

ISUDT 5TH ANNUAL OUTCOMES REPORT

July 2026

Impacts of the Integrated Substance Use
Disorder Treatment (ISUDT) Program
on Morbidity and Mortality





**CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES**

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The authors would like to thank Ike Dodson, Supervisor II and Deanna Minasian, Graphic Design Analyst, Communications; John Dunlap, Deputy Medical Executive and KC King, Research Data Manager, and Michael Selby, Associate Director, Quality Management; Jade Li, Research Scientist, Medical Services and Janene DelMundo, Deputy Director, ISUDT & Special Projects for their assistance and contributions.

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Executive Summary

This report marks the fifth annual review of the Integrated Substance Use Disorder Treatment (ISUDT) Program. It provides a comprehensive overview of the prevalence and impacts of substance use disorders (SUDs) on the California Department of Corrections and Rehabilitation's (CDCR) population, highlighting the persistent challenges SUDs pose and demonstrating the ongoing necessity of this program. This report details how the ISUDT Program addresses these challenges through the delivery of targeted, evidence-based services, and summarizes the program's impact on reducing SUD-related morbidity and mortality. Additionally, the report discusses current challenges and identifies future opportunities for further progress in addressing SUD-related complications, both among people incarcerated within CDCR and as they transition back into the community.

Scope of the Problem and Need for ISUDT Program

Overdose deaths remain a major public health and safety risk for the United States (U.S.), California, and CDCR, with opioids, especially illicit fentanyl, continuing to cause most overdose fatalities. Although overdose deaths declined by 14% nationally in 2025, an average of 192 Americans still died every day from overdose.¹ California, while also experiencing decreases in overall overdose deaths, continues to face a fentanyl crisis, with overdose rates remaining above pre-pandemic levels and substantial quantities of illicit drugs entering the state and our prisons. Expanded access to naloxone (an opioid antagonist medication), medication assisted treatment (MAT), and harm reduction efforts have contributed to recent progress, but overdose remains a leading cause of death among adults aged 18–44.²

The prevalence of SUDs along with availability of illicit drugs within CDCR has resulted in a significant proportion of CDCR's population remaining at high risk of SUD-related harm, including overdose death. As of December 2025, 45% (40,328) of CDCR's population were identified with at least one SUD: 34% (31,053) with opioid use disorder (OUD), 28% (25,615) with a stimulant use disorder (StUD), and 22% (19,528) with alcohol use disorder (AUD). Notably, among people identified with OUD, 61% (19,054) had a co-occurring StUD.

In 2024, the overall overdose death rate in CDCR was 83 per 100,000 with fentanyl remaining the primary cause of these deaths (60 per 100,000); the opioid-related overdose death rate was 67 per 100,000. Stimulant-involved overdose deaths had the second highest rate within CDCR at 28 per 100,000. However, in 2025, preliminary mortality data indicate the overdose death rate among CDCR's population is estimated at 53 per 100,000 representing a 36% reduction in the overdose death rate compared to 2024. While this downward trend is encouraging, overdose death rates in CDCR remain four times higher than rates in California and the nation,

¹ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

² <https://www.cdc.gov/media/releases/2025/2025-statement-from-cdcs-national-center-for-injury-prevention-and-control-on-provisional-2024.html>

underscoring the need to sustain and strengthen supportive environments, access to treatments, and interdiction efforts.

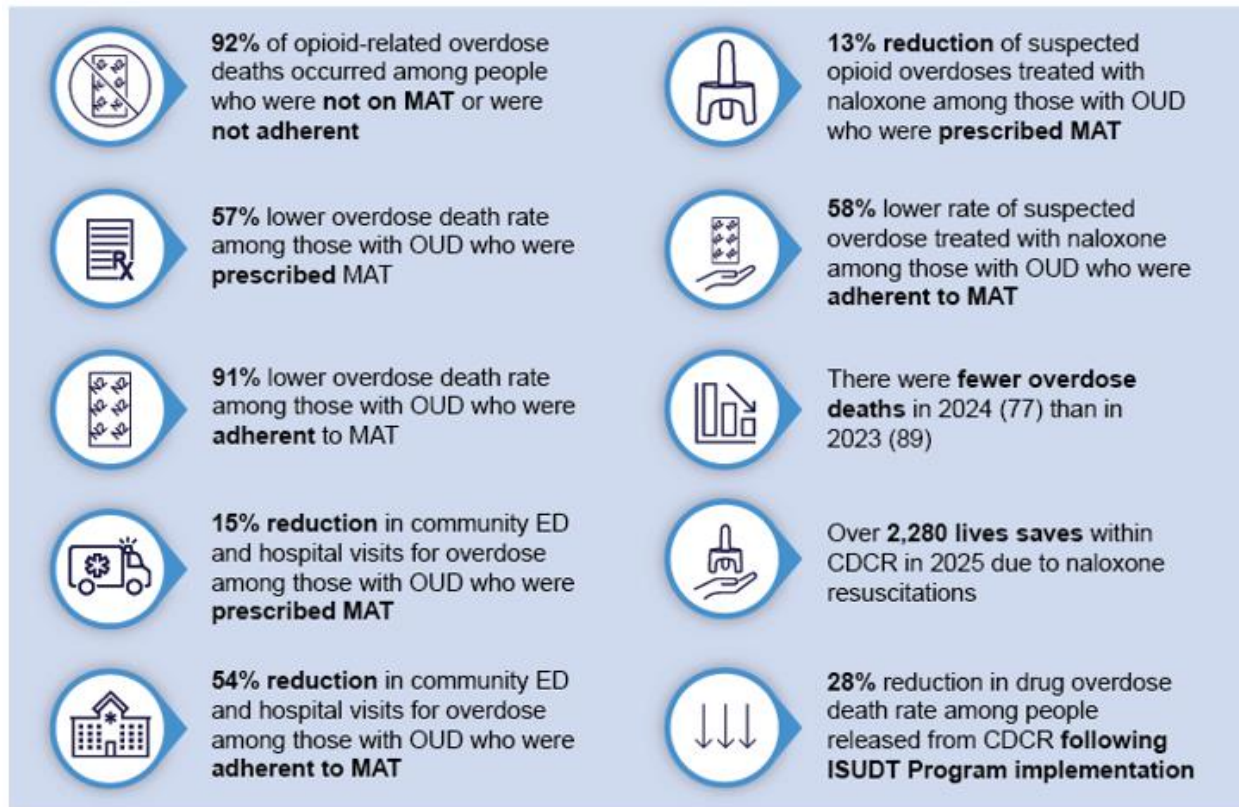
Delivery of ISUDT Program Services

In response to high rate of overdose deaths, the elevated prevalence of SUD among CDCR's population, and evidence of the effectiveness of MAT and other therapies, the Department launched the ISUDT Program in 2020 to improve health outcomes associated with SUD and to reduce SUD-related morbidity and mortality. The ISUDT Program is a statewide model designed to manage SUD as a chronic condition and is comprised of five core components: 1) SUD Screening and Assessment; 2) Cognitive Behavioral Interventions (CBI), psychosocial education and Cognitive Behavioral Therapy (CBT); 3) MAT; 4) Supportive Housing; and 5) Enhanced Pre-Release Planning and Transition Services.

From 2020 through 2025, most components of the program have been implemented including integration of MAT into primary care statewide. During this period, 209,971 people were screened, 103,429 people received a clinical assessment for SUD, 57,754 people were prescribed MAT, 54,863 people received SUD-focused CBI, and 3,186 people received intensive CBT.

ISUDT Program Impacts

Implementation of the ISUDT Program has improved access to OUD treatment within CDCR and aligns our treatment practices with community standards of care. The ISUDT Program continues to achieve its primary goal of reducing morbidity and mortality, especially related to OUD.



Current Challenges & Future Opportunities

This report demonstrates that MAT continues to significantly reduce the risk of fatal and non-fatal overdoses within CDCR, especially among people adherent to treatment. Despite these positive outcomes, the data within this report demonstrates the need for additional interventions to engage and retain more people with OUD in treatment and implement evidence-based strategies to treat StUD including contingency management (CM). Additionally, strengthening rehabilitation and treatment settings is essential for better outcomes. This includes expanding peer support, enhancing education for staff and the population, addressing demographic disparities in access and adherence, and increasing interdiction efforts to reduce the introduction of illicit substances. Efforts such as the California Advancing and Innovating Medi-Cal (CalAIM) Justice-Involved Initiative are essential to providing care continuity for individuals after release. CalAIM seeks to connect individuals to Enhanced Care Managers prior to release to maintain treatment engagement post-release, reduce relapse and recidivism and improve public safety and outcomes for justice-involved populations.

Full Report

Scope of the Problem & Need for ISUDT Program

Overdose Deaths in the U.S.

