
PWUD, and a reduction in overdose risk post-release. As such, the expansion of this evidence-based model is highly recommended.

Wrapping Up

The most essential lesson learned through the implementation and evaluation of the CCCCS Harm Reduction Re-Entry Wrap Around Services Program is the need for trusted reach beyond the correctional facility walls in order to support successful re-entry into the community and reduce the risk of overdose and recidivism among incarcerated people who use drugs. The provision of MOUD in correctional settings is essential and should be incorporated as basic medical care. However, MOUD programs in jails and prisons alone are not enough. It is important to offer release planning and support, educate about harm reduction safer use strategies, provide naloxone upon release, help meet basic needs like housing and transportation, create meaningful linkages to committed community providers for those wanting to continue MOUD, and more, in order to help keep the individuals safe from preventable overdose post-release. Legislation can help to ensure the provision of this life-saving medical care in all correctional settings. Laws and regulations developed to that effect should take into consideration, and build in whenever possible, supportive program requirements that mirror this program model, to be designed, implemented, and delivered by harm reduction organizations with close ties to the communities served. We hope that this guide supports the development of those efforts and look forward to pushing ahead together.

Appendix

Appendix A: Example Harm Reduction Re-Entry Wrap Around Services Program Workflow



Appendix B: Intake and follow-up survey tools

Data Collection Tool #1: Intake Assessment Survey

CCCCS Re-Entry Service Intake Survey

CASE ID: _____

Today's date: ____/____/_____

When was the client admitted to the ACCRCS? ____/____/_____

1. How was the client referred to the CCCCS Re-Entry service?
   ☐ ACCRCS Medical Team
   ☐ Self-referral
   ☐ Other (Specify: _____)

2. Was the client already a client of the CCCCS?
   ☐ No
   ☐ Yes

3. Is the release date already scheduled?
   ☐ No
   ☐ Yes (When? ____/____/_____)

4. Is this client sentenced?
   ☐ Yes
   ☐ No
   ☐ Unknown
   ☐ Other

5. Is the client currently involved in a drug court?
   ☐ Yes
   ☐ No

6. Is the client currently on a probation?
   ☐ Yes
   ☐ No

Sociodemographic information

7. What is the client age?

   _____ years old

8. What is the client's race/ethnicity?
   - ☐ Non-Hispanic White
   - ☐ Non-Hispanic Black/African American
   - ☐ Hispanic/Latino (any race)
   - ☐ Asian
   - ☐ Native American/Native Alaskan
   - ☐ Pacific Islanders/Hawaiian

9. What is the client's gender?
   - ☐ Male
   - ☐ Female
   - ☐ Transgender Male
   - ☐ Transgender Female
   - ☐ Nonbinary/Nonconforming
   - ☐ Other

10. What is the client's county of residence when entered into the ACCRCS?

    - ☐ Albany
    - ☐ Rensselaer
    - ☐ Schenectady
    - ☐ Columbia
    - ☐ Saratoga
    - ☐ Greene
    - ☐ Schoharie
    - ☐ Other: _____

11. What is the client's marital status?
    - ☐ Single, never married
    - ☐ Married/Living with someone as if married
    - ☐ Separated
    - ☐ Divorced
    - ☐ Widowed

12. What is the client's employment status?
    - ☐ Employed full-time (at least 35 hours a week)
    - ☐ Employed part-time
    - ☐ A homemaker or caregiver
    - ☐ A full-time student
    - ☐ Unemployed
    - ☐ Unable to work for health reasons
    - ☐ Other (please specify): _____

13. What is the client's education level?
    - ☐ Less than high school
    - ☐ High school diploma or GED
    - ☐ Some college
    - ☐ Completion of college degree (Associate, Bachelor's and beyond)

14. Did the client have health insurance when entering into the ACCRCS?
    - ☐ No
    - ☐ Yes
        a. If YES, what is the primary form of health insurance?
            - ☐ Private insurance (WHAT COMPANY? _____)
            - ☐ Medicare
            - ☐ Medicaid
            - ☐ Military/VA
            - ☐ Other (Specify: _____)

