Frequently Asked Questions: Health, Mental Health, & Substance Use Disorders

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The FAQ is edited for applicability in Ontario however the full FAQ is available at http://www.nationalreentryresourcecenter.org/faqs/health
National Reentry Resource Center (U.S.)

Q: What health risks do people returning from prison or jail face?

A: In a study of more than 800 individuals released from U.S. prisons, nearly all—eight in 10 men and nine in 10 women—had chronic health conditions requiring treatment or management. In the same study, asthma, diabetes, hepatitis, and HIV/AIDS were the most common physical illnesses among people returning to the community; one-half of men and two-thirds of women had been diagnosed with one of these conditions.1 People in the study often had more than one type of health problem-conditions that they had when they entered the facility and that required ongoing attention upon release. Roughly four in 10 men and six in 10 women reported a combination of physical health, mental health, and substance use conditions.2

Q: What is the prevalence of mental illness, substance use, and co-occurring disorders among incarcerated populations?

A: In a study of more than 20,000 adults entering five local jails, researchers documented serious mental illnesses in 14.5 percent of the men and 31 percent of the women, which taken together, comprises 16.9 percent of those studied. These jail rates are more than three to six times those found in the general population.3 Studies suggest that 10 to 15 percent of individuals in state prisons also have severe mental illnesses.4

The numbers are even higher for substance use. More than two-thirds of jail inmates are dependent on or abused alcohol or drugs—with little difference in the overall prevalence between men (68 percent) and women (69 percent).5 In a U.S. Department of Justice study, 53 percent of state and 45 percent of federal male prisoners meet the DSM-IV criteria for drug dependence or abuse.* Sixty percent of women in state prison and 43 percent in federal prison are estimated to be dependent on or abuse drugs.6 Other research has found as much as seven times the rate of substance abuse among jail inmates compared with the general population.7

Co-occurring mental health and substance use disorders are common. In prisons, approximately 30 percent of individuals with substance use disorders

also have a major mental health disorder.8 Conversely, in jails, an estimated 72 percent of individuals with serious mental illnesses have a substance use disorder.9 In prisons, co-occurring disorder estimates range from 3 to 11 percent of the total incarcerated population.10

Q: Why are healthcare services so critical for successful reentry?

A: Prisons and jails offer uniquely important opportunities for improving the health of individuals in the community by identifying health conditions and providing treatment and disease prevention programs to a large and concentrated group of individuals who often have complex and multiple health needs. Releasing individuals with untreated illnesses can create an additional financial burden on a local community's public health system, particularly its emergency services.

For individuals with substance abuse and mental health disorders, access to continuing community-based care upon release complements jail and prison interventions, supports an individual's recovery and ability to comply with conditions of release, and leverages the financial investment made to treat the person while he or she was incarcerated.

Q: Are some communities affected by the health conditions of returning individuals more than others?

A: Yes. In every state there are relatively few neighborhoods where a disproportionate number of formerly incarcerated individuals return from prison or jail; for example, despite housing only 3.5 percent of Miami's population, a single ZIP code is home to 16.1 percent of all parolees in the city and 10.7 percent of all probationers.11 These "high-stakes" areas may lack the resources and services to address the health needs of reentering individuals—such as a higher prevalence of risky health behaviors, communicable diseases, and multiple complex illnesses. To exacerbate matters, in many of these communities, healthcare services other than hospital emergency rooms are largely inaccessible or underutilized.

Q: Is focusing on addiction treatment for incarcerated individuals a fiscally responsible policy?

A: Yes. It is estimated that for every dollar spent on addiction treatment programs in the community, there is a $4 to $7 reduction in the costs related to drug-related crimes.12 An evaluation of California treatment outcomes found that with some substance abuse outpatient programs, about $12 is saved for every dollar spent on care by avoiding other healthcare costs (including emergency services) and by reducing drug-related crimes.13 A successful treatment episode yields many years of benefits, so most cost-offset studies are considered conservative estimates.14

Q: Why is it important to screen and assess for mental health and substance use disorders at jail and prison intake and at release?