Although drug overdose deaths fell in 2025 by roughly 14%, on average 192 Americans lost their lives each day due to overdose, representing the ongoing, lethal impacts of drugs in the U.S. Opioids continue to be the main driver of overdose deaths contributing to 64% of these deaths with illicit fentanyl accounting for the vast majority (58%) of all overdose deaths.³

Over the past several decades, the U.S. has experienced multiple surges of opioid-related harm, including prescription opioids, heroin, and, most recently, illicit synthetic opioids such as fentanyl.⁴ For context, overdose deaths peaked at nearly 111,000 in 2022.⁵ After a modest decline in 2023, overdose deaths fell sharply in 2024 to approximately 82,000. Preliminary data indicate the decline continued into 2025, reaching levels comparable to 2019. The American Medical Association's report released in 2025 on the nation's overdose epidemic shows that while opioid-related overdose deaths have declined, the epidemic remains widespread and increasingly complex, driven by mixing opioids and other substances including methamphetamines, and an unpredictable illicit drug supply.⁶

Several factors likely contributed to the recent decline in overdose deaths, including broader availability of naloxone, expanded access to MAT, and ongoing harm reduction and public health investments.⁷ Long-term reductions in opioid prescribing may also have helped reduce new cases of OUD.⁸ Despite progress, overdose remains a leading cause of death among adults ages 18–44, and fentanyl continues to drive deaths nationwide.^{9 10}

Fentanyl overdoses have fundamentally changed the landscape of emergency medical care in the U.S., creating a high-burden, high risk environment characterized by increasing Emergency Department (ED) volume, and complex, severe cases of OUD. Between October 2020 to March 2024, ED visits for nonfatal fentanyl-involved overdoses increased by an average of 5.4% per quarter. Centers for Disease Control and Prevention surveillance data indicates fentanyl-related ED visits increased substantially compared to earlier years and remained elevated

³ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

⁴ <https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html>

⁵ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

⁶ <https://www.ama-assn.org/press-center/ama-press-releases/ama-2025-report-substance-use-and-treatment>

⁷ <https://apnews.com/article/overdose-deaths-cdc-fentanyl-8e3a42544f57eea6a9af3be541178a4d>

⁸ <https://www.cdc.gov/overdose-prevention/data-research/facts-stats/opioid-dispensing-rate-maps.html>

⁹ <https://www.cdc.gov/media/releases/2025/2025-cdc-reports-decline-in-us-drug-overdose-deaths.html#:~:text=While%20this%20national%20decline%20is,self%2Dreported%20youth%20substance%20use>

¹⁰ <https://www.dea.gov/press-releases/2025/05/15/dea-releases-2025-national-drug-threat-assessment#:~:text=Drug%20overdose%20deaths%20decreased%20by,is%20as%20dangerous%20as%20ever>

through 2025.^{11 12} These trends reinforce the importance of post-overdose interventions that expand naloxone access and connect people to ongoing treatment including MAT.^{13 14}

Overdose Deaths in California

California continued to experience a severe fentanyl epidemic in 2025, characterized by high numbers of fatal overdoses and massive drug seizures. In 2025, fentanyl remained the primary driver of overdose deaths in California, accounting for 2,530 deaths as of July 2025 (Based on preliminary, half-year data. Finalized year-end numbers will be higher).¹⁵ California's overdose deaths peaked in 2023 (11,359 deaths) and declined in 2024 (9,018 deaths).¹⁶ Reductions in opioid-related overdose death rates per 100,000 accounted for most of the overall decline: those involving any opioid-declined by 30% from 20.1 to 14.0 and those involving fentanyl declined by 33% from 18.3 to 12.2. In the same timeframe, the psychostimulant overdose death rate declined by just 16% from 15.7 to 13.2 per 100,000. Preliminary data through mid-2025 project overdose deaths to remain above 2019 levels, and in several counties the crisis has remained intense, with reports of a "homeless epidemic" related to fentanyl in Los Angeles around areas like Skid Row.¹⁷

Overdose Deaths in Incarcerated and Justice-involved Populations

Overdose continues to disproportionately impact justice-involved populations during incarceration and especially in the period immediately following release.¹⁸ National analyses identifies overdose as a leading cause of death among people recently released from prison and a leading cause of death in prisons and jails.¹⁹ This elevated risk has implications for correctional health services, reentry planning, and community partnerships.²⁰

Illicit Drugs in California and CDCR

Illicit drugs (fentanyl and methamphetamine) continue to enter California at unprecedented rates. State reporting indicates that from 2021 through February 2026, expanded border interdiction efforts seized more than 34,000 pounds of fentanyl or 7.6 billion deadly doses – just one pound of fentanyl contains 225,000 deadly doses.²¹ California has also expanded access to naloxone and fentanyl test strips as part of a statewide overdose prevention strategy.²² Methamphetamine availability remains a major driver of harm; local surveillance in the Los

¹¹ <https://www.cdc.gov/mmwr/volumes/74/wr/mm7416a2.htm>

¹² <https://www.cdc.gov/overdose-prevention/data-research/facts-stats/dose-dashboard-nonfatal-surveillance-data.html>

¹³ https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2840277?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2025.37678

¹⁴ <https://www.cdc.gov/mmwr/volumes/74/wr/mm7416a2.htm>

¹⁵ https://www.cdph.ca.gov/Programs/CCDCPHP/sapb/CDPH%20Document%20Library/Prelim_Monthly_Death_Data_2025_09.pdf

¹⁶ <https://skylab.cdph.ca.gov/ODdash/?tab=CA>

¹⁷ <https://www.pbs.org/video/homeless-in-la-the-fentanyl-crisis-vcmhbt/>

¹⁸ https://www.naccho.org/uploads/downloadable-resources/Final-report_cj_july2025.pdf

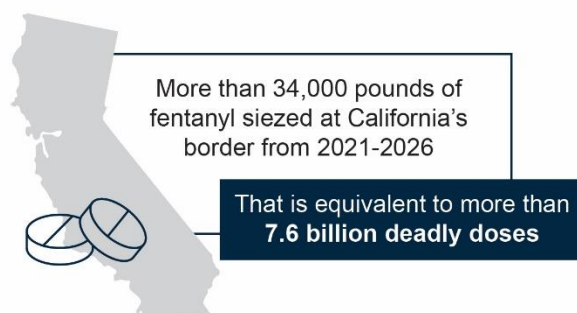
¹⁹ <https://www.vera.org/publications/overdose-deaths-and-jail-incarceration/national-trends-and-racial-disparities#:~:text=Research%20has%20confirmed%20that%20overdose,in%20custody%20in%20U.S.%20jails>

²⁰ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2834846>

²¹ <https://www.gov.ca.gov/2026/02/02/delivering-results-at-the-border-governor-newsom-announces-record-506-million-in-illicit-fentanyl-seized-since-launching-counterdrug-operations/>

²² <https://californiaopioidresponse.org/outcomes/naloxone-distribution-project-data/>

Angeles region reports methamphetamine accounts for nearly 50% of seizures by weight.²³ Even as overdose deaths decline, fentanyl and methamphetamine remain embedded in the supply, requiring sustained prevention and treatment capacity.



In 2025, large quantities of contraband continue to be interdicted within CDCR, with the Department seizing more than 1,800 grams of fentanyl with an additional 3,000 grams associated with packaging, representing increases of 125% and nearly 35%, respectively, compared to 2024. In addition, large quantities of methamphetamine continue to be seized. Ongoing pressures from the illicit drug supply reinforce the need for integrated prevention and treatment strategies.

Overdose Deaths and Prevalence of SUD among CDCR's Population

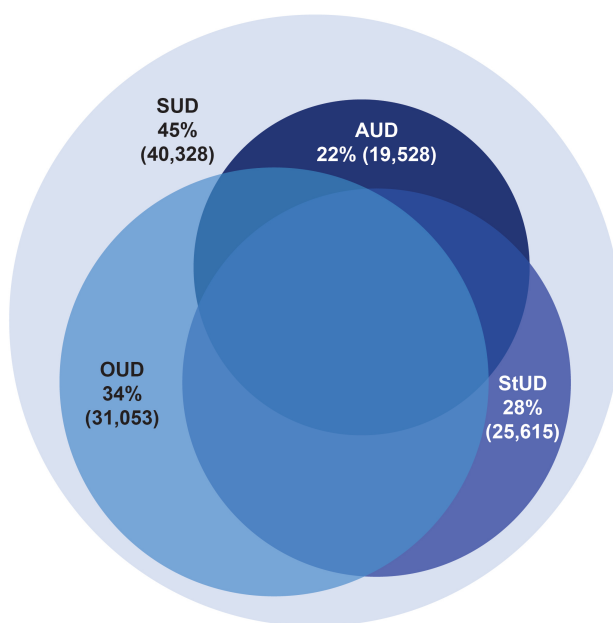
In 2024, the overall overdose death rate in CDCR was 83 per 100,000, and fentanyl remained the primary cause of overdose deaths at a rate of 60 per 100,000. The total opioid-related overdose death rate was 67 per 100,000. Stimulant-involved overdose death rate was the second highest after opioids at 28 per 100,000. However, in 2025, preliminary mortality data indicate the overdose death rate among CDCR's population is estimated at 53 per 100,000, representing a 36% reduction in overdose death rate compared to the 2024 rate. From 2024 to 2025, the proportion of opioid deaths that involved fentanyl declined from 90% to 50% (missingness > 20%; the proportion of opioid deaths in 2025 that involved fentanyl may change significantly as toxicology reports are received). In 2025, the preliminary opioid-related death rate was 27 per 100,000. The fentanyl-involved death rate was the same as the stimulant rate, both at 19 per 100,000 (see **Appendix A**).