15. Is the client currently homeless (i.e., living from place-to-place, including "couch-surfing," on the street, in a car, park, abandoned building, tent, campsite, squat or shelter)?
    - ☐ No
    - ☐ Yes
        a. If NO, what best describes the client's current housing status?
            - ☐ Own a house/apartment
            - ☐ Rent a home/apartment
            - ☐ Live in place owned/rented by someone (e.g., family, friends)
            - ☐ Other (Specify: _____)

Substance use

16. What substance(s) does the client use regularly (check all that apply)?
    - ☐ Opioid
    - ☐ Alcohol
    - ☐ Marijuana
    - ☐ Cocaine/crack
    - ☐ Methamphetamine
    - ☐ Other stimulants (e.g., MDMA, Adderall)
    - ☐ Benzodiazepine
    - ☐ Other (List: _____)

17. What is the primary drug of choice?
    - ☐ Opioid
    - ☐ Alcohol
    - ☐ Marijuana

☐ Cocaine/crack
☐ Methamphetamine
☐ Other stimulants (e.g., MDMA, Adderall)
☐ Benzodiazepine
☐ Other (List: _____)

18. In the 3 months prior to the most recent arrest, on average, how frequently did the client used drugs?
    ☐ Every day or almost every day
    ☐ Not every day, but at least once per week
    ☐ Not every week, but at least once this month
    ☐ The client reported no drug use in the 3 months prior to their arrest

19. Has the client ever experienced drug overdose?
    ☐ No (Skip to Question 21)
    ☐ Yes

20. Did the client report experiences with drug overdose 3 months prior to the most recent arrest?
    ☐ No
    ☐ Yes
        a. If YES, how many times? _____ times

21. Does the client indicate injection drug use prior to his/her most recent arrest?
    ☐ No
    ☐ Yes

22. Is the client part of the SHARP Unit at the ACCRCS?
    ☐ No
    ☐ Yes

Substance use treatment utilization

23. *At the time of arrest*, was the client receiving the following recovery services for their substance use (Check all that apply)?

    ☐ Medication assisted treatment for OUD
        a. Which medication?
    ☐ Methadone
    ☐ Buprenorphine
    ☐ Vivitrol

        b. When did the client start the medication? ____/____/_____

        c. Who is the prescriber? _____

☐ Medication for other SUD

a. What is it? _____

b. When did the client start the medication? ____/____/_____

c. Who is the prescriber? _____

☐ Outpatient professional counseling (individual or group)
☐ Inpatient rehabilitation
☐ AA/NA or other support group
☐ Peer recovery support
☐ A halfway house or therapeutic community
☐ Other (specify: _____)

24. (**For those with OUD**) Was the client enrolled into the ACCRCS MAT program?

☐ No
☐ Yes

a. If Yes, when did the treatment start? ____/____/_____
b. What is the medication prescribed?

☐ Methadone
☐ Buprenorphine
☐ Vivitrol

c. Has a provider already identified to continue MAT after release?

☐ No
☐ Yes

a. If Yes, who is the provider? _____

25. Does the client receive additional support for their substance use from the ACCRCS?

☐ No
☐ Yes

a. If Yes, what services?

☐ MAT counseling
☐ AA
☐ NA
☐ Women's recovery group
☐ Other (Specify: _____)

Harm reduction strategies (for illicit drug use)

26. In the 3 months prior to the most recent arrest, how frequently did the client do the following?

	Never	Rarely	Sometimes	Often	Always	Not applicable
Using drugs with others, not alone	1	2	3	4	5	9
Share needles	1	2	3	4	5	9
Share other equipment	1	2	3	4	5	9
Use drugs in public	1	2	3	4	5	9
Received overdose education training	1	2	3	4	5	9
Carry naloxone	1	2	3	4	5	9
Use clean needles	1	2	3	4	5	9
Use fentanyl test strips	1	2	3	4	5	9
Use a small amount first (i.e., test shot)	1	2	3	4	5	9
Mix multiple types of drugs	1	2	3	4	5	9
Reduce the amount and/or frequency of drug use	1	2	3	4	5	9

