RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Training and Technical Assistance

Health Literacy

Health and Wellness Recovery Self-Management Tools for RSAT Prison, Jail, and Aftercare Programs

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This manual is a cross-disciplinary training tool designed to help RSAT programs integrate health literacy and health promotion activities into treatment and release planning to help justice populations sustain recovery and access continuing care as they transition from custody to community.

Advocates for Human Potential, Inc.

This project was supported by grant No. 2016-MU-BX-K021 and 2013-DP-BX-K013 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.

Health Literacy: Health and Wellness Recovery Self-Management Tools for RSAT Prison, Jail, and Aftercare Programs

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Note: This manual is for informational purposes only. The information provided is not intended to diagnose, treat, cure, or prevent any disease or condition, nor is it intended to substitute for clinical or medical care. Decisions about treatment of medical and behavioral health conditions and the use of medications are the sole responsibility of the patient, treatment providers, treating physician, and other qualified health care professionals. Not all the options presented may be appropriate for every situation.

Module I—Health Literacy: What and Why?

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Learning Objectives

After completing this module, participants will be able to

- define health literacy,
- list at least two examples of the impact of health factors on recidivism,
- name at least two preventable health conditions prevalent in custody settings,
- identify the leading cause of mortality among formerly incarcerated individuals and discuss integrating preventive measures into RSAT programs.

Module I—Health Literacy: What and Why?

A. Introduction—Health Factors and Recidivism

Are Health Factors Important Predictors of Recidivism?

Most justice professionals are acquainted with the risk factors that increase an individual's chance of returning to custody. Rehabilitative programming aims to reduce these risks by addressing the assessed needs of the individuals, both while they are in custody and through release planning and continuing care. A growing body of research suggests that health factors may play a role in recidivism. In short, when re-entering individuals can successfully access and utilize available and appropriate health services, their chances of staying out of prison or jail significantly improve. This is particularly true for individuals with substance use disorders (SUDs) and the attendant physical and behavioral health needs associated with these disorders.

Facilitating access to appropriate health care services among justice-involved individuals with SUDs is a multifaceted process supported by health literacy. This requires introducing Residential Substance Abuse Treatment (RSAT) participants to a body of knowledge and a skillset that few justice-involved individuals are likely to possess. And, just as re-entry planning begins when people enter custody, integrating health literacy and wellness into RSAT programming must start at the outset and continue through re-entry planning to achieve the desired post-release results.

Even though health services are not the primary focus of correctional systems, prisons and jails have, in effect, become the default health care provider for people with some of the highest and most complex clinical needs coupled with histories of very limited access to care.

What the Research Tells Us

- *Research shows that prior to entering a correctional facility, most RSAT clients have limited access to health services.* Studies show that up to 80% of individuals report no community care prior to their last arrest. Further, less than 25% of re-entering individuals with a diagnosed chronic condition see a physician in the first 12 months after release.[1]
- *Justice-involved individuals with SUDs who have comorbid medical conditions have higher rates of criminal activity compared to those without either health problem.* They are also more likely to be homeless and unemployed—two destabilizing factors that contribute to recidivism.[2]
- *People with mental health conditions tend to have higher rates of victimization in prison and end up serving longer sentences*, often due to disciplinary issues related to their psychiatric symptoms. In general, studies have found that

[1] Regenstein, M., & Christie-Maples, J. (2012). Medicaid coverage for individuals in jail pending disposition: Opportunities for improved health and health care at lower costs. *Health Policy Faculty Publications, Paper 1*, 1-18.
[2] Taxman, F.S., Thanner, M. & Weisburd. (2016). Risk, need, and responsivity (RNR): It all depends. *Crime & Delinquency*. Vol 52, Issue 1. pp. 28-51; Wang, E.A., White, M.C., Jamison, R., Goldenson, J., Estes, M., & Tulsy, J.P. (2008). Discharge planning and continuity of healthcare: Findings from the San Francisco county jail. *American J of Public Health, 2008* December; 98(12): 2182–2184

individuals with mental health problems serve an average prison sentence of 15 months longer for comparable crimes than those without such conditions.[3]