Compounding the risk of overdose created by the availability of illicit drugs within CDCR is the high prevalence of SUDs among CDCR's population. As of December 2025, 45%, (40,328) of CDCR's population was identified with at least one SUD, 34% (31,053) with OUD, 28% (25,615) with StUD, and 22% (19,528) with AUD (**Figure 1**). Among people identified with OUD, 61% (19,054) had a co-occurring StUD (see **Appendix B**).

²³ <https://lacountydphsappc.inzastories.com/meth-availability/>

Significant proportions of people continue to enter CDCR with OUD and are at elevated risk of overdose death. During 2025, 41% (10,642) of people who entered a CDCR Reception Center were identified with OUD based on a SUD assessment, diagnosis, and treatment, overdose ED/hospital claims, and naloxone administration data. An additional 5% (1,223) of people who entered CDCR tested positive for fentanyl, a non-fentanyl opioid (without a prescription), or were on MAT (buprenorphine or methadone). Therefore, an estimated 46% of new arrivals to CDCR have an OUD, higher than the 34% prevalence in CDCR's population as a whole. The high prevalence of SUDs and access to supply of illicit drugs within CDCR has resulted in a significant proportion of CDCR's population remaining at high risk of SUD-related harm including risk of overdose death.

Figure 1: CDCR SUD Prevalence Estimates, December 2025



MAT & Effective Behavioral Interventions

MAT for OUD is a well-established standard of care and is associated with significantly lower overdose rates and overall mortality.²⁴ In CDCR, these medications are provided as part of the ISUDT Program and are paired with behavioral interventions and recovery supports. A large body of research shows that MAT reduces drug-related deaths and all-cause mortality by more than half, including during incarceration and after release.²⁵ Evidence also shows stopping MAT increases overdose risk, and that longer, continuous treatment is associated with better outcomes.^{26 27 28} Research on justice-involved populations indicates providing MAT improves

²⁴ <https://biologyinsights.com/medication-assisted-treatment-statistics-what-the-data-shows/>

²⁵ <https://nida.nih.gov/publications/drugfacts/naloxone>

²⁶ <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2780655>

²⁷ <https://www.nature.com/articles/s41380-018-0094-5>

²⁸ <https://pubmed.ncbi.nlm.nih.gov/35652681/>

survival and can reduce downstream costs by preventing overdoses and other complications.²⁹ Evidence shows initiating MAT and CM for StUD during incarceration improves engagement in community care after release.^{30 31}

Although most of CDCR's population identified with OUD has used MAT at some point during their incarceration, about one third of people with OUD in CDCR have never initiated or are not currently on MAT. In addition, the prevalence of StUD and risk of overdose from methamphetamines within CDCR remains high and supports the need for treatment such as CM to specifically address StUD.

Delivery of ISUDT Services and Program Impacts

Service Delivery in the First Five Years of Implementation

CDCR recognizes SUD as a chronic, treatable medical condition requiring a comprehensive, interdisciplinary, and integrated treatment strategy. Within CDCR, this strategy is structured around five core components: 1) **SUD Screening and Assessment**: Identifying individuals with SUD and determining the appropriate level of care through systematic screening and assessment processes, 2) **MAT for OUD and AUD**: Providing evidence-based medication therapies as part of the standard of care, 3) **Behavioral Interventions**: Offering CBI and CBT to address all forms of SUD and support recovery, 4) **Supportive Housing**: Ensuring stable housing environments that facilitate recovery and ongoing treatment engagement, and 5) **Enhanced Pre-Release Planning and Transition Services**: Preparing individuals for successful reentry into the community through coordinated transition services and planning.

Since the launch of the integrated approach in 2020 and continuing through 2025, CDCR has made significant strides in implementing these components, resulting in large-scale delivery of SUD treatment services. As outlined in the following sections CDCR operates one of the largest correctional SUD treatment programs in the nation.

The Five Core Components of the ISUDT Program

SUD Screening and Assessment

Since ISUDT implementation, there have been nearly 210,000 individuals screened and more than 90,000 individuals assessed for SUD. In 2025, CDCR updated clinical assessment workflows to identify the appropriate level of care for those nearing release and to strengthen early reentry planning. Assessment processes were also integrated with pain management workflows to reduce relapse risk during incarceration.

MAT for OUD and AUD

From 2020 through 2025, nearly 58,000 people with OUD in CDCR were prescribed MAT. As of December 2025, 87% of CDCR's population identified with OUD had used MAT at some point

²⁹ <https://onlinelibrary.wiley.com/doi/10.1111/add.70211>

³⁰ <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2848542>

³¹ <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2778020>

during their incarceration (a 7% increase from 2024) and 63% (19,643) were actively prescribed MAT (a 5% increase from 2024) (see **Appendix C** for methodology and summary data), greatly exceeding the most recent community estimates in California (31%) and nationally (25%).^{32 33}

In 2025, processes were enhanced to support timely evaluation and initiation of MAT, including further integration of OUD treatment into primary care settings. Clinicians continued to use treatment monitoring and follow-up to support patient-centered care, including additional interventions when MAT is not being taken as prescribed.

Behavioral Interventions

While the COVID-19 pandemic initially hindered the ability to deliver behavioral interventions in group settings during the early years of the ISUDT Program, nearly 189,000 individuals received cognitive behavioral services through 2025. These services included 3,186 participants who received CBT, 8,490 individuals who took part in CBI Aftercare, and 10,044 participants who engaged in Short-term Educational programming. The short-term programming was particularly impactful for individuals with brief sentences who might not have otherwise accessed services.

In 2025, CDCR continued efforts to broaden and enhance behavioral programming. Significant operational improvements included the introduction of updated service delivery models aimed at reducing wait times and increasing accessibility, refreshed curriculum tailored to better meet participant needs, and enhancements in reporting mechanisms to promote oversight and ongoing improvement. An external evaluation is currently underway to assess the impact of these operational changes on program access, completion rates, and the populations served.

CBT is available at all institutions for people who have worsening SUD or if they are not progressing in treatment, particularly following a SUD-related ED visit, hospitalization, or a suspected opioid overdose treated with naloxone. Behavioral Health Clinicians deliver CBT in an individualized manner, focusing on addressing unique barriers to treatment, building effective coping skills, and addressing trauma and dysregulation that impedes progress in recovery. In 2025, emphasis was placed on assessing and treating individuals with co-occurring SUD and pain, as a way of reducing factors that contribute to continued or intensified substance use. Additionally, access to care was improved, with most individuals receiving CBT placement within two weeks of referral.

Supportive Housing

The Department continues to explore options to create more therapeutic residential environments that support people in rehabilitation and recovery free from violence, illicit drugs, and other negative influences.

³² <https://www.sciencedirect.com/science/article/pii/S0955395922002031>

³³ <https://www.cdc.gov/mmwr/volumes/73/wr/mm7325a1.htm>

Enhanced Pre-Release Planning & Transition Services

Between 2020–2025, 43,556 (73%) of 59,638 people identified with SUD who were released from CDCR were prescribed MAT at the time of release or received CBI while incarcerated. From 2020 to 2025, the percentage of people with SUD who were on MAT at the time of release increased from 42% to 58% and the percentage who were released on MAT or received any CBI increased from 45% to 94%.

Figure 2: Enhanced Pre-Release & Transition Services among People Released from CDCR



¹Veterans Administration application assistance is offered to all known Veterans.

²MAT medications and appointments in the community are offered to all people actively prescribed MAT at release.

Integration of Other Initiatives with the ISUDT Program

Peer Support Specialist Program (PSSP)

In December 2025, the Department expanded the PSSP across all CDCR institutions. This initiative creates opportunities for incarcerated individuals to support peers dealing with SUDs while providing meaningful employment both during incarceration and after release. The program's primary goals are to foster recovery and rehabilitation, as well as to enhance the overall therapeutic environment within CDCR institutions.

Since its implementation, the PSSP has trained 1,020 incarcerated individuals to become Peer Support Specialists (PSS). Certification is a key component of the program: as of March 2026, 495 individuals successfully completed certification requirements, with additional certification exams scheduled statewide throughout 2026. To support those released before taking the exam, a process has been established to obtain certification post-release through the California

Mental Health Services Authority (CalMHSA). The Department continues to explore ways to optimize the delivery of recovery and rehabilitative peer support by PSS at all CDCR institutions.