CJS involvement

27. How many times has the client been <u>arrested</u>, including the one that led to the ACCRCS today?

    Ever (lifetime): ____ times
    Past 12 months: ____ times

28. How many times has the client been <u>incarcerated</u>, including the one that led to the ACCRCS today?

    Ever (lifetime): ____ times
    Past 12 months: ____ times

29. Does the client have outstanding warrants that they are aware of at this point?
    - ☐ No
    - ☐ Yes
        a. Which county (list all counties if multiple)? _____

        _____

Health care utilization

30. Prior to arrest, did the client have somewhere to go to be seen by a doctor, nurse, or other healthcare provider if he/she is sick?
    - ☐ No
    - ☐ Yes

a. If Yes, is it a primary care provider?

☐ No

☐ Yes

Needs prior to arrest

31. Please select the statement that describe the client's needs…

In the 3 months prior to arrest, the client felt they needed assistance for…	*Yes, and assistance was provided*	*Yes, the client needed to, but the assistance was denied/unavailable*	*Yes, the client needed, but didn't seek assistance*	*No, the client didn't need to*
Food insecurity (e.g., food pantry)	1	2	3	4
Disability	1	2	3	4
Welfare/entitlement programs	1	2	3	4
Transportation	1	2	3	4
Employment	1	2	3	4
Housing	1	2	3	4
Insurance	1	2	3	4
Primary care	1	2	3	4
Substance use treatment	1	2	3	4
Mental health treatment	1	2	3	4
Other specialty care	1	2	3	4

Mental health service utilization

32. At the time of arrest, did the client have psychiatric disorder(s) that were formally diagnosed by a health care professional?

☐ No

☐ Yes

a. If YES, what diagnosis (check all that apply)?

☐ Depression

☐ Anxiety disorders

☐ PTSD

☐ Schizophrenia

☐ Personality disorders

☐ Eating disorders

☐ Other: _____

33. Does the client have a history of suicide attempt?

☐ No

☐ Yes

a. If YES, does the client report suicidal ideation right now?

☐ No

☐ Yes

b. Was a referral made to a mental health counselor?

☐ No

☐ Yes

c. Has a safety plan been discussed?

☐ No

☐ Yes

34. At the time of arrest, was the client receiving professional help for their mental health problem(s)?

☐ No

☐ Yes

a. If YES, what type of help (all that apply)?

☐ Inpatient treatment facility

☐ Outpatient counseling

☐ Medication

35. Is the client able to receive mental health services at the ACCRCS?

☐ No

☐ Yes

a. If YES, what will the client receive (Check all that apply)?

☐ Individual counseling

☐ Group counseling

☐ Medication

Medical Conditions

36. Does the client have any other medical problems?

☐ No

☐ Yes

a. If Yes, what is the condition(s) (list all)?

_____

_____

b. Does the client have access to medical care needed in the ACCRCS?

☐ No

☐ Yes

37. Is the client currently pregnant?

☐ No

☐ Yes

CCCCS Re-entry Service

38. What services is the client interested in receiving while at the ACCRCS?
    - ☐ Overdose prevention education
    - ☐ How to administer naloxone
    - ☐ General harm reduction education
    - ☐ Advocacy and support for linkage to a community provider
    - ☐ Linkage to peer navigation
    - ☐ Safety planning

39. What services is the client interested in receiving from the CCCCS Re-entry service after release from the ACCRCS?
    - ☐ Linkage to community MAT provider
    - ☐ Linkage to other SUD treatment services
    - ☐ Overdose prevention education
    - ☐ Naloxone kits
    - ☐ HCV testing/linkage to treatment
    - ☐ HIV testing/linkage to treatment
    - ☐ Transportation
    - ☐ Insurance
    - ☐ Entitlement
    - ☐ Syringe exchange program
    - ☐ Peer navigation
    - ☐ Housing
    - ☐ PrEP
    - ☐ Linkage primary doctor
    - ☐ Linkage to mental health specialist
    - ☐ Other (Specify: _____)