A: Prior to incarceration, many individuals have not received treatment, which may be due in part to the limited access in most communities to publicly funded treatment for substance use and mental health disorders. Estimates indicate that only 10 percent of individuals with substance use disorders receive treatment and 11.4 percent of individuals with co-occurring serious mental illness (SMI) and substance use disorders receive care for both.15 Screening and assessment on intake and release are critical personal and public health opportunities that must not be missed. They can detect people who have not been diagnosed or treated previously, and help ensure uninterrupted care for those who have. The information obtained through the screening and assessment process should follow the individual through the criminal justice system and be used to match the individual to appropriate treatment services while incarcerated and upon release. In general, individuals who are at high risk for committing a new crime and have more severe disorders require more structured and intensive treatment interventions before and after release, such as intensive outpatient treatment, day treatment, residential treatment, or therapeutic communities (TCs).† Conversely, low-risk and low-need individuals should receive less intense interventions such as peer support or mutual support aid groups that help people find and sustain recovery.16

Q: What is the difference between screening and assessment?

A: Screening is a process for determining the likelihood of whether someone may have a substance use and/or mental health problem. The screening process does not identify the nature or severity of the problem, but determines whether further assessment is warranted. During the screening process administering staff use instruments that have a limited focus, simple format, and are quick to administer.‡ Although there are seldom any legal or professional restraints on who can conduct a screening, individuals who administer these instruments should receive appropriate training.

Assessment is a process to more fully define the nature of a problem and determine appropriate types of treatment. A basic clinical assessment consists of gathering key information and engaging the client to understand his or her readiness for change, problem areas, any diagnosis(es), disabilities, and strengths. The assessment process typically requires trained professionals with relevant certification in substance abuse and mental health treatment, advanced professional degrees, and specialized training in the use of particular assessment instruments to administer and interpret results.

For those screening and assessment approaches that require an interview, specialized training is needed in basic counseling techniques such as rapport-building and reflective-listening. Given the large proportion of cultural and ethnic minorities in the criminal justice system, screening and assessment approaches should consider influences of ethnicity, social class, gender, sexual orientation, race, disability status, socioeconomic level, and religious and spiritual affiliation.

Q: How can correctional facilities improve healthy transitions to the community?

A: Few prison systems release individuals with medications or primary care referrals. Furthermore, many individuals leaving prisons and jails lack adequate health insurance.17 To strengthen the planning and pre-release process, correctional facilities should develop collaborative relationships with community agencies. For example, correctional staff and community health providers can share needs assessments and treatment information (within the parameters set by federal and state law; see questions on information sharing, below), determine which programs have treatment slots available, and identify programs that serve people with special needs. Taking these steps creates linkages and support between the time of release and placement in community services. This is particularly important for individuals with serious mental illnesses and others who require uninterrupted access to medication.§

Q: How can continuity of care policies at release improve outcomes for people with substance use disorders and/or mental illnesses?

A: Without a careful pre-release planning policy that stresses aftercare, individuals with histories of substance use and mental health disorders are particularly vulnerable to resuming substance use or experiencing a mental health crisis in the months soon after release. For example, a study of reentering individuals in Washington state found the increased risk of death in the first two weeks after release is 12 times greater than among other state residents. In this study, the leading causes of death among formerly incarcerated individuals was found to be drug overdose, cardiovascular disease, homicide, and suicide.18 Ineffective continuity of care diminishes treatment gains and opportunities for successful reintegration, wastes treatment resources, and increases health and safety risks for the individual.19

Q: What is health literacy education and why should corrections facilities and their healthcare partners promote it?

A: Health literacy is the degree to which individuals have the capacity to obtain, process, and retain basic health information needed to make appropriate decisions and to secure required services. Health-literate individuals are better able to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctors' directions and consent forms, and

negotiate complex healthcare systems. Individuals with limited health literacy incur medical expenses that are up to four times greater than patients with adequate literacy skills, costing the healthcare system billions of dollars every year in unnecessary doctor visits and hospital stays.20 Correctional healthcare services and correctional programming can enhance individuals' health literacy before they leave the facility; this is especially important for individuals with infectious diseases.

Q: What health issues do women tend to face when incarcerated and on their return to the community?

A: Since the early 1990s, the number of women held in state and federal prisons has increased more than six-fold.21 This produced an annual rate of increase for women that roughly doubled the rate for men in six of the first seven years of the new millennium.22 The increase in the number of incarcerated women behind bars, many of whom are mothers and the primary caregivers to their dependent children upon release, warrants greater attention to their health concerns.

