Overview of Written Work/Abstract

(100-200 words)

The period immediately following release from incarceration represents a critical "cliff edge" for opioid overdose, with risk levels significantly higher than the general population. Despite known interventions, U.S. reentry remains fragmented, relying on discretionary programs rather than standardized clinical safeguards. This paper proposes a "safe release standard", a non-negotiable discharge bundle including MOUD initiation, take-home naloxone, and "warm" handoffs to community care. By shifting the framing from elective programming to a health services design problem, jurisdictions can leverage new federal Medicaid opportunities to ensure continuity. Transitioning to a standardized, measurable protocol is essential to convert predictable risks into manageable public health outcomes.

Having a Safe Release Standard from Prisons in the United States

(800-1200 words)

Opioid overdose is a leading cause of death in the period immediately after release from incarceration, driven by reduced opioid tolerance, interrupted treatment, unstable housing, and abrupt transitions in care [1,2]. In a landmark cohort study, the first two weeks after release from prison were associated with a markedly elevated risk of death from drug overdose compared with the general population [1]. More recent analyses that track both fatal and nonfatal events similarly show that overdose risk concentrates in the early post-release window and is closely tied to gaps in continuity of addiction care [2]. This pattern is not only a clinical problem affecting individuals. Instead, it reflects a failure in how prison-to-community transitions are designed.

One clear improvement is to establish a safe release standard for prison systems, defined as a minimum set of evidence-based steps that must occur before release for people at risk of opioid overdose. In practice, this is analogous to a discharge bundle used in hospitals: a standardized pathway that ensures the highest-risk transition is supported by basic safeguards, rather than left to ad hoc decision-making. A safe release standard does not require new pharmacology or novel clinical insights. It simply applies what is already known about overdose prevention and treatment continuity, and it makes those practices routine so that a person's safety does not depend on the facility they leave, the county they return to, or whether a single staff member has time to coordinate reentry.

International guidance from the World Health Organization and the United Nations Office on Drugs and Crime emphasizes continuity of evidence-based treatment for drug dependence in custodial settings and linkage to care in the community [4]. In the United States, correctional health guidance increasingly frames medications for opioid use disorder (MOUD) and reentry planning as implementation problems rather than elective programming, highlighting service

delivery models, staff training, and operational steps needed for consistent uptake [5]. This shift in framing matters because it positions safe release as a health services design problem, where the key question is not whether reentry support is desirable, but what minimum standard of transition should be considered safe.

The United Kingdom offers a useful example of how system design can standardize outcomes when risk is concentrated around a predictable transition. Scotland's national take-home naloxone program is explicitly structured to reach people at high risk of opioid death, including those leaving prison, and has been evaluated using opioid-related deaths within weeks of prison release as a core outcome [7]. The significance of this model is not that the United States must adopt Scotland's governance structure or commissioning arrangements, but that it demonstrates feasibility: naloxone-on-release can be treated as a routine system function, supported by written protocols and measurable targets, rather than as a discretionary add-on.

The baseline U.S. system stands in sharp contrast. Many jurisdictions still do not provide comprehensive MOUD access in custody, and reentry coordination varies widely across facilities and counties [3,5]. Even where treatment is initiated, continuity can break at the point of release because of administrative barriers, lack of identification, lapsed insurance, limited appointment availability, transportation constraints, and stigma in downstream settings. The result is a fragmented pathway in which the highest-risk period is managed with the least reliable infrastructure.

A safe release standard would therefore treat release as a structured clinical handoff and would make a small number of steps non-negotiable for people at risk of opioid overdose. At a minimum, this includes early identification of OUD and overdose risk, with a clear discharge plan that travels with the patient; initiation or continuation of MOUD during incarceration paired with a plan for uninterrupted dosing or rapid follow-up after release; provision of take-home naloxone at release with brief education that is realistic and non-stigmatizing; benefits activation and "warm" linkage to community care so that treatment and medications are actually accessible in the first days after release; and basic release logistics designed around service availability, such as release timing that permits pharmacy access, clinic intake, and transportation. The goal is not to create an idealized reentry program. It is to ensure that the system reliably delivers the minimum conditions for a safer transition.

Not only does standardization improve safety, but it also enables accountability and iterative improvement. When safe release is framed as a defined bundle, systems can track a small number of indicators that directly measure implementation: the proportion of people released with an active MOUD plan and confirmed follow-up; the proportion released with naloxone in hand; the proportion with insurance active on day of release; and the frequency of documented medication gaps across the transition. These measures convert a broad moral imperative into an operational agenda that can be audited and improved.

Experience with statewide correctional MOUD programs underscores why these components should be treated as standard rather than exceptional. Implementation in Rhode Island's unified jail and prison system, for example, has been associated with substantial reductions in post-incarceration overdose deaths, illustrating both feasibility and the potential for population-level impact when treatment is scaled and linked to reentry [8,9]. The mechanism is straightforward: people are more likely to survive the transition when treatment is available during incarceration and continuity is protected at release. The safe release standard builds on this insight by making continuity and linkage explicit design requirements rather than assumptions.

Recent federal policy developments also make standardization more plausible. The Medicaid Reentry Section 1115 Demonstration Opportunity is explicitly intended to improve care transitions by supporting coverage of certain pre-release services, thereby reducing discontinuity at the moment of release [6]. Financing does not solve implementation by itself, but it addresses one of the structural reasons reentry planning remains inconsistent: many of the necessary coordination tasks are time-consuming, require cross-system communication, and historically have not been reimbursed. A safe release standard can therefore align clinical intent with practical capacity by pairing clear expectations with workable payment and accountability structures.

To that end, a health services improvement agenda for safe release in U.S. prison systems would build on existing evidence in three ways. First, it would treat safe release as a multi-level intervention rather than a single program, examining how the standard changes the patient journey, including time spent traveling, waiting, and navigating administrative barriers, as well as experiences of respect or stigma in the transition [2,5]. Second, it would use rigorous evaluation designs that compare jurisdictions implementing safe release standards with those that do not, tracking changes over time in overdose events, treatment initiation and retention, and the equity effects of implementation across rural and urban areas and across racial and insurance-related gaps [2,3]. Third, it would build feedback loops that link data to practice, using simple dashboards co-designed with people who use drugs, correctional health teams, and community providers so that missed steps translate into targeted workflow fixes and clearer operating procedures, rather than vague calls for "better reentry."

In a country where overdose risk is tightly linked to structural vulnerability, establishing a safe release standard offers a concrete way to redesign a predictable high-risk transition so that it functions as a true public health handoff rather than a cliff edge. The evidence base already supports the core components: medications for opioid use disorder reduce overdose risk and improve continuity of care, and naloxone distribution is a pragmatic intervention for an acute high-risk window [5,7–9]. The remaining question is whether prison systems will treat these steps as optional programs that depend on local champions, or as the minimum standard required for safe release.

References

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