Data Collection Tool #2: Post-Release Assessment (2-weeks and 1-month follow-up)

CCCCS Re-Entry Program Post-Release Assessment

Case ID: _____

Date of assessment: ____ / ____ / _____

Place of assessment: _____

Date of release from the ACCRCS: _____ / _____ / _____

Last contact with the client: _____ / _____ / _____

Unmet Needs

1. Please select the statement that describe the client's needs…

Since the ACCRCS, the client felt they needed assistance for…	*Yes, and assistance was provided*	*Yes, the client needed to, but the assistance was denied/unavailable*	*Yes, the client needed, but didn't seek assistance*	*No, the client didn't need to*
Food insecurity (e.g., food pantry)	1	2	3	4
Disability	1	2	3	4
Welfare/entitlement programs	1	2	3	4
Transportation	1	2	3	4
Employment	1	2	3	4
Housing	1	2	3	4
Insurance	1	2	3	4
Primary care	1	2	3	4
Substance use treatment	1	2	3	4
Mental health treatment	1	2	3	4
Other specialty care	1	2	3	4

CCCCS Re-Entry Service

2. What services has the client received from the CCCCS Re-entry service since the last contact on [date]?

☐ Linkage to community MAT provider
☐ Linkage to other SUD treatment services
☐ Overdose prevention education
☐ Naloxone kits
☐ HCV testing/linkage to treatment
☐ HIV testing/linkage to treatment
☐ Transportation
☐ Insurance
☐ Entitlement
☐ Syringe exchange program

☐ Peer navigation
☐ Housing
☐ PrEP
☐ Linkage primary doctor
☐ Linkage to mental health specialist
☐ Other (Specify: _____)

Sociodemographic information

3. What is your current employment status?
   ☐ Employed full-time (at least 35 hours a week)
   ☐ Employed part-time
   ☐ A homemaker or caregiver
   ☐ A full-time student
   ☐ Unemployed
   ☐ Unable to work for health reasons
   ☐ Other (please specify): _____

4. Since we last spoke on [date], how many days were you paid for working, including “under-the-table” work, paid sick days, and vacation.

   ____ days

5. Since we last spoke, how many days have you experienced employment problems (e.g., inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized).

   ____ days

6. Are you currently homeless (i.e., living from place-to-place, including "couch-surfing," on the street, in a car, park, abandoned building, tent, campsite, squat or shelter)?
   ☐ Yes
   a. If YES, where did the client spend last night?
   ☐ With family
   ☐ With friends
   ☐ In a shelter
   ☐ Outside on the street, or in a car, park, abandoned building, tent, campsite, or squat
   ☐ Other (please specify): _____

   ☐ No
   b. If NO, what best describes the client’s current housing status?
   ☐ Own a house/apartment
   ☐ Rent a home/apartment
   ☐ Live in place owned/rented by someone (e.g., family, friends)

☐ Other (Specify: _____)

7. Do you currently have health insurance?
   ☐ No
   ☐ Yes

a. If YES, please indicate the type of insurance:
   ☐ Private insurance (Plan: _____)
   ☐ Medicaid
   ☐ Medicare
   ☐ Uninsured
   ☐ Unknown
   ☐ Other (Specify: _____)

Relationship

8. Has your relationship or marital status changed since the last time we spoke?
   ☐ No
   ☐ Yes

9. With whom do you spend most of your free time?
   ☐ Family
   ☐ Friends
   ☐ Alone

10. Are you satisfied spending your free time this way?
    ☐ No
    ☐ Indifferent
    ☐ Yes

11. Since the last time we spoke, have you had significant periods in which you have experienced serious problems getting along with:

Who?	How many days?
Parent(s)	
Sibling(s)	
Spouse/significant other/partner	
Children	
Other relatives (specify:)	
Close friends	
Co-workers	
Neighbors	

Substance use

12. Have you used drugs since the last time we spoke?
    - ☐ No
    - ☐ Yes (When did the client start using? ____ / ____ / _____)

13. On average, how frequently do you use drugs?
    - ☐ Every day or almost every day
    - ☐ Not every day, but at least once per week
    - ☐ Not every week, but at least once this month
    - ☐ No reported drug use since last contact

14. Have you injected drugs since the last time we spoke?
    - ☐ No
    - ☐ Yes

15. Have you experienced any drug overdose since the last time we spoke?
    - ☐ No
    - ☐ Yes
        b. If YES, how many times? _____ times

16. Do you currently carry a naloxone kit?
    - ☐ No
    - ☐ Yes
        a. If YES, how the client obtained the kit?
            - ☐ Received at the time of release from the ACCRCS
            - ☐ I had it prior to arrest
            - ☐ Received it from CCCCS or other community provider
            - ☐ My friend/family gave me one
            - ☐ Other (Specify: _____)

Substance use treatment

17. Do you currently receive any of the following recovery services for a substance use disorder? (Check all that apply)

    - ☐ Medication assisted treatment for OUD
    - ☐ Medication for other SUD
    - ☐ Professional counseling (individual or group)
    - ☐ Inpatient rehabilitation
    - ☐ AA/NA
    - ☐ Other support group
    - ☐ Peer recovery support
    - ☐ A halfway house or therapeutic community
    - ☐ Other (specify: _____)

For those receiving MAT

18. What medication?
    - ☐ Methadone
    - ☐ Buprenorphine
    - ☐ Naltrexone

19. Did the client received a bridge prescription upon release from the ACCRCS? [Ask only for first follow-up.]
    - ☐ No
    - ☐ Yes
        a. If YES, how many day? ____ days

20. Who is the current prescriber? _____

For those who discontinued MAT after last meeting

21. Reason(s) for discontinuation

_____

_____

Harm reduction strategies (for illicit drug use)

22. Since last week spoke, how frequently did you do the following?

	Never	Rarely	Sometimes	Often	Always	Not applicable
Using drugs with others, not alone	1	2	3	4	5	9
Share needles	1	2	3	4	5	9
Share other equipment	1	2	3	4	5	9
Use drugs in public	1	2	3	4	5	9
Received overdose education training	1	2	3	4	5	9
Carry naloxone	1	2	3	4	5	9
Use clean needles	1	2	3	4	5	9
Use fentanyl test strips	1	2	3	4	5	9
Use a small amount first (i.e., test shot)	1	2	3	4	5	9
Mix multiple types of drugs	1	2	3	4	5	9
Reduce the amount and/or frequency of drug use	1	2	3	4	5	9

CJS involvement

23. Have you interacted with law enforcement since our last meeting? This includes interactions that did not result in arrest.
    ☐ No
    ☐ Yes
    If Yes, how many times? ____ times

24. Have you been arrested due to your drug use since the last time we spoke?
    ☐ No
    ☐ Yes
    If Yes, how many times? ____ times

25. How many times have you been incarcerated due to your drug use since the last time we spoke?
    ☐ No
    ☐ Yes
    If Yes, how many times? ____ times

Health care utilization

26. Do you have somewhere to go to be seen by a doctor, nurse, or other healthcare provider if you are sick?
    ☐ No
    ☐ Yes
    a. If Yes, is it a primary care provider?
    ☐ No
    ☐ Yes

27. Have you gone to an emergency room since the last time we spoke?
    ☐ No
    ☐ Yes
    a. If YES, how many times? ____ times
    b. If YES, what was the reason? _____