- Interviews with incarcerated women indicate a lack of regular gynecological and breast examinations is common.23 The gynecological needs of incarcerated women are critical to their health and should be considered during incarceration and post-release.
- Nationwide, approximately half of women in state prisons and jails report having been physically and sexually abused in the past.24 This is consistent with research estimates for women generally: between 55 and 99 percent of women in substance abuse treatment (not necessarily limited to those in incarcerated settings) have had traumatic experiences; typically, childhood physical or sexual abuse, domestic violence, or rape. Of these, between 33 and 59 percent have been found to be experiencing current post-traumatic stress disorders (PTSD). Trauma puts these women at greater-than-average risk for PTSD, high-risk pregnancies, life-threatening illnesses such as HIV/AIDS, and human papilloma virus infection (which may increase the risk for cervical cancer).25 Women are also at an increased risk for hepatitis C through the relationship between trauma, addiction, and injection use. A history of trauma greatly increases the likelihood that women will abuse drugs and alcohol.26 For people who abuse drugs intravenously, 50 percent to 80 percent will become infected with hepatitis C within the first six to 12 months of beginning to inject drugs.27

Q: How can pre-release planning help elderly individuals address their healthcare needs?

A: The number of elderly (ages 50 and above) state and federal prisoners increased dramatically—by approximately 173 percent between 1992 and 2001.**,28 Pre-release planning is particularly important for those who are

elderly, who are chronically or terminally ill, or who have other special or complex health needs.[29] Older adults should be discharged with an appointment or referral to a healthcare provider in the community to which they are returning, and they should have a supply of medication sufficient to last until the community provider is seen.[30] Individuals who are too frail or too ill to be candidates for home care will need assistance in finding placement in an appropriate community facility, such as a hospital, nursing home, or hospice.[31]

Q: How can reentry initiatives address the behavioral healthcare needs of individuals who are homeless or in transitional housing upon release?

A: Individuals with behavioral health problems who are homeless or in transitional housing upon release benefit from assertive community treatment,* dual diagnosis programs, and supportive housing with on-site substance abuse and mental health services, access to medication, and social services.

When contacted by social workers and healthcare professionals, whether in shelters or on the streets, outcomes for the homeless are improved. A study of homeless people who were contacted by social workers and healthcare professionals on the streets and in shelters revealed that even individuals with the most severe disorders and who were the most reluctant to accept treatment enrolled in services and showed improved outcomes when served by an outreach team.[32] For people in transitional housing, providing supportive services is effective in achieving residential stability, improving mental health and recovery from substance abuse, and reducing the costs of homelessness to the community.

Q: What is the role of drug testing in supervising individuals on probation or parole with substance use and co-occurring mental health disorders?

A: Drug testing can help indicate when an individual with a history of substance use is having difficulties engaging in treatment or sustaining their recovery. Positive test results can be answered with graduated sanctions, which invoke less punitive responses for early and less serious noncompliance and increasingly severe sanctions for more serious or continuing problems.‡ The first response to drug use detected through urinalysis should be clinical—for example, an increase in treatment intensity or an alternative treatment. (Note that more intensive treatment should not be considered a sanction, but rather a routine progression in healthcare practice when a treatment seems less effective than expected.)

Q: What should substance abuse treatment for individuals under criminal justice supervision address?

A: Treatment should address issues of motivation, problem solving, and skill-building for resisting drug use and criminal behavior. Lessons aimed at

supplanting drug use and criminal activities with constructive activities and at understanding the consequences of one's behavior are also important to include. Treatment and criminal justice personnel should work together on treatment planning—including implementation of screening, placement, drug testing, monitoring, and supervision—as well as on the systematic use of sanctions and rewards.

Research demonstrates that effective treatment and supervision models integrate criminal justice and addiction treatment systems and services. Examples of evidence-based practices in treating individuals with substance use disorder in criminal justice settings are listed below.