- Recent research suggests drug and alcohol addiction and co-occurring mental health conditions are important predictors of recidivism.[4] Specifically, risky use of cannabis, amphetamines, or opioids prior to incarceration and the use of prescribed central nervous system medications are associated with recidivism.[5]
- Drug overdose is the leading cause of post-release death, and fatality rates are currently higher than ever. Overdose prevention is becoming an essential component of RSAT programming. A recent study found that almost 15% of all former prisoner deaths between 1999 and 2009 were related to opioids.[6] Another study found that 85% of fatalities that occurred in the immediate post-release period were attributable to drug overdose.[7]

This manual provides suggestions for health promotion activities and priorities for RSAT programs. It offers RSAT staff tools for assessing health literacy levels, materials that introduce health and wellness as a component of recovery self-management, and ways of increasing access to post-release care. It also includes a section on overdose prevention that can help RSAT programs impart basic, potentially life-saving information to participants.

Integrating Health and Addiction Treatment

Integrating health and wellness into addiction treatment and recovery has coincided with the shift from an acute care model of treatment for substance use and addiction-related disorders to a chronic care model. Professional treatment has continued to deliver time-limited, intensive levels of care but with an increased emphasis on facilitating linkages with a variety of supportive services that help people sustain ongoing recovery. Primary care providers have stepped-up efforts to screen for SUDs and now offer critical addiction treatment services to many communities. More addiction treatment programs now screen for mental and physical health conditions prevalent among people with SUDs.

Treatment practices and programs have always aimed to prepare clients for maintaining abstinence from compulsive drug and alcohol use and to continue building a life in recovery after discharge. Addressing health issues has become a part of that preparation. According to 2015 data on specific services at public and private community-based SUD treatment facilities, providers are offering the following health services (in addition to screening all women for pregnancy):

- HIV testing—28%

[3] Bailargeon, J., Binswanger, I.A., Penn, J.V., Williams, B.A., & Murray, O.J. (2009). Psychiatric disorder and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry*, 166(1), 103-109.
[4] Baillargeon, J, Hoge, SK, & Penn, JV. (2010). Addressing the challenge of community reentry among released inmates with serious mental illness. American Journal of Community Psychology, 46(3–4), 361–375.
[5] Thomas, E.G, Spittal, M.J., Taxman, F.S. & Kinner, S.A. (2015). Health-related factors predict return to custody in a large cohort of ex-prisoners: New approaches to predicting re-incarceration. *Health & Justice*, 20153:10.
[6] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.
[7] Bukten et al. The Norwegian Offender mental health and addiction Study – design and Implementation of a national Survey and Prospective Cohort Study. *Substance Abuse: Research and Treatment* 2015:9(S2) 59–66 doi: 10.4137/SaRt.S23546.

- Hepatitis education, counseling, or support—45%
- Early intervention for HIV—25%
- Health education (on topics other than HIV/AIDS or hepatitis)—52%
- Smoking/tobacco cessation counseling—44%[8]

Over the last decade, the view of substance misuse and dependency has shifted from a problem primarily for criminal justice to a public health issue, in part due to an opioid epidemic rooted in the misuse of prescribed rather than illicit drugs. Today, individuals with opioid use disorders (OUDs) are far more likely to have initiated the use of a prescribed opioid analgesic than to have started out using heroin or other illicit opioids.[9] A better understanding of the co-occurrence of SUDs and mental health conditions, of chronic pain and opioid use disorders, and of the neurophysiology of addiction has led to an increased appreciation of the role medications can play in facilitating recovery.

Health reform has made Medicaid available to a substantial portion of the justice-involved population. This has created new opportunities for this population to access behavioral health treatments and medical care that was once out of reach. The challenge is making sure justice populations take advantage of these new opportunities. All this translates to a greater need to ensure individuals in custody undergoing treatment for a SUD understand the basic health information, learn to navigate a complex health care system, and are prepared to make informed health care decisions that safeguard their recovery. RSAT participants will benefit greatly from our efforts to integrate health and wellness into the recovery management skills and improved health literacy they obtain in treatment programs.

