

# Health Challenges of Reentry: Briefing Paper

The prevalence of communicable disease, mental illness, and substance abuse is much higher among former prisoners than the general population (Hammett et al. 2001). Health and health treatment play an important role in facilitating a successful reentry back to the community. Health concerns affect not only the returning prisoner, but also the family and community to which s/he returns. It is important to note how little we know about the extent to which these conditions were pre-existing and how these problems overlap. The difficulties faced in dual and triple diagnoses (for substance abuse, mental illness, and HIV infection, for example) are particularly acute, and the associated service needs are even more complex and challenging.

According to a recent report by the National Commission on Correctional Health Care (2002), while most inmates developed their health problems before being incarcerated, the time spent in prison offers a window of opportunity to serve the public interest by providing treatment that will reduce transmission of communicable diseases, health care costs in the community, and the potential for continued criminal behavior. The incarcerated population is unique in American society in that since the mid-1970s prisoners have had a constitutionally protected right to adequate medical care (McDonald 1999). This means that there is an opportunity to maximize the investment made in in-prison mental health care, medical care and substance abuse services by linking individuals to follow-up treatment in the community.

At prison intake, new prisoners frequently report medical complaints that had not been treated in the community, often because they lacked health insurance. A high percentage of incoming prisoners (25 percent of men and 50 percent of women) report a desire for obtaining help with their health-related problems. A similar percentage reports an interest in changing their health related behavior (Conklin, Lincoln, Tuthill 2000).

## Substance Abuse

Substance abuse is the most common health issue among the prison population, which has important implications for both the public health and public safety concerns of released prisoners and their communities. Not only do a significant number of released prisoners have addiction problems, but the use of alcohol and other drugs is closely linked to the commission of crime. Despite the clear need for this issue to be addressed, both in prison and after release, there is a lack of substance abuse treatment for those who need it.

The National Center on Addiction and Substance Abuse at Columbia University reports that alcohol abuse is linked to 80 percent of crimes committed by incarcerated prisoners in the United States (Belenko 1998). More than half of state prisoners reported they were using drugs or alcohol when they committed the offense that led to their incarceration. Nearly one in five state prisoners said they committed their most recent crime to obtain money for drugs (Mumola 1999). Substance abuse problems that are not addressed during the period of incarceration and/or upon return to the community can severely hinder the reintegration process.

Despite the overwhelming percentage of prisoners who report a history of substance abuse, in-prison treatment is not available to most who need it. Nationally, only 10 percent of state prisoners in 1997 reported receiving formal substance abuse treatment, down from 25 percent in 1991. An additional 20 percent (up from 16 percent in 1991) participated in other drug abuse programs such as peer counseling groups and awareness programs (Lynch and Sabol 2001). In the absence of treatment, the risk of relapse following release from prison is high. For example, an estimated two-thirds of untreated heroin abusers resume their heroin/cocaine use and patterns of criminal behavior to support their habit within three months of release from prison (Wexler, Lipton, and Johnson 1998).

Several studies have found that drug treatment can be a beneficial and cost-effective way to reduce both substance abuse and criminal activity (Gaes et al. 1999; Harrison 2001; Seiter and Kadela 2003). In-prison drug treatment has been associated with positive outcomes, including reduced use of injection drugs and fewer prison returns and hospital stays for drug and alcohol problems (Gaes et al. 1999). The most successful outcomes, however, were found in programs such as KEY-Crest, where individuals participated both in prison treatment followed by treatment in the community upon release (Harrison 2001). Helping to smooth the transition from prison to home—through connections to community-based treatment, perhaps immediately upon release—could reduce the likelihood of recidivism and the resumption of drug use (Iguchi et al. 2002).

### **Communicable Diseases: HIV/AIDS, Hepatitis C, and Tuberculosis**

The rate of communicable disease is much higher for incarcerated populations than among the general population. People passing through our nation's prisons and jails account for a significant share of the total population who are infected with HIV or AIDS, hepatitis C, and tuberculosis (Hammett et al. 2001). In 1997, nearly one-quarter of all people living with HIV or AIDS, nearly one-third of people with hepatitis C, and more than one-third of those with tuberculosis were released from a prison or jail that year.