CalAIM Initiative Integration

The Department began implementing the CalAIM initiative in February 2025, focusing on coordinated reentry care plans and seamless transitions (“warm handoffs”) with external enhanced care managers. These services are designed to improve the transition from incarceration to community life and support ongoing care for justice-involved individuals. Collaboration with the Department of Health Care Services, Medi-Cal Managed Care Plans, county behavioral health agencies, and community-based organizations has been central to refining workflows for the Mixed Care Management Model, which is adapted to the unique needs of different counties and correctional facilities.

Integrating CalAIM with CDCR’s enhanced pre-release and transition services during 2025 has significantly improved outcomes, more than doubling the Medi-Cal application approval rate at time of release from 34% in 2020 to 81% in 2025. This progress reflects the Department’s commitment to supporting successful reentry and continuity of care for individuals leaving CDCR facilities.

Naloxone Distribution Within CDCR

Naloxone is a lifesaving rescue medication for opioid overdoses but is not a treatment for OUD. CDCR ensures access for staff, direct access for incarcerated people, and universal distribution at release. Since 2020, over 114,000 kits were provided upon release, with more than 95% of releases receiving education and naloxone. In 2025, naloxone was used to resuscitate 2,287 incarcerated individuals after suspected overdoses. CDCR introduced self-service dispensers statewide in March 2025, distributing 286,061 kits in FY 2024–25. Based on current public information, it appears CDCR is the only state prison system allowing incarcerated people to carry naloxone, enabling prompt peer intervention. Universal access and education are vital post-release, but ongoing treatment, especially MAT, is necessary to prevent repeat overdoses and fatalities.



*Based on publicly available information

Communication & Outreach

In 2025, the ISUDT Program enhanced efforts to promote treatment engagement, prevent overdoses, and reduce SUD stigma using materials and tablet messaging designed for the population. The ISUDT Insider newsletter shared recovery tips, facts about SUD, and encouraged participation in care, including insights from incarcerated contributors. Topics ranged from community support and mental health to nutrition, fentanyl awareness, and peer programs. Over 1,280,000 copies have been distributed statewide, with incarcerated individuals regularly sharing recovery practices and milestones. Key communications like overdose prevention and naloxone education reached participants both in print and on tablets, positively impacting lives.

"My cellmate returned from the evening meal. Within a few minutes of him returning to the cell, he fell backwards onto the bed. I immediately tried opening his eyes, and his eyes were rolled back in his head. He was not breathing. He did not have a pulse... I went to the door and yelled, "Man Down!" When I knew the tower officer heard my call, I returned to see if he was breathing and had a pulse. He did not. I remembered that he had brought a box of Narcan into the cell, so I located the box. I cleared his airway and placed the Narcan in his nose and administered the first dose. After about a minute, he began to respond... I told the officer that my cellmate was overdosing and that I had administered one dose of Narcan and then he went unconscious again and was not breathing and did not have a pulse. I administered the second dose. Medical personnel arrived and I shared the doses administered before he was taken by ambulance. But for quick staff response, the instructional Narcan video I watched on my tablet and the fact that CDCR makes Narcan available, it is my belief my cellmate would have died. This issue is an important one for me, because my baby sister died from a heroin overdose and her nine-year-old son found her dead. Everyone should be knowledgeable that administering Narcan saves lives." - Incarcerated person at Sierra Conservation Center

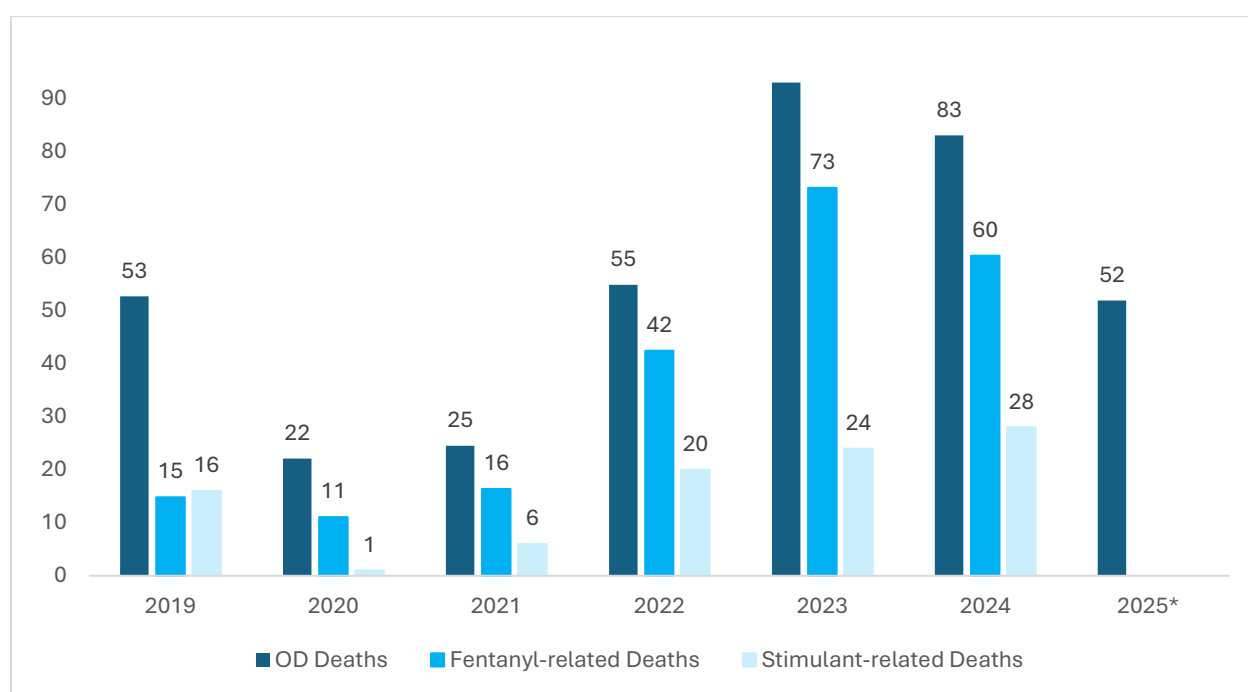
ISUDT Impacts on Morbidity and Mortality

Decline in Overdose Deaths in CDCR

Overall overdose death rate among CDCR's population declined in 2024 (83 per 100,000) compared to 2023 (93 per 100,000). Preliminary data indicate continued improvement in 2025 with a 36% reduction in the rate compared to 2024 (52 per 100,000). In 2024, overall overdose deaths and fentanyl-involved overdose deaths decreased after increases from 2021–2023 (see **Figure 3** and **Appendix A, Table A1**). The stimulant-involved overdose death rate has also declined.

Figure 3: Overdose Death Rates in CDCR: All, Fentanyl-related, and Stimulant-related

Rate per 100,000 CDCR Population, 2019-2025



**2025 death rates are preliminary and may be adjusted accordingly*

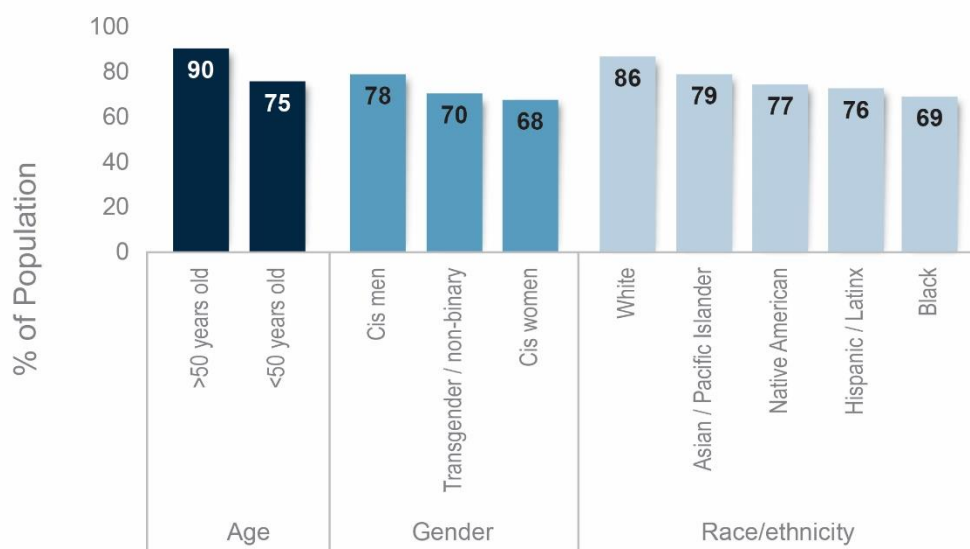
In 2024, 81% of overdose deaths in CDCR involved an opioid and of the opioid deaths, 90% involved fentanyl. Of the overdose deaths, 26 (34%) involved a stimulant. Opioid-related overdose deaths occurred mostly among people who were not receiving MAT or were not taking it consistently. Of the 62 people who died of an opioid overdose in 2024, 92% were either not prescribed MAT or were prescribed MAT but were not adherent. These findings indicate opportunities to prevent overdose deaths through improved identification of OUD, timely initiation of treatment, and additional supports to maintain adherence and retention.