B. What is Health Literacy?

The Institute of Medicine defines health literacy as *the degree to which individuals can obtain, process, and understand basic health information needed to make appropriate health decisions and access health care services.*[10] The challenge for RSAT is operationalizing program components that provide essential health literacy skills unaddressed through other aspects of rehabilitation or release planning. Below are some topics for RSAT programs to consider:

- Although individuals may be screened for several health conditions at intake, they may not understand the meaning of the test results, appreciate their risk factors and the ways to reduce them, or understand their treatment options. They may need counseling to deal with the impact of hearing about a difficult diagnosis before they can process information about treatment options.

[8] Substance Abuse and Mental Health Services Administration, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2015. Data on Substance Abuse Treatment Facilities.* BHSIS Series S-88, HHS Publication No. (SMA) 17-5031. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.
[9] CDC - Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015 MMWR December 30, 2016 / 65(50-51);1445–1452.
[10] Institute of Medicine (2004) Health Literacy: *A Prescription to End Confusion.* Committee on Health Literacy Board on Neuroscience and Behavioral Health, Lynn Nielsen-Bohlman, Allison M. Panzer, David A. Kindig, Editors.

- Rates of hepatitis C are about 10 times higher in prisons and jails than among the general population, and rates of HIV infection are 5 times higher.[11] RSAT participants need basic information about preventing the spread of communicable diseases and other health hazards in custody settings, as well as information about common mental and physical health conditions that affect people with SUDs.
- RSAT participants need to understand how to use prescribed medications. Individuals who have only taken medications to get high and have never tried to follow a doctor's instructions may not have basic skills such as the ability to read the label on a prescription bottle or know why they need to finish a course of antibiotics.
- Recovery from SUDs requires proactive involvement in medical decisions about pain management and the safe use of prescribed medications. Certain medications can benefit people in recovery; some can be used if necessary without great risk, whereas others have a high potential for misuse and can contribute to relapse. It is important for RSAT participants to talk with providers and prescribers about these issues.
- Re-entering individuals must know how to navigate the complexities of the health care system, obtain coverage, and locate health services. RSAT programs can help with pre-release benefit enrollment, link RSAT participants with enrollment assistance or options for low-cost care upon release, and help them understand how to use their coverage to anticipate and budget for out-of-pocket costs.
- Last but not least, re-entering individuals need to be prepared for the elevated health risks they face during the immediate post-release period. This includes learning how to reduce the risk of overdose; where to access emergency services; steps they can take to mitigate the likelihood, severity, and duration of a relapse; and how to reduce the harm that can result.

Why Does Health Literacy Matter?

Poor health literacy is associated with frequent hospitalizations, high health care costs, poor health outcomes, and premature death, as well as increased recidivism. It is a stronger predictor of health status than income, education level, employment, or race.[12] Improving health literacy helps reduce disparities and contributes to health equity. Many sentenced individuals have experienced significant health disparities. They often come from and return to neighborhoods where environmental health risks are high and quality health care services are scarce. There are pronounced differences in life expectancy, health, and care costs for people who experience these disparities. Specifically, people convicted of drug offences are disproportionately African American (33%) and tend to

[11] Maruschak, L. & Beavers, R. (2009) HIV in Prisons, 2007-08. NCJ 228307. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics. www.bjs.ojp.usdoj.gov/content/pub/pdf/hivp08.pdf

[12] Berkman, N.D., S.L. Sheridan, K.E. Donahue, D.J. Halpern and K. Crotty. 2011. Low health literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine*, 155(2):97-107. Retrieved from http://annals.org/article.aspx?articleid=747040&atab=10.
Weiss, B. 2007. *Health literacy and patient safety: Help patients understand*. Chicago: American Medical Association. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf.

lack economic means.[13] Up to 87% of those convicted of drug-related offenses relied on indigent defense resources during criminal proceedings.[14]

The good news is that preventive health interventions directed at high-risk populations are the most cost-effective because they can achieve such beneficial results for this population.[15] Recent studies have confirmed the advantages of expanded access to health coverage for justice-involved populations, especially during re-entry care transitions. Coverage that allows immediate access to behavioral health services and recovery supports upon release can double or triple an individual's chances of re-entry success. Medicaid expansion has already made a measurable impact on re-entering populations and has demonstrated the advantages of preventing and treating physical and behavioral health conditions among justice populations.