Looking only at the prison population, we also see substantially higher levels of serious communicable disease as compared to the general population. (See Table 1 below.) The percent of confirmed AIDS cases among prisoners was five times greater than in the general population (0.55 percent versus 0.9 percent, respectively) (Maruschak 1999). State prisoners also tested positive for HIV (2.2 percent in 1997) at a rate five to seven times greater than the general public (NCCHC 2002). In 1997, an estimated 35,000 to 47,000 inmates were HIV-positive and 8,900 inmates had AIDS.

The prisoner population also has a high rate of hepatitis C virus (HCV) infection. Estimates range from 17 to 19 percent of the national prison population is infected with HCV (NCCHC 2002). Hepatitis C, unlike the A and B types, can be treated, but it has no vaccine or cure. Conditions in prison that involve the sharing of personal care items lead to a high rate of in-prison transmission. Few prison systems test for or treat HCV, so prisoners may be released while still unaware they are infected. More than 300,000 inmates were estimated to have HCV in 1997. An estimated 131,000 prison and jail inmates tested positive for latent tuberculosis (TB) infection in 1997. TB infections respond well to preventive therapies that can reduce the risk of developing active TB. Although the prevalence estimates of active TB among inmates is relatively small (0.04 percent), it is still four times greater than among the U.S. population.

There are opportunities during imprisonment to screen, manage, and treat many of these diseases that would make a significant impact in terms of improving the health of the individual prisoners, the community, and their families as well as result in more successful reintegration outcomes. One nonprofit, Centerforce, Inc., provides health and wellness services, prevention case management, family support services, literacy, and policy, research, and training consultation to inmates and their families throughout Northern and Central California. An evaluation of its peer HIV education program for male inmates found that program participants were more likely to use condoms and be tested for HIV than non-participants. They also found a significant difference between the intervention group and non-intervention group in their perception of risk of contracting HIV. Inmates reported a preference for peer educators over other types of educators.

**Table 1. National Prevalence Estimates of Selected Communicable Diseases Among Inmates and U.S. Population, 1997**

Condition	Estimated Prevalence among Prisoners	Estimated Number of Inmates	Prevalence among U.S. Population
AIDS	0.55%	8,900	0.09%
HIV Infection	2.3–2.98%	35,000–47,000	0.3%
Hepatitis C	17.0–18.6%	303,000–332,000	1.8%
Tuberculosis Infection	7.4%	131,000	N/A
Tuberculosis Disease	0.04%	1,400	0.01

National Commission on Correctional Health Care. 2002. "Prevalence of Communicable Disease, Chronic Disease and Mental Illness Among the Inmate Population" in *The Health Status of Soon-to-be-Released Prisoners, A Report to Congress*, Volume 1.

### Chronic Diseases: Asthma, Diabetes, and Hypertension

In terms of chronic diseases, the prevalence of asthma among jail and prison inmates was estimated to be higher than among the general population (8.5 percent versus 7.8 percent). Although the prevalence of diabetes and hypertension were lower among the prison population, the prevalence is still fairly high given that these conditions are typically associated with older populations. (See Table 2 below.) This means that these conditions may increase as the state prison population ages (Davis 2002).

Inmates with untreated chronic diseases can create substantial burdens on both the correctional health care system and the community health care system. Asthma, diabetes, and hypertension can be managed in ways that would result in improved health outcomes for returning inmates and reduce the demand for costly acute care and hospitalization services.

**Table 2. National Prevalence Estimates of Selected Chronic Diseases Among Inmates and U.S. Population, 1997**

Condition	Estimated Prevalence among Prisoners	Estimated Number of Inmates	Prevalence among U.S. Population
Asthma	8.5%	140,738	7.8%
Diabetes	4.8%	73,947	7.0%
Hypertension	18.3%	283,105	24.5%

National Commission on Correctional Health Care. 2002. "Prevalence of Communicable Disease, Chronic Disease and Mental Illness Among the Inmate Population" in *The Health Status of Soon-to-be-Released Prisoners, A Report to Congress*, Volume 1.