MAT Adherence & Retention

MAT is dosed either daily (administered orally) or monthly (administered as an injection). CDCR defines adherence as having received oral doses on at least 80% of the days of the preceding month or having received an injection within the preceding month. On average during 2025, 85% of people on MAT were adherent. Additionally, 92% of Urine Drug Screen (UDS) tests done within 7 days of administration of a dose of buprenorphine detected the drug and its metabolite, consistent with high adherence to treatment.

MAT retention in CDCR is defined as the percentage of people who were on MAT 6 months ago and remain on MAT. On average, the MAT retention rate in 2025 was 86%. Among the subset of people who started MAT for the first time 6 months ago, 71% remained on treatment indicating patients who have newly started treatment are at higher risk of discontinuing treatment and need more support. Although overall MAT adherence and retention in CDCR remain high, notable demographic differences persist (**Figure 4**). Younger people, cis women, and certain racial and ethnic groups have lower adherence levels than their counterparts. (See **Appendix D** for methodology and summary data).

Figure 4. MAT Adherence by Demographic Group in CDCR
December 2025

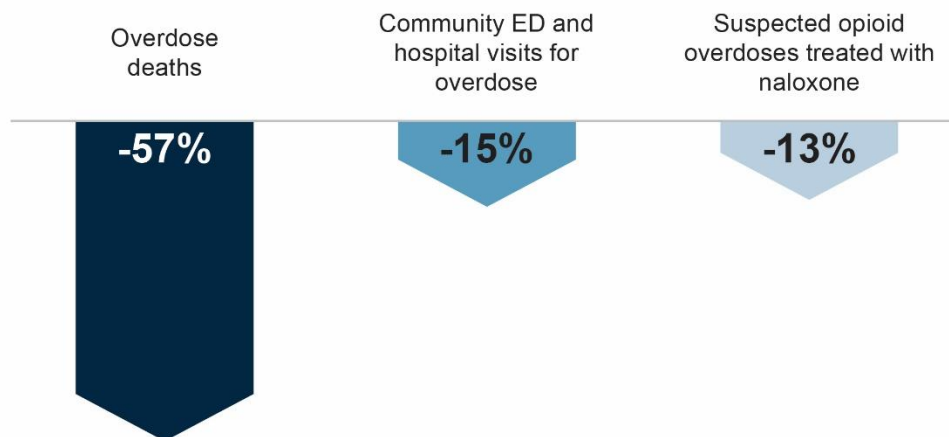


MAT Impacts on Overdoses in CDCR

In CDCR, the association between overdose outcomes and MAT was evaluated in three areas: overdose deaths, ED or hospital visits for overdose, and suspected opioid overdoses treated with naloxone at CDCR institutions. People with OUD who were prescribed MAT had better outcomes than those who were not. Specifically, overdose deaths were 57% lower, community ED and hospital visits for overdose were 15% lower, and suspected opioid overdoses treated

with naloxone on-site were 13% lower compared to patients with OUD who were not prescribed MAT (see **Figure 5; Appendix E, Table E1**).

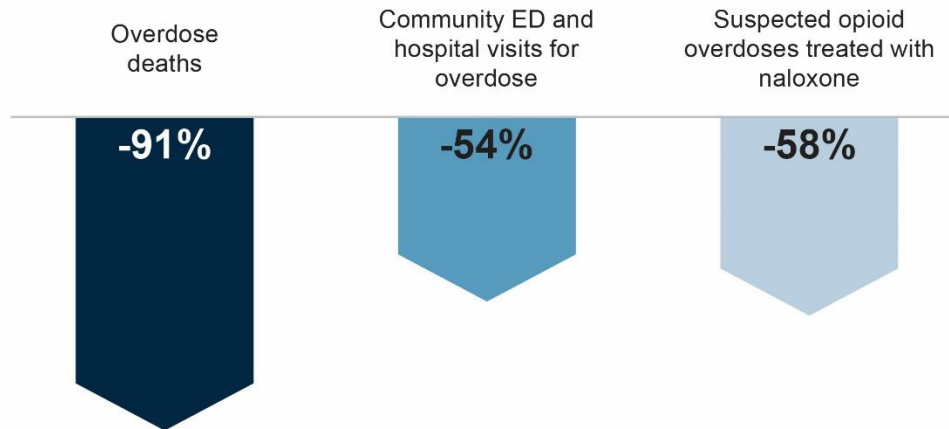
Figure 5. Reduction in the Rates of Overdose Outcomes among the CDCR Population with OUD Prescribed MAT Compared to those with OUD not on MAT
Percent Reduction 2024



A sub-analysis of the impacts of injectable buprenorphine was also performed. An average of 711 people were prescribed injectable buprenorphine each month in 2024. There were no deaths among people on injectable buprenorphine that year, and both community ED and hospital visits for overdose and suspected opioid overdoses were 57% lower among people on injectable buprenorphine compared to people with OUD not on MAT.

CDCR also assessed whether consistent use of prescribed medication is associated with better outcomes. Among patients prescribed MAT in 2024, those who took medication as prescribed had substantially lower overdose risk. Specifically, overdose deaths were 91% lower, community ED and hospital visits were 54% lower, and suspected opioid overdoses treated with naloxone were 58% lower compared to people with OUD who were not adherent to MAT (see **Figure 6; Appendix E, Table E2**). Together, these studies show access to MAT, including injectable buprenorphine, saves lives in CDCR, and that adherence is essential. Additional outcomes related to HCV and reinfection are provided in **Appendix F**.

Figure 6. Reduction in the Rates of Overdose Outcomes among the CDCR Population Adherent to MAT for OUD Compared to those not Adherent
Percent reduction, 2024



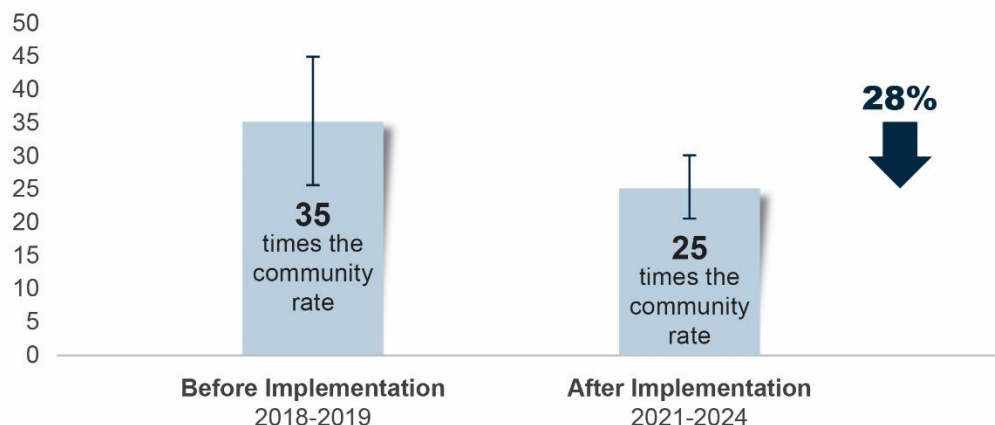
Post-release Overdose Deaths

People leaving prison face a much higher risk of dying from a drug overdose compared to the general public. To assess whether the ISUDT Program is helping to reduce these deaths, CCHCS tracked outcomes in the 30 days after release for more than 201,000 people released from California prisons between 2018 and 2024. During 2018–2024, 214 people died from a drug overdose within 30 days of release, about 28 times more deaths than would be expected if those people had the same overdose rates as other Californians of similar age and sex.

When comparing the overdose death rate among people released from prison to the rate in the general community, that difference in the overdose death rate was reduced by 28% after the program was put in place, dropping from 34.6 times the community rate in 2018–2019 to 24.9 times in 2021–2024. In 2024, the death rate fell to 10.2 per 1,000 person years, its lowest point since 2019, down from its 2023 peak of 17.4 per 1,000 person-years (**Figure 7** and **Appendix G, Table G1**). Despite this progress, people leaving prison still die from drug overdoses at much higher rates than their peers in the community, underscoring the need to continue strengthening transition support and treatment continuity.