- Studies in Florida, Washington state, Rhode Island, and Michigan have shown a 16% to 17% reduction in re-incarceration for re-entering individuals who are covered by Medicaid at the time of release.[16]
- Justice-involved populations with Medicaid or private insurance are more likely to receive treatment for serious mental illness or alcohol use disorders than the general population. Those with Medicaid are even more likely than those with private insurance to get treatment for depression or a drug problem.[17]
- Individuals with OUDs are more likely to receive medication-assisted treatment (MAT) when they are enrolled in a Medicaid plan that covers their treatment. Rates of utilization for opioid replacement therapy were 45% for Medicaid-enrolled individuals compared with 30% in states with block grant coverage only and 17% in states with no coverage.[18]

If mere access to Medicaid has resulted in such significant gains for justice-involved populations, it stands to reason that as their health literacy increases, these gains will increase even more.

Health Insurance Literacy

Health insurance literacy is a part of one's overall health literacy. When re-entering individuals have a basic understanding about health insurance, they are better equipped to take advantage of whatever coverage is available to them.

RSAT programs can address health insurance literacy needs by using resources available through state and federal health insurance exchanges or through their state's Medicaid office and contracted Medicaid managed care organizations (MMCOs), local

[13] E. Ann Carson, PhD, and Elizabeth Anderson. Prisoners In 2015. Washington, DC: U.S. Dept. of Justice Bureau of Justice Statistics, Dec. 2016, NCJ250229, p. 30, Appendix Table 5.0 https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5869
[14] U.S. Department of Justice, Office of Justice Programs. Bureau of Justice Statistics Special Report, Defense Counsel in Criminal Cases, November 2000, NCJ 179023
[15] Godell, S., Cohen, J.T. & Neumann, P.J. (2009). Cost Savings and Cost-Effectiveness of Clinical Preventive Care. Robert Wood Johnson Foundation Synthesis Project. Available online at: http://www.rwjf.org/en/library/research/2009/09/cost-savings-and-cost-effectiveness-of-clinical-preventive-care.html
[16] Morrissey, J. *Medicaid Benefits and Recidivism of Mentally Ill Persons Released from Jail*, National Institute of Justice, May 2006; Agency for Healthcare Research & Quality.
[17] Winkelman, T.N.A., Kieffer, E.C., Gold, S.D. et al. (2016) Health Insurance Trends and Access to Behavioral Healthcare Among Justice-Involved Individuals—United States, 2008–2014 *J of General Internal Medicine* (2016) 31: 1523. Available online at: https://link.springer.com/article/10.1007/s11606-016-3845-5
[18] McKnight, Courtney, "Assessing the Impact of Restrictions to Medicaid Coverage of Methadone and Buprenorphine on Opioid Users' Access to and Utilization of Substance Use Treatment" (2015). *CUNY Academic Works.*

enrollment outreach and assistance, or Medicare and disability services. Resource sections of this manual contain links to short videos and printed materials that help educate potential and new beneficiaries about health coverage basics. Once individuals have access to coverage, it is equally important they learn how to use whatever coverage they have to access quality care after they are released.

Research in Massachusetts, a state that adopted universal health care coverage several years before the rest of the country, found that Medicaid enrollment alone did not alter how formerly uninsured persons accessed health care. For example, it was expected that once people enrolled in Medicaid, they would avail themselves of primary and preventive care and use of expensive emergency room care for routine health issues would decrease. However, it turned out that increased enrollment did not automatically lead to decreased emergency room utilization. Newly enrolled beneficiaries needed help learning how to use their coverage to access non-emergency health care and preventive care services, as well as how to connect with a primary care provider. Emergency room usage went down in Massachusetts among newly covered individuals after the state addressed these needs.[19]

C. Unique Needs and Challenges of RSAT Participants

Compounding the challenge of helping incarcerated populations understand health information is the fact that the highest concentrations of functional illiteracy in the U.S. are found in prisons.[20] RSAT programs can work with educational staff to identify participants who will benefit from verbal or video explanations of critical health information. Programs can make use of the health information plain language resources listed in this manual and consistently reinforce health and wellness as an important aspect of recovery. Research suggests this has an impact on re-entry success. In a recent large-scale study on re-entry and health, participants who reported that maintaining their health post-release was not important had a 50% greater risk of re-incarceration.[21]

There is also an unusually high incidence of co-occurring disorders (CODs) among justice-involved individuals with drug and alcohol problems (about 74%).[22] Easy-to-understand materials are important for RSAT participants who have disorders that affect concentration. The ability to access ongoing psychiatric medication management can also play a crucial role in re-entry success.

