Co-occurring disorders in the incarcerated population: Treatment needs

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The World Prison Brief reported 2.1 million people were incarcerated in the U.S. in 2016, a rate of 655 per 100,000 people. Whereas the national incarceration rate has declined over the past decade, the U.S. continues to incarcerate more people than any other country in the world.[1] America's "War on Drugs," with its stringent changes in drug laws and law enforcement at county, state and federal levels, coupled with deinstitutionalization of state mental health facilities, has fueled the growth of the incarceration population.[2]

The decades-long deinstitutionalization movement released people with serious mental illness from state hospitals back into the community without substantial services or support. As a result, three times more people with serious mental illness, which includes people with schizophrenia, bipolar disorder and major depression have resided in jails and prisons than in hospitals.[3] In a report by the Bureau of Justice Statistics (BJS), nearly 1 in 7 state and federal inmates (14%) and 1 in 4 jail inmates (26%) recounted experiencing clinically significant symptoms of mental health and 37% of state and federal inmates and 44% of jail inmates reported a previous mental health disorder diagnosis.[4] More than half of inmates in state prisons (53%) and 45% of federal inmates reported symptoms consistent with a Substance Use Disorder (SUD) in the year prior to incarceration.[5]

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The facts

According the Substance Abuse and Mental Health Services Administration (SAMHSA) there are lower incidence rates of mental health disorders and SUDs within the community when compared to rates within incarcerated population. The NSDUH found 19% of adults report experiencing a mental illness, and 7.8% of adults meet criteria for a SUD.[6] The National Survey on Drug Use and Health (NSDUH) found more than 9 million adults (3.7%) meet criteria for both a mental illness and substance use disorder simultaneously.[7] The convergence of a substance use disorder and a mental health disorder is termed a co-occurring disorder (COD). In 2006, the BJS reported that 42% of state prison inmates and 37% of federal inmates met criteria for a COD. The rates of CODs are especially high in the female offender population (74%).[8]

States slashed $4.35 billion from an already underfunded mental health care system despite an upturn in public awareness of mental illness in the wake of national tragedies like the 2012 mass shooting in Newtown, Connecticut and the Great Recession.[9] These reductions resulted in an increasing paucity of community-based care, raising rates of emergency services utilization, homelessness and death.[10] Among the 47.6 million adults who met criteria for a mental illness in 2018, less than half (43.3%) received treatment. Additionally, 20 million adults needed treatment for a SUD in 2018, but only 3% of this population received treatment within the previous year. Among the 9.2 million adults who meet criteria for a COD, about 4.7 million received either substance use or mental health treatment. Therefore, 48.6% of adults who meet criteria for a COD did not receive either type of care in 2018.

Defining the problem

As social safety nets and treatment opportunities have steeply declined within the community, symptoms of mental health and substance use have become criminalized, resulting in growing rates of incarceration. As a result, American jails and prisons have become de facto treatment facilities. Despite the pressing need, treatment programs in correctional facilities for people with CODs remain sparse.[11, 12] When treatment is present in a jail or prison, its focus is largely on crisis intervention and psychotropic medication administration.[13] Hunt, et al.[14] reported only 38% of inmates received mental health treatment, and a mere 7% received both mental health and substance use treatment.

Another factor associated with the rate of CODs in correctional facilities is violence. Van Dorn et al.[15] demonstrated within a large community sample that people with CODs are at increased risk of violent behavior compared to people diagnosed with a singular mental health or a substance use disorder. Offenders with mental illness or CODs are more likely to be perpetrators and victims of violence and more likely to have been charged with violent crimes prior to incarceration.[16]

Correctional researchers have discovered that incarcerated women diagnosed with CODs are more likely to demonstrate aggression and misconduct as well as become victims of aggression themselves.[17, 18, 19, 20] Houser & Belenko [21] found incarcerated women with CODs are more likely to demonstrate disciplinary problems than inmates with either a singular mental health disorder or a SUD and tend to be punished more harshly for minor infractions when compared to inmates with a single disorder or no disorder. Special actions associated with increased incident reports and disciplinary actions are monetarily costly to correctional systems and lead to staff demoralization.[22]

Across genders and settings, people diagnosed with CODs demonstrate more impairment in psychosocial skills, are less likely to enroll in and complete treatment of any sort and are more likely to reoffend and relapse once released from prison. Once released from jail, prison or a treatment facility, people with CODs struggle to find and engage in community mental and substance use treatment resulting in relapse of symptoms of both disorders.[23, 24] Moreover, people with CODs face other barriers to successful reentry, including difficulty securing affordable transportation and housing, and termination of social safety net programs.[25]

Treating people diagnosed with CODs in any setting is economically preferable when compared to the collective economic cost of substance use. The National Drug Intelligence Center reported the overall cost of substance use was $193 billion in 2007. Of that total, $113 billion was linked to costs of drug-related crime and criminal justice system expenditures. Comparatively, the estimated cost of diabetes in the U.S. in 2007 was less at $174 billion.