Figure 7. Overdose Deaths Within 30 Days of Release from CDCR Relative to Californians of the Same Age and Sex, by Year of Release

Standardized Mortality Ratios, 2018 – 2019 and 2021 – 2024



Current Challenges & Future Opportunities

Despite the significant progress achieved by the ISUDT Program, several challenges persist that must be addressed to further improve outcomes. These include gaps in the initiation and continuity of MAT for approximately one-third of individuals with OUD who are currently not receiving adequate treatment, ongoing demographic disparities in treatment engagement and retention, paucity of effective treatments for StUD, access to illicit drugs and environments that are not conducive to rehabilitation and recovery. Opportunities exist to improve outcomes through expanded peer support, CM for StUD, establishment of rehabilitative environments and culture based on therapeutic community models, enhanced interdiction efforts and strengthening community partnerships. By leveraging these opportunities and improving outcomes for justice-involved individuals, CDCR can realize its mission of rehabilitation and public safety.

Appendix A: Overdose Deaths in CDCR

Table A1. All drug overdose deaths, fentanyl overdose deaths, and stimulant overdose deaths in CDCR, 2019–2025, compared to 2019.

Year	Average Population	Drug overdose deaths				Fentanyl-related overdose				Stimulant-related overdose			
		Deaths, N	Death Rate per 100,000	Rate Ratio	p value	Deaths, N	Death Rate per 100,000	Rate Ratio	p value	Deaths, N	Death Rate per 100,000	Rate Ratio	p value
2019	121,438	64 ¹	53	ref	ref	18	15	ref	ref	19	16	ref	ref
2020	108,544	24 ²	22	0.42	0.0001	12	11	0.75	0.4387	1	1	0.06	<0.0001
2021	97,840	24	25	0.47	0.0009	16	16	1.10	0.7742	6	6	0.39	0.0376
2022	96,610	53	55	1.04	0.8272	41	42	2.86	0.0001	19	20	1.26	0.4841
2023	95,720	89 ³	93	1.76	0.0005	70	73	4.93	<0.0001	23	24	1.54	0.1691
2024	92,736	77 ⁴	83	1.57	0.0072	56	60	4.05	<0.0001	26	28	1.79	0.0536
2025	90,592	48 ⁵	53	1.01	0.9741	--	--	--	--	--	--	--	--

¹2019 count includes 2 overdose deaths among persons not residing at CDCR institutions (one community correctional facility resident, one escapee).

²2020 count includes 1 death categorized by CCHCS Mortality Review as Death Type "Drug Overdose (Accidental)" and Diagnostic Category "Accidental Injury".

³2023 count includes 3 deaths categorized by CCHCS Mortality Review as suicides, where the method was drug overdose and 1 death categorized by CCHCS Mortality Review as Death Type "Accidental Injury to Self" and Diagnostic Category "Drug Overdose".

⁴2024 count excludes 1 death previously reported by CCHCS Mortality Review and Kent Imai as a drug overdose but reclassified as not an overdose after a later autopsy result.

⁵2025 count includes overdose deaths with CCHCS Mortality Review investigations closed as of April 13, 2026. Counts of fentanyl-related and stimulant-related overdose deaths are pending autopsy results.

Methodology: Overdose deaths were defined as deaths categorized as a drug overdose by a death review and the date of death was during the year. Fentanyl-related overdose deaths are overdose deaths where fentanyl or a fentanyl analogue was identified through toxicological testing. Stimulant-related overdose deaths are overdose deaths where stimulant drugs (including methamphetamines, amphetamines, or cocaine, but excluding caffeine) were identified through toxicological testing. Denominators were calculated as the average number of people in CDCR prisons at the end (last day) of every month in the year.

Appendix B: Estimated Prevalence of SUDs and AUD in CDCR

Table B1. SUD and AUD prevalence estimates among demographic, high-risk, and vulnerable groups in CDCR, December 2025

Population	AUD identified		OUD identified		StUD identified		OUD and StUD identified	
	N (%)	p value	N (%)	p value	N (%)	p value	N (%)	p value
Overall	19,528 (21.6)	--	31,053 (34.4)	--	25,615 (28.4)	--	19,054 (21.1)	--
Age								
Age <50	15,002 (23.7)	<0.00 01	25,640 (40.5)	<0.00 01	20,081 (31.7)	<0.00 01	15,658 (24.7)	<0.00 01
Age ≥50	4,526 (16.8)	Refere nce	5,413 (17.4)	Refere nce	5,534 (20.5)	Refere nce	3,396 (82.2)	Refere nce
Race/ethnicity								
White	4,136 (23.8)	<0.00 01	7,765 (44.6)	<0.00 01	6,403 (36.8)	<0.00 01	5,129 (29.5)	<0.00 01
Native American	378 (32.6)	<0.00 01	543 (46.8)	<0.00 01	484 (41.7)	<0.00 01	377 (32.5)	<0.00 01
Hispanic/Latinx	9,861 (23.3)	<0.00 01	15,588 (36.8)	<0.00 01	12,781 (30.1)	<0.00 01	9,634 (22.7)	<0.00 01
Black	4,259 (17.2)	0.49	5,973 (24.2)	0.35	4,870 (17.7)	0.01	3,159 (12.8)	0.06
Asian/Pacific Islander	250 (18.0)	Refere nce	321 (23.1)	Refere nce	315 (22.6)	Refere nce	202 (14.5)	Refere nce
Gender								
Transgender/non-binary/other	906 (37.1)	<0.00 01	1,293 (52.9)	<0.00 01	1,211 (49.6)	<0.00 01	966 (39.5)	<0.00 01
Female	797 (28.7)	<0.00 01	974 (35.0)	0.19	1,105 (39.7)	<0.00 01	690 (24.8)	<0.00 01
Male	17,825 (20.9)	Refere nce	28,786 (33.8)	Refere nce	23,299 (27.4)	Refere nce	17,398 (20.4)	Refere nce
Known HCV history								
Yes	7,973 (36.9)	<0.00 01	15,345 (71.0)	<0.00 01	12,109 (56.1)	<0.00 01	10,511 (48.7)	<0.00 01
No	11,555 (16.8)	Refere nce	15,708 (22.9)	Refere nce	13,506 (19.6)	Refere nce	8,543 (12.4)	Refere nce
Known HIV infection								
Yes	175 (23.7)	0.18	327 (44.2)	<0.00 01	312 (42.2)	<0.00 01	221 (29.9)	<0.00 01
No	19,353 (21.6)	Refere nce	30,726 (34.3)	Refere nce	25,303 (28.2)	Refere nce	18,833 (21.0)	Refere nce
Mental health level of care								

EOP or higher	3,079 (33.7)	<0.00 01	4,793 (52.5)	<0.00 01	4,372 (47.9)	<0.00 01	35,04 (38.4)	<0.00 01
CCCMS	7,750 (27.7)	<0.00 01	12,731 (45.6)	<0.00 01	10,437 (37.3)	<0.00 01	7,921 (28.3)	<0.00 01
None	8,699 (16.3)	<i>Refere nce</i>	13,529 (25.4)	<i>Refere nce</i>	10,806 (20.3)	<i>Refere nce</i>	7,629 (14.3)	<i>Refere nce</i>
Developmental disability								
Yes	241 (22.5)	0.45	316 (29.6)	0.001	307 (28.7)	0.79	210 (19.6)	0.24
No	19,287 (21.6)	<i>Refere nce</i>	30,737 (34.4)	<i>Refere nce</i>	25,308 (28.4)	<i>Refere nce</i>	18,844 (21.1)	<i>Refere nce</i>
Physical disability								
Yes	3,206 (22.1)	0.10	4,587 (31.7)	<0.00 01	4,174 (28.8)	0.18	3,056 (21.1)	1.00
No	16,322 (21.5)	<i>Refere nce</i>	26,466 (34.9)	<i>Refere nce</i>	21,441 (28.3)	<i>Refere nce</i>	15,998 (21.1)	<i>Refere nce</i>

CCHCS data available as of January 6, 2026.

Methodology: SUD and AUD prevalence was estimated among people incarcerated in CDCR's adult institutions on December 31, 2025, from multiple CCHCS data sources. SUD/AUD indicators include National Institute on Drug Abuse (NIDA)-Modified ASSIST substance-involvement scores of 4 or higher (moderate-high use disorder severity), active diagnostic codes for alcohol, opioid, or stimulant dependence, abuse, use disorder, or withdrawal entered by providers in the patient's medical chart, ever being on MAT for OUD or AUD, and claims data for alcohol or stimulant-involved overdose send out (emergency department, hospitalization). Additional OUD indicators include assessment with the DSM-5, evaluation and referral for opioid treatment services using American Society of Addiction Medicine (ASAM) tools (RISE, Continuum), opioid-involved send out in the past year, or at least two suspected opioid overdoses treated with naloxone in the past year. SUD/AUD prevalence was also estimated among people who entered a CDCR Reception Center during 2025 from the indicators described above supplemented with routine urine drug screening tests positive for alcohol, fentanyl, non-fentanyl opioids, or stimulants within 30 days of entry.