Washington State Prison Mortality Study (Binswager et al, 2007)

Cause	Former Inmate	Current Inmate
Overdose	181	1
Heart Disease	98	68
Homicide	95	6
Suicide	70	16
Cancer	68	42
Car accident	61	1
Liver disease	40	23
Other accident	30	1
AIDS	12	3
Diabetes Mellitis	11	3
Police Firearm	9	3

[19] Kolstad, J.T. & Kowalski, A.E. (2010). The impact of health care reform on preventative and hospital-based care: Evidenced from Massachusetts. National Bureau of Economic Research.
[20] US Department of Education. (20o7) Literacy Behind Bars: Results From the 2003 National Assessment of Adult Literacy Prison Survey.
[21] Thomas, E.G, Spittal, M.J., Taxman, F.S. & Kinner, S.A. (2015). Health-related factors predict return to custody in a large cohort of ex-prisoners: New approaches to predicting re-incarceration. *Health & Justice*, 20153:10.
[22] Henry J. Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60, no. 6 (2009): 761–765.

Health literacy will not only save money by decreasing emergency room care; it will provide better care. Emergency room care is a very expensive level of care, and the quality and safety of hospital emergency department care for routine health problems can be questionable.

In 1999, an Institute of Medicine report on the "epidemic" of preventable medical errors shook the medical establishment.[23] A recent study by researchers at Johns Hopkins University ranked medical mistakes as the **third leading cause of death in the U.S.**[24] Many mistakes are made in hospital settings and especially in emergency departments. The risk of developing a hospital-based infection is also high. When re-entering individuals learn how to take advantage of preventive care, utilize behavioral health treatments, and connect with a primary care provider for routine services, it translates to better outcomes and lower care costs.

People in custody are at an elevated risk of developing chronic conditions and contracting many communicable diseases. One-half of men and two-thirds of women leaving prison are diagnosed with one or more chronic medical conditions such as asthma, diabetes, hepatitis, or HIV/AIDS. Smoking rates are double those of the general population, and although smoking is prohibited in most correctional facilities, without smoking cessation services, nearly all individuals leaving custody resume smoking upon release.[25] Mental health conditions and SUDs can compound physical health problems. Nearly one-third of state prisoners report a mental, developmental, cognitive, or physical disability. Suicide is the leading cause of death in jails and a common cause of post-release fatality.[26]

Left untreated, mental and physical health conditions tend to worsen, making it difficult for re-entering individuals to function in the community, maintain employment, and stay in recovery, which, in turn, increases their risk of re-offending and re-incarceration. For RSAT program graduates, planning the transition from health care in custody to community-based care is crucial if treatment gains are to be maintained. Treatment lays a foundation for ongoing recovery. However, that foundation erodes very quickly in the absence of follow-up services during the critical transitional period from custody to community.

The elevated health hazards of the immediate post-release period are dramatic. In the first two weeks after leaving custody, the risk of dying of any cause is 12 times higher and the risk of dying from a drug overdose is 40 to 129 times higher than for the general population.[27] At the very least, information about community emergency overdose services is essential, since people leaving custody, those initiating recovery, and those leaving treatment for an OUD are especially vulnerable to overdose fatality.

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[23] Institute of Medicine (US) Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System.* Kohn LT, Corrigan JM, Donaldson MS, editors**. Source:** Washington (DC): National Academies Press (US); 2000.
[24] Makary Martin A, Daniel Michael. Medical error—the third leading cause of death in the US BMJ 2016; 353: i2139. Available online at: http://www.bmj.com/content/353/bmj.i2139
[25] Urban Institute, Justice Policy Center. (2009). Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration.
[26] Bainbridge, A. (2012). BJA White Paper -The Affordable Care Act and Criminal Justice: Intersections and Implications.
[27] Merrall et al. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction*, Volume 105, Issue 9 September 2010, Pages 1545–1554. Available online at: http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2010.02990.x/full

Administration of naloxone can reverse respiratory failure and the fatal effects of opioid overdose. Overdose prevention programs teach people how to recognize and respond to an overdose, including rescue breathing and other lifesaving skills. Several state and local correctional systems offer overdose prevention. Some have started to equip at-risk re-entering individuals and/or their families with naloxone kits. A survey of people who inject drugs in San Francisco revealed that 87% would actively participate in an overdose prevention program if given the opportunity.[28] Integrating overdose prevention education into RSAT programming and release planning is not particularly difficult. It can become a standard part of any prison or jail health program.