Mental health & mental health service utilization

28. Have you received professional help for your mental health since the last time we spoke?
    ☐ No
    b. If NO, is there a plan to refer the client to mental health service?
    ☐ No (Why not? _____)
    ☐ Yes
    ☐ Yes
    a. If YES, what type of help?
    ☐ Inpatient treatment facility
    ☐ Outpatient counseling
    ☐ Medication

29. Have you experienced any suicidal ideation (thoughts of suicide) since the last time we spoke?
    ☐ No
    ☐ Yes

30. Have you attempted suicide since the last time we spoke?
    ☐ No
    ☐ Yes

    If YES,
    a. Was a referral made to a mental health specialist?
        ☐ No
        ☐ Yes
    b. Has a safety plan been discussed?
        ☐ No
        ☐ Yes

Data Collection Tool #3: Post-Release Assessment (3- and 6-month follow-ups)

CCCCS Re-Entry Program Post-Release Assessment (3 and 6 months)

Case ID:_____

Date of assessment: ____ / ____ / _____

Place of assessment: _____

Last contact with the client: _____ / _____ / _____

Unmet Needs

1. Please select the statement that describe the client's needs…

In the past 30 days, the client felt they needed assistance for…	*Yes, and assistance was provided*	*Yes, the client needed to, but the assistance was denied/unavailable*	*Yes, the client needed, but didn't seek assistance*	*No, the client didn't need to*
Food insecurity (e.g., food pantry)	1	2	3	4
Disability	1	2	3	4
Welfare/entitlement programs	1	2	3	4
Transportation	1	2	3	4
Employment	1	2	3	4
Housing	1	2	3	4
Insurance	1	2	3	4
Primary care	1	2	3	4
Substance use treatment	1	2	3	4
Mental health treatment	1	2	3	4
Other specialty care	1	2	3	4

CCCCS Re-entry Service

2. What services has the client received from the CCCCS Re-entry service since the last contact on [date]?
   - ☐ Linkage to community MAT provider
   - ☐ Linkage to other SUD treatment services
   - ☐ Overdose prevention education
   - ☐ Naloxone kits
   - ☐ HCV testing/linkage to treatment
   - ☐ HIV testing/linkage to treatment
   - ☐ Transportation
   - ☐ Insurance
   - ☐ Entitlement
   - ☐ Syringe exchange program
   - ☐ Peer navigation

☐ Housing
☐ PrEP
☐ Linkage primary doctor
☐ Linkage to mental health specialist
☐ Other (Specify: _____)

Sociodemographic information

3. What is your current employment status?
   ☐ Employed full-time (at least 35 hours a week)
   ☐ Employed part-time
   ☐ A homemaker or caregiver
   ☐ A full-time student
   ☐ Unemployed
   ☐ Unable to work for health reasons
   ☐ Other (please specify): _____

4. In the past 30 days, how many days were you paid for working, including “under-the-table” work, paid sick days, and vacation.

   ____ days

5. In the past 30 days, how many days have you experienced employment problems (e.g., inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized).

   ____ days

6. Are you currently homeless (i.e., living from place-to-place, including "couch-surfing," on the street, in a car, park, abandoned building, tent, campsite, squat or shelter)?
   ☐ Yes
      a. If YES, where did the client spend last night?
         ☐ With family
         ☐ With friends
         ☐ In a shelter
         ☐ Outside on the street, or in a car, park, abandoned building, tent, campsite, or squat
         ☐ Other (please specify): _____

   ☐ No
      b. If NO, what best describes the client’s current housing status?
         ☐ Own a house/apartment
         ☐ Rent a home/apartment
         ☐ Live in place owned/rented by someone (e.g., family, friends)
         ☐ Other (Specify: _____)

7. Do you currently have health insurance?
   ☐ No
   ☐ Yes

   b. If YES, please indicate the type of insurance:
      ☐ Private insurance (Plan: _____)
      ☐ Medicaid
      ☐ Medicare
      ☐ Uninsured
      ☐ Unknown
      ☐ Other (Specify: _____)