Appendix C: Use of MAT for OUD in CDCR

Table C1. Use of MAT for OUD among demographic, high-risk, and vulnerable groups in CDCR's population, December 2025

Population	OUD identified		Among OUD, ever on MAT		Among OUD, active MAT	
	N (%)	p value	N (%)	p value	N (%)	p value
Overall	31,053 (34.4)	--	26,943 (86.8)	--	19,643 (63.2)	--
Age						
Age <50	25,640 (40.5)	<0.0001	22,356 (87.2)	Reference	16,469 (64.2)	Reference
Age ≥50	5,413 (17.4)	Reference	4,587 (84.7)	<0.0001	3,174 (58.6)	<0.0001
Race/ethnicity						
White	7,765 (44.6)	<0.0001	7,124 (91.8)	Reference	5,498 (70.8)	Reference
Native American	543 (46.8)	<0.0001	483 (89.0)	0.02	384 (70.7)	0.97
Hispanic/Latinx	15,588 (36.8)	<0.0001	13,560 (87.0)	<0.0001	9,554 (61.3)	<0.0001
Black	5,973 (24.2)	0.35	4,775 (80.0)	<0.0001	3,479 (58.3)	<0.0001
Asian/Pacific Islander	321 (23.1)	Reference	259 (80.7)	<0.0001	202 (62.9)	0.003
Gender						
Transgender/non-binary/other	1,293 (52.9)	<0.0001	1,137 (87.9)	0.23	804 (62.2)	0.37
Female	974 (35.0)	0.19	827 (84.9)	0.09	589 (60.5)	0.06
Male	28,786 (33.8)	Reference	24,979 (86.8)	Reference	18,250 (63.4)	Reference
Known HCV history						
Yes	15,345 (71.0)	<0.0001	14,017 (91.4)	<0.0001	10,195 (66.4)	<0.0001
No	15,708 (22.9)	Reference	12,296 (82.3)	Reference	9,448 (60.2)	Reference
Known HIV infection						
Yes	327 (44.2)	<0.0001	284 (86.9)	0.96	206 (63.0)	0.92
No	30,726 (34.3)	Reference	26,659 (86.8)	Reference	19,437 (63.3)	Reference
Mental health level of care						
EOP or higher	4,793 (52.5)	<0.0001	4,212 (87.9)	<0.0001	3,209 (67.0)	<0.0001
CCCMS	12,731 (45.6)	<0.0001	11,338 (89.1)	<0.0001	9,014 (70.8)	<0.0001
None	13,529 (25.4)	Reference	11,393 (84.2)	Reference	7,420 (54.9)	Reference
Developmental disability						
Yes	316 (29.6)	0.001	274 (86.7)	0.98	197 (62.3)	0.73
No	30,737 (34.4)	Reference	26,669 (86.8)	Reference	19,446 (63.3)	Reference
Physical disability						
Yes	4,587 (31.7)	<0.0001	4,032 (87.9)	0.01	2,916 (63.6)	0.63
No	26,466 (34.9)	Reference	22,911 (86.6)	Reference	16,727 (63.2)	Reference

CCHCS data available as of January 6, 2026.

Methodology: OUD prevalence was estimated among people incarcerated in CDCR's adult institutions on December 31, 2025, from multiple CCHCS data sources. OUD indicators include NIDA-Modified ASSIST opioid-involvement scores of 4 or higher (moderate-high use disorder severity), assessment with the DSM-5, evaluation and referral for opioid treatment services using ASAM tools (RISE, Continuum), active diagnostic codes for opioid, dependence, abuse, use disorder, or withdrawal entered by providers in the patient's medical chart, opioid-involved send out (emergency department, hospitalization) in the past year, at least two suspected opioid overdoses treated with naloxone in the past year, and ever being on MAT for OUD.

Appendix D: MAT Adherence and Retention in CDCR

Table D1. MAT adherence and retention among demographic, high-risk, and vulnerable groups in CDCR, December 2025

	MAT Adherence (≥80% of days)		MAT Retention: Overall (among continuing 6		MAT Retention: New Starts (among started 6 months	
<i>MAT Patients</i>	<i>N (%)</i>	<i>p value</i>	<i>N (%)</i>	<i>p value</i>	<i>N (%)</i>	<i>p value</i>
Overall	14,568 (77.6)	--	13,939 (85.3)	--	665 (69.7)	--
Age						
Age <50	11,826 (75.4)	<0.0001	11,352 (84.4)	Reference	589 (69.1)	Reference
Age ≥50	2,745 (89.9)	Reference	2,587 (89.2)	<0.0001	76 (74.5)	0.27
Race/ethnicity						
White	4,487 (86.3)	Reference	3,842 (87.8)	Reference	187 (76.0)	Reference
Native American	281 (76.8)	<0.0001	286 (90.8)	0.11	13 (76.5)	0.97
Hispanic/Latinx	6,953 (75.8)	<0.0001	6817 (83.6)	<0.0001	323 (65.3)	0.003
Black	2,297 (68.8)	<0.0001	2,457 (84.8)	0.0003	115 (71.0)	0.26
Asian/Pacific Islander	153 (78.9)	<0.0001	143 (86.7)	0.68	14 (87.5)	0.3
Gender						
Transgender/non-binary/other	546 (69.5)	<0.0001	643 (86.7)	0.34	19 (76.0)	0.72
Female	361 (68.1)	<0.0001	285 (77.2)	<0.0001	22 (66.7)	0.5
Male	13,661 (78.3)	Reference	13,011 (85.4)	Reference	624 (69.6)	Reference
Known HCV history						
Yes	7,802 (79.1)	<0.0001	7,837 (86.1)	0.001	280 (68.1)	0.36
No	6,766 (75.9)	Reference	6,102 (84.2)	Reference	385 (70.9)	Reference
Known HIV infection						
Yes	142 (72.1)	0.06	143 (91.1)	0.04	7 (87.5)	0.3
No	14,426 (77.7)	Reference	13,796 (85.2)	Reference	658 (69.6)	Reference
Mental health level of care						
EOP or higher	2,521 (81.6)	0.0001	2,462 (87.4)	<0.0001	90 (74.4)	0.01
CCCMS	6,481 (75.6)	0.0001	6,225 (88.1)	<0.0001	308 (77.2)	<0.0001
None	5,566 (78.2)	Reference	5,252 (81.3)	Reference	267 (61.5)	Reference
Developmental disability						
Yes	167 (85.6)	0.01	159 (88.3)	0.24	8 (88.9)	0.24
No	14,401 (77.5)	Reference	13,780 (85.2)	Reference	657 (69.5)	Reference
Physical disability						
Yes	2,387 (83.9)	<0.0001	2,425 (88.3)	<0.0001	70 (74.5)	0.29
No	12,181 (76.5)	Reference	11,514 (84.7)	Reference	595 (69.2)	Reference

Methodology: MAT for OUD adherence and retention was estimated among people incarcerated in CDCR's adult institutions on December 31, 2025, from data in the California Correctional Health Care (CCHCS) Health Care Services Dashboard. MAT is dosed either daily (administered orally) or monthly (administered as an injection). CDCR defines adherence as having received oral doses on at least 80% of the days of the preceding month or having received an injection within the preceding month. MAT retention in CDCR is defined as the percentage of people who were on MAT 6 months ago and remain on MAT.

Appendix E: MAT Impact on Overdose Outcomes

Table E1. Drug overdose outcomes among the CDCR population with OUD: Comparing those with a prescription for MAT for OUD to those without a prescription for MAT for OUD, 2024

Outcome	MAT prescription	No MAT prescription	MAT prescription compared to no MAT prescription		
	Rate per 1,000 (95% CI)	Rate per 1,000 (95% CI)	Rate Ratio (95% CI)	Rate Difference (95% CI)	p value
Overdose deaths	1.12 (0.68, 1.72)	2.57 (1.68, 3.76)	0.43 (0.24, 0.78)	-1.45 (-2.55, -0.35)	0.0052
Community ED and hospital visits for overdose	43.62 (40.62, 46.79)	51.44 (47.12, 56.05)	0.85 (0.76, 0.95)	-7.82 (-13.19, -2.45)	0.0037
Suspected opioid overdoses treated with naloxone	62.70 (59.08, 66.47)	71.88 (66.75, 77.30)	0.87 (0.79, 0.96)	-9.19 (-15.56, -2.81)	0.0040

Table E2. Drug overdose outcomes among the CDCR population on MAT for OUD: Comparing those adherent to MAT for OUD to those with a prescription for MAT for OUD but not adherent, 2024

Outcome	Adherent	Non-adherent	Adherent compared to non-adherent		
	Rate per 1,000 (95% CI)	Rate per 1,000 (95% CI)	Rate Ratio (95% CI)	Rate Difference (95% CI)	p value
Overdose deaths	0.41 (0.15, 0.89)	4.45 (2.43, 7.47)	0.09 (0.03, 0.24)	-4.04 (-6.40, -1.69)	<0.0001
Community ED and hospital visits for overdose	36.13 (33.12, 39.34)	78.83 (69.32, 89.28)	0.46 (0.39, 0.53)	-42.70 (-52.98, -32.42)	<0.0001
Suspected opioid overdoses treated with naloxone	50.78 (47.20, 54.57)	119.5 (107.7, 132.2)	0.42 (0.38, 0.48)	-68.73 (-81.35, -56.11)	<0.0001

Methodology:

A cohort study examined whether MAT for OUD reduced overdoses in CDCR across three outcomes: 1) overdose deaths, 2) ED and hospital visits for overdose, and 3) suspected opioid overdoses treated with on-site naloxone. The study followed persons with OUD (identified through screening/diagnosis or a history of two or more likely opioid overdoses) incarcerated in CDCR in 2024 (average 28,056/month), comparing those receiving MAT to those who were not. Sub-analyses examined the impact of injectable buprenorphine specifically, and the effect of MAT adherence among those with an active MAT prescription (average 17,928/month).