Overdose prevention measures extend beyond reviving people who are already experiencing respiratory depression and turning blue. There are definite steps that can reduce the risk of overdose fatality in the event of a return to drug use. Harm reduction and safer use programs specifically directed at prison populations and other high-risk groups have been operating in many other countries for years and have produced significant positive results. Given the current opioid crisis and the dangerous re-entry environments in affected regions, finding a way to get this information to RSAT participants without implying that it is okay to relapse is both possible and worthwhile.

The next section of this manual has information and resources on ways to assess health literacy levels, clinical risk factors that contribute to post-release fatality,[29] and tools for incorporating overdose prevention and risk reduction information into RSAT programs. It includes both health and health insurance information tools that can help RSAT programs integrate health and wellness into recovery self-management.

[28] ACLU Foundation, Drug Policy Alliance, and Daliah Heller (2013). Healthcare Not Handcuffs: Putting the Affordable Care Act to Work
for Criminal Justice and Drug Policy Reform.

[29] Binswanger et al. (2016). Clinical risk factors for death after release from prison in Washington State: a nested case-control study. *Addiction.* 2016 Mar;111(3):499-510. Available online at: https://www.ncbi.nlm.nih.gov/pubmed/26476210

Module I Review

- New research suggests that certain health factors can affect recidivism. Justice populations tend to have complex health care needs but limited access to services they require, both before and after periods in custody. Access to post-release medical and behavioral health care can multiply the chances of re-entry success.
- Racial, ethnic, and economic disparities affect the health of people in prisons and jails, as well as the communities they come from and return to. Low reading comprehension and mental health problems also present challenges. Efforts to assess health literacy levels and resources that introduce "plain language" health information can have an impact on outcomes and are worthwhile additions to RSAT programming.
- Health literacy is defined as *the degree to which individuals can obtain, process, and understand basic health information needed to make appropriate health decisions and access health care services.* Health insurance literacy is an important element of health literacy for individuals who are newly covered so they can learn how to use their benefits.
- Justice-involved individuals with SUDs face specific health risks when they enter custody, while they are incarcerated, and upon their release. They require information at each of these points but especially during transitions from custody to the community. The elevated health hazards of the immediate post-release period can be reduced through preventive measures.
- Overdose prevention and harm reduction have become a critical need for RSAT participants, especially for those re-entering communities gravely affected by the opioid epidemic. The risk of drug overdose during the immediate post-release period is extremely high. Some states and local jurisdictions are addressing this issue. All RSAT programs have an opportunity make a difference.
- Research suggests that incorporating health literacy and wellness into RSAT program activities and linking re-entering individuals with the appropriate post-release coverage and care can have a positive effect on re-entry success, lower care costs, and improve post-release mortality and morbidity.

Module I Resources

Improving Health Literacy with Inmates
By D. Young and C. Weinert in *Corrections Today,* November/December 2013. This brief article discusses specific health literacy issues for correctional populations and describes a pilot prison health literacy program.

National Institutes of Health (NIH) Office of Communications and Public Liaison, Clear Communication
Information on NIH communication initiatives, including a resource library of health literacy research and NIH educational products.

Agency for Healthcare Research and Quality—Literacy and Health Outcomes
A summary of results of a systematic review outlining the relationship between health literacy and health outcomes, as well as interventions to mitigate the effects of low health literacy.

U.S. National Library of Medicine—MedlinePlus: Health Literacy
Links to easily understood consumer resources, multimedia, and research information.

Centers for Disease Control and Prevention (CDC)—Health Literacy
Provides information and tools to improve health literacy and public health for organizations that interact and communicate with people about health issues.