### Mental Illness

Mentally ill reentering prisoners face significant barriers when reintegrating. The mentally ill, particularly those with severe illness, may have difficulty coping with the most basic reentry activities like finding housing and employment. If mental health treatment is initiated in prison, continuing such treatment after release can have a positive impact on the ability of the prisoner to reintegrate successfully.

Serious mental health disorders such as schizophrenia/psychosis, major depression, bipolar disorder, and post-traumatic stress disorder are more common among prisoners than among the general population. (See Table 3 below.) Rates of mental illness among prisoners are two to four times higher than among the general population. An estimated eight to 16 percent of the prison population has at least one serious mental disorder and is in need of treatment.

**Table 3. National Prevalence Estimates of Psychiatric Disorders Among State Prison Inmates and U.S. Population, 1995**

Condition	Estimated Prevalence among Prisoners	Estimated Number of Inmates	Prevalence among U.S. Population
Schizophrenia/ Psychosis	2.3–3.9%	22,994–39,262	0.8%
Major Depression	13.1–18.6%	132,619–188,259	18.1%
Bipolar (Manic)	2.1–4.3%	21,468–43,708	1.5%
Post-Traumatic Stress Disorder	6.2–11.7%	62,388–118,071	7.2%

National Commission on Correctional Health Care. 2002. "Prevalence of Communicable Disease, Chronic Disease and Mental Illness Among the Inmate Population" in *The Health Status of Soon-to-be-Released Prisoners, A Report to Congress*, Volume 1.

Some researchers have attributed the current high levels of mentally ill prisoners to the policy of deinstitutionalization of the mentally ill in the years following World War II. That policy was designed to shift the burden of caring for the mentally ill population from large state hospitals to smaller community-based programs. The state hospital population was greatly reduced, but many community-based treatment programs were overwhelmed by the needs of this large population. In the absence of effective sustained treatment and shrinking mental health budgets, the criminal justice system, rather than the mental health care system, increasingly responded to the erratic behavior exhibited by the untreated mentally ill (Lurigio 2001).

Prisons are making an effort to treat mentally ill inmates. According to the Bureau of Justice Statistics (2002), nearly 70 percent of state correctional facilities regularly screen incoming prisoners for mental illness. More than half (60 percent) of mentally ill state prisoners have received some form of mental health treatment while in prison (Ditton 1999). Of these, half reported taking prescription medication and 44 percent reported receiving counseling services.

Often, little assistance is available for inmates in making linkages to community-based mental health treatment upon release. Although two-thirds of state prisons report providing at least a referral for community mental health services upon release, few help prisoners establish appointments with treatment providers in the community (Beck and Maruschak 2001). Parole agencies are generally ill equipped to identify and address the mental health needs of released prisoners. A national survey of parole administrators found that less than a quarter of the respondents indicated that they provide special programs for parolees with mental illness (Lurigio 2001).

One example of a promising strategy that links individuals with mental health disorders to necessary social services is the Dangerous Mentally Ill Offender Program (DMIO) in Olympia, Washington. Generally, the program enhances the screening and the mental health treatment of eligible individuals who are released from incarceration in order to improve their transition back to the community. The program began in March 2000 in response to a 1999 Substitute Senate Bill by the Washington Legislature, which sought to improve screening, assessment, and treatment of mentally ill offenders who were a high risk to themselves or others.

In 2002, the Washington State Institute for Public Policy published a preliminary report on the implementation of the DMIO law of 1999, the process of selecting participants, and the treatment services provided (Phipps and Gagliardi 2002). The researchers tried to compare the DMIO population (26 participants) to a comparison group. The preliminary results show that the DMIO program is making an improvement in providing pre- and post-release mental health and post-release chemical dependency services. For example, 83 percent of DMIO clients have received pre-release mental health treatment

from community organizations compared to 10 percent of the comparison group. The authors will report the program's impact on recidivism in 2004.