The cost of treating people with substance use disorders appears paltry at just $14.6 million.[26] Administration of treatment cuts expenses related to lost productivity, crime and incarceration across populations and settings.[27] For example, medication-assisted substance use treatment in the community costs up to $5,000 a year per person while incarcerating a person for a year costs up to $24,000.[28]

Solutions for success

Deployment of treatment services for CODs within the correctional system has been provided in parallel, sequential or integrated approaches. The first two approaches reflect the historical separation of the mental health and substance use treatment systems, varying sources of funding along with divergent types of services, staff education, training and credentialing.[29]

In the parallel paradigm, a person diagnosed with a COD receives treatment for both disorders concurrently but from different providers and even from different facilities. In the sequential treatment design, the disorders are handled one at a time, and once the first disorder is in remission, treatment will begin for the other active disorder. The practice of parallel and sequential treatment has resulted in disjointed, ineffectual and piecemeal treatment for CODs due to dissimilarities between mental health and substance use treatment programming.[30] Even with poor treatment outcomes, implementation of these two approaches is common in the treatment of CODs in the correctional setting, increasing the risk of symptom relapse and recidivism upon release.

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The integrated approach is the preferred method for COD treatment and has the best research-based outcomes for success. In the integrated method, treatment focuses on the interdependent characteristics of mental health disorders and SUD and treats both as primary conditions. Services are administered simultaneously and use a single treatment provider or a unified group of providers.[31] Evidenced-based treatment (EBT) for CODs includes cognitive-behavioral therapy (CBT), motivational interviewing (MI), illness management and recovery, family therapy and behavioral modification. CBT targets treatment participants' distorted thought patterns resulting from mental illness, SUD and criminal behavior and emphasizes constructive coping and social skills. MI is a client-centered method used to help treatment participants identify consequences of SUD and criminality and to enhance treatment engagement and retention. Behavior modification is a system of providing rewards and penalties to alter maladaptive patterns of behavior and increase treatment retention.[32]

Integrated treatment for CODs within the correctional setting has demonstrated increased participant retention and reduction in symptom relapse and recidivism.[33] Integrated EBT provided in a therapeutic community (TC) setting where the participants live and attend treatment together has demonstrated the most robust and consistent reduction in substance use relapse and recidivism.[34] A specialized type of TC called a modified therapeutic community (MTC) integrates features of conventional therapeutic communities with an additional focus on addressing attendant mental health conditions. Participants in MTCs demonstrate a lower risk for recidivism, substance use relapse, mental health distress and HIV transmission after release. Additionally, MTC participants have better outcomes with employment and housing post-release.[33]

Participants progress through treatment at differing rates, but research has reliably indicated that persistent declines in substance abuse and criminal behavior are correlated with length of treatment. Largely, treatment that extends beyond ninety days begets better results. CODs are chronic in nature, and relapse of mental health and substance abuse symptoms are a common facet of the recovery process. Therefore, treatment is most efficacious when it is prolonged. The corrections environment presents longer time periods where this type of treatment could be very effectual.

Measuring success

The growing body of research clearly indicates that providing long-term integrated EBT for inmates diagnosed with a COD is preferable in terms of effectiveness and cost efficiencies. The provision of integrated treatment for offenders with CODs offers a distinct opportunity for states to improve outcomes for offenders during and long after their incarceration as well as improving the working conditions and morale of correctional staff. Furthermore, implementation of these treatment modalities can often occur within existing correctional staffing matrices and infrastructure.

Summary

As inadequate access to care for mental health and substance use disorders within the community continues, community resources remain underfunded and overburdened**.** State correctional systems are tasked with greater responsibilities, but they can meet these challenges by expediently providing efficacious integrated treatments for offenders diagnosed with CODs; this will improve the lives of millions of people and contribute to the public's economic and societal benefit.

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Correctional systems can implement integrated EBT programs often within their existing mental health and substance use treatment framework. Treatment professionals can be cross trained in the treatment of both disorders. Assessment for mental health disorders and SUDs upon intake to an institution could be combined, and an integrated treatment plan can be created and employed. These plans

can be regularly reviewed in a multidisciplinary team format. MTCs can be established for those diagnosed with a COD upon intake by repurposing the existing infrastructure within an institution to provide housing, treatment space for individual and group sessions and a sense of community for the participants. Reentry coordinators would be cross trained to facilitate aftercare planning for continuity of services post-release. All correctional staff including security and administrative staff should be receiving continuing training about the nature of CODs and their effect on an individual's functioning within the correctional system. The realignment of already existing staff, housing and resources would be a small budget expenditure when compared to the cost of the revolving door of untreated mental illness, substance use and reincarceration.

Ohio has deployed a program specifically targeting offenders diagnosed with CODs within their correctional system.[35] The Ohio Department of Rehabilitation and Corrections partners with the state's Bureau of Mental Health Services to provide treatment through the Substance Abuse and Mental Illness (SAMI) Intensive Outpatient Program. SAMI is comprised of three distinct programs consisting of a 28-hour Treatment Readiness program, an 84-hour Intensive Outpatient program and a 24-hour Recovery Maintenance program. Each intensive program is delivered for a minimum of six hours weekly and involves additional hours of supplemental services. The Recovery Maintenance is delivered two hours weekly. The SAMI Non-Intensive Program is a 12-week education group that involves various mental health and substance use focused topics and related exercises. Groups meet weekly for up to two hours.[35]

While different states choose to implement EBTs for CODs differently, the research reliably indicates that treatment participation reduces symptom relapse and recidivism. Proactively helping this population while they are incarcerated is an excellent return on investment as it increases the participants' quality of life pre and post release and can reduce crime within our communities. To perfectly encapsulate these ideas, renowned journalist and author Malcolm Gladwell wrote in "The Tipping Point: How Little Things Can Make a Big Difference," "If you want to bring a fundamental change in people's belief and behavior ... you need to create a community around them, where those new beliefs can be practiced and expressed and nurtured."[36]

ENDNOTES

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