Journal of the American Medical Association (JAMA)—Patient Page: Health Literacy
Tips for patients on self-advocacy at doctor visits and identifying reliable health information online.

CDC List of Health Literacy Activities by State (19 states)

Module II—Health Literacy Tools for RSAT Programs

A. Assessing Health Literacy

B. Essential Health Information for RSAT Participants

C. Overdose Prevention

Review

Resources

Learning Objectives

After completing this module, participants will be able to

- administer a simple screening tool to identify individuals with low health literacy levels,
- list at least three categories of health information essentials for RSAT participants,
- select at least one piece of overdose prevention material to disseminate in RSAT programs, and
- locate information on emergency overdose services in local communities of re-entry.

Module II—Health Literacy Tools for RSAT Programs

A. Assessing Health Literacy

Expanded Definitions of Health Literacy

The previous section included a standard definition of health literacy from the Institute of Medicine, but this is not the only definition in use. The field of health literacy is evolving, and there is a steady stream of new information and perspectives. Some of the newer definitions of health literacy are based on skills and competencies that enable people to find and understand reliable health information and to communicate clearly during patient/provider exchanges. For RSAT participants in prison and jail-based programs preparing to re-enter the community, some of the necessary competencies include the following:

- **Reading and comprehension**—Can patients read at a level sufficient to understand most health information, and does their vocabulary include basic health terminology? For example, can they read a hospital discharge summary, home care instructions, and prescription labels? Can they understand test results?
- **Basic computer skills**—Can they search for information, fill out online forms, and obtain a user name and a password to access information online. Can they formulate questions for health care providers, send them electronically, and receive the answers?
- **Navigation**—Do they know how to find services; search for primary care providers; determine who accepts their health insurance; and locate a specialist, dental care, mental health services, and/or alcohol and drug services?
- **Communication**—Can they make appointments and communicate with intake staff, effectively describe symptoms and concerns to nurses and doctors, and give a relevant history regarding their condition. Can they understand information a doctor gives them during an exam, express concerns, and ask questions?
- **Decision making**—Can patients use health information to make health decisions and/or modify risk behaviors? For example, when RSAT participants learn how hepatitis C is transmitted, can they act on this information and avoid getting tattoos, sharing drug use equipment, and participating in other high-risk behaviors? Do they understand consent forms?
- **Health insurance literacy**—Can they read and fill out enrollment forms, determine what services their plan covers, and understand co-payments and other terms that pertain to reimbursement and coverage? Can they contact a help desk or a managed care provider to get the information they need? Do they understand which types of services are costly?

There is good news and bad news regarding these categories of heath literacy skills. The good news: there are simple strategies that can help people gain minimum levels of competency in many of these areas. The bad news: research shows that even highly literate and educated people do not have all these skills. Only an estimated 12% of

Americans have adequate health literacy levels.[30] However, research also shows that acquiring these basic competencies can help compensate for a host of other factors associated with health disparities and poor health outcomes, which makes it imperative that RSAT programs include health literacy.

The first challenge facing RSAT programs is the fact that, although roughly one-quarter of the U.S. population is functionally illiterate, the rate is even higher among individuals in custody—half the incarcerated population at a minimum. A 12th grade reading level is required to understand most health information. This is challenging for the average American who reads at an 8th grade level. Almost 75% of the prison population reads at a 6th grade level or below. Further, the incarcerated population has a disproportionally high incidence of conditions that can affect concentration, such as attention deficit disorder (ADD), learning disabilities, posttraumatic stress disorder (PTSD), and other mental disorders and fetal alcohol effects.[31]

By now, you must be asking yourself the logical question: ***Wouldn't it be simpler to just make health information easier to understand?*** The answer is YES!

Most of the material on health literacy is actually directed at health care providers, not consumers. Although these efforts to ensure providers increase the clarity and understandability of health communications, RSAT programs can take steps to improve the situation for their graduates. Information in the next two sections is aimed at helping RSAT staff and participants locate clear and relevant health information, teaching people how to ask and who to ask for clarification and help with health information, and identifying those who face particular challenges.