OUD was identified if a person met any one of seven criteria based on chart diagnosis, clinical evaluation tools (NIDA Modified Assessment, ASAM, DSM-5 PowerForm), history of MAT for OUD, or prior opioid overdose history. A person was classified as on MAT if they had an active prescription or completed administration of buprenorphine, methadone, or naltrexone within one day (oral/sublingual) or thirty days (injectable). The injectable buprenorphine sub-analysis excluded patients on other MAT forms (naltrexone, methadone, or sublingual buprenorphine). MAT adherence was defined as receiving MAT on at least 80% of days owed in the prior 30 days. Patients were excluded from the adherence sub-analysis if adherence could not be calculated (no MAT days owed in the prior 30 days, KOP MAT prescriptions, or methadone prescriptions).

Overdose deaths were those categorized as drug overdoses by death review (event date: date of death or hospital send-out start date). ED/hospital overdose visits were hospital send-outs with a primary ICD-10-CM billing diagnosis of F10–F19, F55, T36–T51, or T65 (excluding under-dosing codes). Suspected overdoses treated with naloxone were naloxone administrations with documented improvement. Denominators were the monthly average of persons meeting each

measure's criteria at month-end. Rate statistics and 95% confidence intervals were calculated using OpenEpi Version 3.01 (PersonTime2, accessed at www.OpenEpi.com).

Appendix F: Hepatitis C Virus (HCV) Outcomes

People who have been treated for HCV are at risk of reinfection mainly from chronic untreated SUD and ongoing injection drug use. As previously reported, people who were treated for HCV and followed in CDCR while on MAT for OUD had a 60% lower reinfection rate (7%) compared to people with OUD who were not on MAT (17%) over a 14-month follow-up period.³⁴ Among a subset of people on MAT for OUD, those who were reinfected were more likely to disclose they injected drugs (76% vs. 44%), received a tattoo (32% vs. 13%), or used methamphetamine (62% vs. 42%) compared with those who were not reinfected. Being adherent to MAT (at least 90% of days) at an adequate dose (at least 16 mg/day of buprenorphine) reduced the risk of HCV reinfection by 70%. Most reinfections occurred soon after HCV treatment; 30% within 6 months and another 34% within 6–9 months.³⁵ These data show that even with high adherence to MAT, some people will relapse into opioid or stimulant use (not treated with MAT) or engage in other risky behaviors, highlighting the need for ongoing support and linkage to other ISUDT Program services

In addition to MAT adherence, the timing of MAT initiation is key to reducing the risk of HCV reinfection after treatment. Reinfection rates were compared among people who were successfully treated for HCV between January 2017 and April 2024 and retested at least once over the next year in CDCR. HCV reinfection rates were highest among people who were never on MAT (16%), had a delay in starting MAT (16%), or had at least a 1-week gap in adherence (12%) compared with people who were continuously on MAT since their HCV treatment (8%). These data show the importance of starting MAT before or during HCV treatment and being retained on MAT.

³⁴ https://cchcs.ca.gov/wp-content/uploads/sites/60/2023-ISUDT-Report_v36.pdf

³⁵ <https://academic.oup.com/cid/article/81/5/943/8113482?guestAccessKey=>

Appendix G: Post-release Deaths

Table G1. Standardized Mortality Ratios comparing observed drug overdose deaths (OD) in the first 30 days after release from CDCR with age- and sex-adjusted expected OD deaths in the general California population, 2018–2024

Year of Release	People within 30 days of release from CDCR				General California population		Comparison	
	Release s, N	Follow-up time, person-years	Observed OD deaths, N	Rate of OD deaths per 1,000 person-years	Age- and sex-adjusted OD death rate per 100,000 person-years	Expected OD deaths, N	Standardized Mortality Ratio (SMR)	
							Observed / Expected OD deaths	95% CI
2018	32,198	2,646.4	22	8.3	23.9	0.6322	34.8	22.4 , 51.8
2019	32,334	2,657.6	27	10.2	29.6	0.7859	34.4	23.1 , 49.3
2020	35,093	2,884.4	45	15.6	45.7	1.3192	34.1	25.2 , 45.2
2021	22,354	1,837.3	24	13.1	58.4	1.0734	22.4	14.7 , 32.8
2022	28,245	2,321.5	36	15.5	60.7	1.4087	25.6	18.2 , 35.0
2023	27,260	2,240.5	39	17.4	63.1	1.4139	27.6	19.9 , 37.3
2024	23,784	1,954.8	21	10.7	47.2	0.9223	22.8	14.5 , 34.2
2018-2024	201,268	16,542.6	214	12.9	45.7	7.5555	28.3	24.7 , 32.3
2018-2019	64,532	5,304.0	49	9.2	26.7	1.4181	34.6	25.8 , 45.3
2021-2024	101,643	8,354.2	120	14.4	57.7	4.8182	24.9	20.7 , 29.7

Methodology: CCHCS sought to assess whether the ISUDT Program reduced drug OD deaths after release from a CDCR institution. To do this, CCHCS examined data for incarcerated persons who were released to parole or post-release community supervision (PRCS) between January 1, 2018, and November 30, 2024. Such individuals were matched to the California Comprehensive Master Death File (CCMDF; Static, 2018–2024) obtained from the California Department of Public Health (CDPH). The matching procedure used name, date of birth, gender, and Social Security number (when available). CCHCS determined whether each released person died in

California within 30 days of release. If the underlying cause of a death was coded as ICD-10 X40–44, X60–64, X85, or Y10–14, the death was classified as caused by OD.

CCHCS compared the observed numbers of OD deaths with the expected numbers in the general California population as follows. For the general California population, age- and sex-adjusted OD death rates were derived from the CDC WONDER Online Database (<http://wonder.cdc.gov/ucd-icd10-expanded.html>, accessed Apr 14, 2026). California OD death rates were adjusted to match the age and sex distribution of the CDCR release cohort for each corresponding year. Based on the adjusted rates, CCHCS calculated expected OD death counts. Standardized mortality ratios (SMRs) and their 95% confidence intervals (CI) were calculated using OpenEpi Version 3.01 (<https://www.openepi.com/>, accessed Apr 16, 2026).

All analyses, interpretations, and conclusions based on the CCMDf data are attributable to the authors of this report, not to CDPH.

Appendix H: Urine Drug Screening (UDS)

UDS is the standard of care for managing OUD. UDS is used to monitor treatment adherence, to detect relapses and illicit drug use (including opiates, fentanyl, and methamphetamine), to guide clinical decisions, and to build trust and accountability. In 2025, CDCR performed 174,719 UDS tests, using three distinct UDS panels: 1) Screening (used at reception centers or in preparation for an initial evaluation for MAT; 19% of UDS); 2) Monitoring (used for ongoing monitoring on MAT; 71% of UDS); and 3) Comprehensive (used when a patient exhibits severe, unstable, co-occurring disorders requiring testing of psychotropic medications; 10% of UDS). In 2025, people on MAT were monitored with an average of 4.6 UDS per person; changes in UDS monitoring guidance from every 30–45 days to at least every 90 days caused a decrease from 5.8 UDS per person in 2024.

In 2025, 93% of UDS tests among people prescribed MAT and adherent had results consistent with treatment of which 96% had no illicit opioid detected. However, the presence and use of illicit drugs within CDCR remains a problem. Among all UDS tests in 2025, 4.5% detected any opioid, 2.2% detected fentanyl, and 9.5% detected methamphetamine, lower than detections in 2024 (8.8%, 4.3%, and 12.5% respectively). Notably, 70% of the UDS that were positive for any opioid occurred among people who were already on MAT, and of those prescribed MAT, 36% were non-adherent at the time of the UDS test. Therefore, although there are risks of exposure to illicit opiates and fentanyl in CDCR, these risks are mitigated by MAT.