Relationship

8. Has your relationship or marital status changed since the last time we spoke?
   ☐ No
   ☐ Yes

9. With whom do you spend most of your free time?
   ☐ Family
   ☐ Friends
   ☐ Alone

10. Are you satisfied spending your free time this way?
    ☐ No
    ☐ Indifferent
    ☐ Yes

11. In the past 30 days, have you had significant periods in which you have experienced serious problems getting along with:

Who?	How many days?
Parent(s)	
Sibling(s)	
Spouse/significant other/partner	
Children	
Other relatives (specify:)	
Close friends	
Co-workers	
Neighbors	

Substance use

12. Have you used drugs since the last time we spoke?
    - ☐ No
    - ☐ Yes (When did the client start using? ____ / ____ / _____)

13. On average, how frequently do you use drugs?
    - ☐ Every day or almost every day
    - ☐ Not every day, but at least once per week
    - ☐ Not every week, but at least once this month
    - ☐ No reported drug use since last contact

14. Have you injected drugs since the last time we spoke?
    - ☐ No
    - ☐ Yes

15. Have you experienced any drug overdose since the last time we spoke?
    - ☐ No
    - ☐ Yes
        a. If YES, how many times? _____ times

16. Do you currently carry a naloxone kit?
    - ☐ No
    - ☐ Yes
        a. If YES, how the client obtained the kit?
            - ☐ Received at the time of release from the ACCRCS
            - ☐ I had it prior to arrest
            - ☐ Received it from CCCCS or other community provider
            - ☐ My friend/family gave me one
            - ☐ Other (Specify: _____)

Substance use treatment

17. Do you currently receive any of the following recovery services for a substance use disorder? (Check all that apply)

    - ☐ Medication assisted treatment for OUD
    - ☐ Medication for other SUD
    - ☐ Professional counseling (individual or group)
    - ☐ Inpatient rehabilitation
    - ☐ AA/NA
    - ☐ Other support group
    - ☐ Peer recovery support
    - ☐ A halfway house or therapeutic community
    - ☐ Other (specify: _____)

For those receiving MAT

18. What medication?
    - ☐ Methadone
    - ☐ Buprenorphine
    - ☐ Naltrexone

19. Who is the current prescriber? _____

For those who discontinued MAT **after last meeting**

20. Reason(s) for discontinuation

_____

_____

Harm reduction strategies (for illicit drug use)

21. In the past 30 days, how frequently did you do the following?

	Never	Rarely	Sometimes	Often	Always	Not applicable
Using drugs with others, not alone	1	2	3	4	5	9
Share needles	1	2	3	4	5	9
Share other equipment	1	2	3	4	5	9
Use drugs in public	1	2	3	4	5	9
Received overdose education training	1	2	3	4	5	9
Carry naloxone	1	2	3	4	5	9
Use clean needles	1	2	3	4	5	9
Use fentanyl test strips	1	2	3	4	5	9
Use a small amount first (i.e., test shot)	1	2	3	4	5	9
Mix multiple types of drugs	1	2	3	4	5	9
Reduce the amount and/or frequency of drug use	1	2	3	4	5	9

22. You selected “Never”, “Rarely”, and “Sometimes” for ____[**LIST HARM REDUCTION STRATEGIES]**_____.
    In your opinion, what are the barriers to consistently use these strategies?

CJS involvement

23. Have you interacted with law enforcement since our last meeting? This includes interactions that did not result in arrest.
    ☐ No
    ☐ Yes
    If Yes, how many times? ____ times

24. Have you been arrested due to your drug use since the last time we spoke?
    ☐ No
    ☐ Yes
    If Yes, how many times? ____ times

25. How many times have you been incarcerated due to your drug use since the last time we spoke?
    ☐ No
    ☐ Yes
    If Yes, how many times? ____ times

Health care utilization

26. Do you have somewhere to go to be seen by a doctor, nurse, or other healthcare provider if you are sick?
    ☐ No
    ☐ Yes
    a. If Yes, is it a primary care provider?
    ☐ No
    ☐ Yes
27. Have you gone to an emergency room since the last time we spoke?
    ☐ No
    ☐ Yes
    a. If YES, how many times? ____ times
    b. If YES, what was the reason? _____

Mental health & mental health service utilization

28. Have you received professional help for mental health problems since the last time we spoke?
    ☐ No
    a. If NO, is there a plan to refer the client to mental health service?
    ☐ No (Why not? _____)
    ☐ Yes
    ☐ Yes
    a. If YES, what type of help?