- Research has demonstrated that **motivational interviewing** and **motivational enhancement therapies**§ are associated with greater participation in treatment and better treatment outcomes. These outcomes include reductions in consumption, increased abstinence rates, better social adjustment, and successful referrals to treatment.
- **Cognitive-Behavioral Therapy (CBT)**,** designed to change the thinking processes and patterns that foster criminal behavior, have been found effective in reducing recidivism and relapse among justice-involved individuals.
- **Community-based drug treatment combined with intensive community supervision** has been shown to significantly lower recidivism rates.33
- **Contingency management strategies** (such as the use of voucher-based incentives and rewards) can help support abstinence and promote progress toward treatment goals.
- **Medication-assisted treatment** for addiction (including methadone, buprenorphine, and naltrexone) can normalize brain function and help individuals remain in treatment.

Q: Why should people re-entering the community who need health care receive more routine assessment and treatment for past traumas?

A: Research shows that the vast majority of incarcerated people have histories of childhood trauma, especially childhood abuse. For example, a recent study of men incarcerated in a county jail reported that 59 percent acknowledged some form of sexual abuse occurring before age 13.34 A jail survey of women found 48 percent had a history of physical or sexual abuse and 27 percent reported rape.35 A history of abuse, as well as other forms of trauma, is especially likely for people in the criminal justice system who struggle with mental health and/or substance use disorders.

Healthcare providers need to consider past traumas when connecting reentering individuals with community-based care.‡ Reentry programs that recognize that trauma experiences are so pervasive in justice-involved populations can help individuals avoid re-traumatization and improve the safety of the correctional staff and those incarcerated. Treatment programs should recognize the individual's need to be respected, informed, connected, and hopeful regarding his or her recovery. They should promote an understanding of how trauma can lead to particular symptoms. Participants in "gender-responsive treatment" have greater reductions in drug use, are more likely to remain in residential aftercare longer, and are less likely to be reincarcerated within 12 months of release.36

Practitioners should work collaboratively with other service agencies that are empowering to the individual who experienced trauma. Training can provide staff with the most effective approaches for intervening with people who live with the effects of trauma.§

Q: What role do peer support services play in recovery from substance use disorders, mental illnesses, and co-occurring disorders?

A: Peer-based recovery support is the exchange of nonprofessional, non-clinical assistance to achieve long-term recovery. Peer providers assist an individual with developing coping and problem-solving strategies to improve the self-management of his or her addiction or mental illness. Peers may contact the individual frequently in-person and by phone to offer support and assistance, and to encourage engagement in support groups and other services. They may also organize structured leisure and recreational activities that provide opportunities for participants to practice social and coping skills.

For substance abuse, this support is provided by people who have experience (and who may be credentialed) assisting others in initiating recovery from severe alcohol and/or other drug-related problems, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.** The services may precede formal treatment, strengthening a peer's motivation for change, or follow treatment, supporting relapse prevention.*

For mental illness, peer-based recovery services (sometimes called consumer-operated services) are provided by individuals with personal recovery experience. When combined with traditional mental health services, a majority of studies show peer support improves mental health outcomes.37 Some studies also show improvement in clinical outcomes, such as reduced hospitalizations. When working as a substitute for traditional mental health providers, peer providers typically perform as well as non-peer providers furnishing the same non-medical service.38 Peer support is often provided by consumer-run organizations, in which most or all staff and the majority of board members have a history of mental illness.†

Q: How can families assist in promoting positive health outcomes?

A: Families and pro-social networks can play a critical role when their loved ones are involved in the juvenile or criminal justice system. Studies have found that increased positive contact with family during incarceration can reduce the likelihood of recidivism.39 In addition to playing an important role in addressing addiction and encouraging reentering individuals to find and keep jobs, families can provide other motivation for change. However, it is important to evaluate the influence that family members may have on an individual's substance use or criminal activity, which are often intergenerational issues.40 It is important to pay particular attention to the distinct issues that women may encounter upon release when connecting with former partners, who may have had a role in their substance use or may have committed acts of domestic violence. Conversely, any risk to family members posed by re-integrating an individual who has been incarcerated should always be evaluated as well.

Programs including family members in treatment during incarceration and after their release can produce positive results for individuals, families, institutions, and communities.41 Social connections that are maintained during the period of incarceration can be an important resource to help individuals achieve positive post-release outcomes.42 Most formerly incarcerated individuals believe that family support is an important factor in helping them stay out of prison.