### **Multiple Diagnoses**

With such a high proportion of prisoners experiencing mental and physical ill health, the presence of dual and triple diagnoses is not surprising. These multiple diagnoses of physical illness, mental illness, and substance abuse pose additional challenges in terms of treatment, both in prison and after release. Though we do not have exact numbers, it appears that dual diagnoses of mental health and substance abuse issues are not uncommon among the prisoner population (Hammett et al. 2001). Prisoners with mental illness were more likely than those without mental illness to be under the influence of alcohol or drugs when they committed their most recent offenses. More than one-third of mentally ill state prisoners indicated a history of alcohol dependence and nearly six in ten indicated that they were under the influence of alcohol or drugs while committing their current offenses (Ditton 1999). This combination is a strong predictor of recidivism (Steadman et al. 1998).

The prevalence of prisoners diagnosed with some combination of HIV disease, substance abuse problems, and mental illness is still unknown. However, some researchers point to various emerging trends—such as shifts in the spread of HIV to drug users and their sexual partners and increases in incarceration rates of people with mental illness—as potential signals that the numbers may be increasing (Hammett et al. 2001). Integrated treatments for HIV, substance abuse, and mental illness are rarely provided, yet are very important due to the complexity of the effects of drug interactions (McKinnon et al. 1997). A recent survey by Abt Associates on discharge planning practices found that few state correctional systems have programs in place to help transition dually and triply diagnosed prisoners from prison back to the community (Roberts et al. 2001).

### **Potential Costs of Not Addressing Health Needs of Prisoners are High**

The potential costs of not addressing health needs for reentering prisoners are high. Prisoners who are on prescribed medications while incarcerated are often released with a limited supply of drugs or with no medications at all. Those released with infectious disease risk developing drug-resistant viral strains that can spread within the community if treatment is interrupted. Lack of treatment of substance abuse and alcoholism may result in domestic violence, unemployment, and recidivism. Lack of treatment of chronic conditions may lead to higher long-term public health costs and additional barriers to employment. Furthermore, the difficulties faced in dual and triple diagnoses (for substance abuse, mental illness, and HIV infection, for example) are particularly acute, and are better addressed through a coordinated system of care and case management services offered by a network of providers. Thus, the adequacy of discharge planning and integration of community services can have critical public health implications.

### **Reentry as an Opportunity for Intervention**

The circumstances surrounding the moment of release from prison are critical to the success of a prisoner's reentry. The moment of release and the following days are particularly critical to those ex-prisoners on medication or other regular treatment.

Since most released prisoners do not have access to private health insurance, they will need to access Medicaid or Medicare benefits upon release. Prisoners are barred from accessing these federally funded programs while incarcerated. Therefore, there is almost always a gap, ranging from days to months, between release and being approved for the health benefits (Roberts et al. 2001). This gap can be a

major obstacle to continuity of the care received in prison. When released, a prisoner is more likely to stay on treatment if they have the following at the time of release (Roberts et al. 2001):

- Medication to cover the gap before medical benefits are obtained
- A copy of the prison medical summary
- Scheduled follow-up appointments
- Assistance completing applications for medical benefits
- Connections to other reentry services such as for housing, cash benefits, and treatment for mental health and substance abuse, if necessary.

Effective health planning for a prisoner's return to the community, specifically connecting the prisoner with community services, greatly increases the chance of his/her continuing to receive medical care. One promising effort that assists inmates in order to improve their overall health status and health care utilization is the Hampden County Correctional and Community Health Program. The program uses a public health model for preventing, detecting, and treating various health issues among inmates at the Hampden County Correctional Center (HCCC). The model was originally created to provide continuity of care for inmates with HIV before, during, and after incarceration. It has since been expanded to include medical, dental, and hospice care, as well as substance abuse treatment. The program is currently being evaluated. Initial findings indicate that the program is cost-effective, leads to lower rates of reincarceration, and increases the number of released prisoners receiving medical care.

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