☐ Inpatient treatment facility
☐ Outpatient counseling
☐ Medication

29. Have you experienced any suicidal ideation (thoughts of suicide) since the last time we spoke?
    ☐ No
    ☐ Yes

30. Have you attempted suicide since the last time we spoke?
    ☐ No
    ☐ Yes

    If YES,
    a. Was a referral made to a mental health specialist?
        ☐ No
        ☐ Yes
    b. Has a safety plan been discussed?
        ☐ No
        ☐ Yes

Data Collection Tool #4: Re-Entry Program Client Acceptability Survey

Client Acceptability Survey Questions

First, we'd like to ask about your experiences with the Albany County Correctional facility (ACCRCS) Medication-Assisted Treatment (MAT) program.

1. How did you learn about the program?

   __ From the ACCRCS Medical Team during a medical screening

   __ When I was reading orientation materials on the tablet provided by the jail

   __ From the CASAC team

   __ From a mental health counselor

   __ From other inmate(s)

   __ During overdose education and Narcan® training

   __ Other (please describe: _____)

2. Can you briefly tell us why you decided to enroll into the MAT program?

3. Please read the following statements about your experiences with MAT program and indicate the extent to which you agree or disagree with each.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
My experience with the staff at ACCRCS was free of stigma (judgement).					
The staff at ACCRCS treated me with respect.					
The staff at ACCRCS were encouraging and supportive of the MAT program.					
I felt comfortable talking about my substance use with the staff at ACCRCS.					
I felt comfortable voicing questions/concerns about my medication to the staff at ACCRCS.					

4. Please indicate how satisfied you were with each of the following aspects of the ACCRCS MAT Program.

	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
The time it took for you to get your first dose of medication					
The dosage options available to you					
The medication distribution process					

Next, we'd like to ask your experiences with the Catholic Charities Care Coordination Services (CCCCS) Re-Entry Program.

5. Please read the following statements about your experiences with the Re-Entry Program and indicate the extent to which you agree or disagree with each.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
I have a clear understanding of the services offered by the CCCCS Re-Entry Program.					
My experience with the CCCCS re-entry specialists has been free of stigma (judgement).					
The re-entry specialists have treated me with respect.					
The re-entry specialists have been supportive with my re-entry into the community.					
I have felt comfortable talking about my drug use with the re-entry specialists.					
I have felt comfortable asking the re-entry specialists for help.					
The Re-Entry Program has helped me overcome challenges during my re-entry into the community.					
The Re-Entry Program has helped me overcome challenges with working on my substance use.					

6. What aspects of the Re-Entry Program have been most helpful in working on your substance use and/or re-entry into the community following your release from ACCRCS (check all that apply)?

	Check
Linkage to services that address my basic needs (food, housing, insurance, transportation)	
Linkage to medical care that helps address my physical and/or mental health issues	
Feeling supported and cared for by someone	
The opportunity to talk about my substance use or life problems without feeling stigmatized (judged)	
Access to safer injection and/or other safer use equipment	
Overdose prevention education	
Access to Narcan/naloxone for reversing opioid overdose	

7. In your own words, please describe how the services from CCCCS Re-Entry Program have impacted you upon your return to the community.

8. Please provide any suggestions you may have for the CCCCS Re-Entry Program at this point.

The following questions are for the clients who received MAT in jail.

9. In your own words, please describe how your experience was with MAT in jail?

10. Please provide any suggestions you may have for the ACCRCS MAT Program.