Stem	Key or Distracter		Don't know
1. kidney	urine	fever	don't know
2. occupation	work	education	don't know
3. medication	instrument	treatment	don't know
4. nutrition	healthy	soda	don't know
5. miscarriage	loss	marriage	don't know
6. infection	plant	virus	don't know
7. alcoholism	addiction	recreation	don't know
8. pregnancy	birth	childhood	don't know
9. seizure	dizzy	calm	don't know
10. dose	sleep	amount	don't know
11. hormones	growth	harmony	don't know
12. abnormal	different	similar	don't know
13. directed	instruction	decision	don't know
14. nerves	bored	anxiety	don't know
15. constipation	blocked	loose	don't know
16. diagnosis	evaluation	recovery	don't know
17.hemorrhoids	veins	heart	don't know
18. syphilis	contraception	condom	don't know

[30] White, S. (2008). Assessing the nation's health literacy: Key concepts and findings from the National Assessment of Adult Literacy (NAAL). Available online at: www.ama-assn.org/ama1/pub/upload/mm/367/hl_report_2008.pdf

[31] National Center on Adult Literacy (1993). Prison Literacy: Implications for Program and Assessment Policy. Newman, A.P., Lewis, W. & Beverstock, C. Technical Report 1R93-1

Screening for Health Literacy

Even if RSAT participants obtain coverage prior to release and intend to seek community-based continuing care and recovery supports, very low levels of health literacy can cause frustration and embarrassment, sabotaging even the best of release plans developed at RSAT program completion. Health literacy screening serves the same purpose as many other screenings RSAT participants undergo. It flags the proportion of the population that has literacy levels that can present an obstacle to accessing care and identifies candidates for interventions to address their needs or for further assessment.

The Short Assessment of Health Literacy (SAHL) is an 18-item brief screening tool available in English and Spanish that RSAT programs can use to identify individuals with low health literacy levels. The SAHL is in the public domain and available online. The shorter 18-item tool has been validated, but it is also available in a longer 50-item version. It consists of a simple orally administered word recognition test that asks subjects to recognize, understand, and pronounce each item. The questions consist of a health-related term with two words next to it. One of them pertains to the term and the other does not. Subjects are asked to read the term out loud and then choose the word that goes with it. It is recommended that each three-word set be copied on to index cards to show one at a time to subjects, like flash cards. Scores of 15 or more indicate sufficient health literacy levels, but scores between 0 and 14 indicate low levels. A link to the screening tool and user manual is listed at the end of this section and a copy is included in the appendix.

Another screening tool RSAT programs can use instead of, or along with, the SAHL is a four-item multiple choice questionnaire: the Brief Health Literacy Screening Tool (BHLS). It asks the following questions about difficulties understanding health information and asks subjects to choose the best response from a five-point Likert scale:

1. *How often do you have someone help you read hospital materials?*
2. *How often do you have problems learning about your medical condition because of difficulty understanding written information?*
3. *How often do you have a problem understanding what is told to you about your medical condition?*
4. *How confident are you filling out medical forms by yourself?*

A link to a printable PDF version of the BHLS tool is included below, along with a link to a more comprehensive 16-question version of the instrument. These tools can help RSAT staff identify individuals who are likely to need help gaining minimum levels of knowledge and skill required to access care and benefit from health services.

Health Literacy Assessments

There are a wide variety of health literacy assessment tools, ranging from specialized tools that target knowledge levels about specific conditions such as diabetes, HIV, or arthritis, to more general assessments of skills, competencies, and knowledge. One widely used assessment is the Test of Functional Health Literacy in Adults (TOFHLA), which takes about 22 minutes to administer and has been translated into multiple

languages.[32] Another assessment recently developed by Pfizer is the Newest Vital Sign (NVS). It is a valid and reliable tool, in the public domain and available in English and Spanish, which can be administered by a nurse or other health care practitioner. The patient is shown a nutritional label from a pint of ice cream and then asked a series of questions based on the label information. The NVS Toolkit also includes other user-friendly tips and patient handouts aimed at improving patient/provider communications (see appendix).

The TOFHLA, the NVS, and many other health literacy assessment tools are available through the National Library of Medicine (NLM) from the online Health Literacy Tool Shed. RSAT program staff can review a variety of assessments by visiting the online database. **Note:** Some assessments listed are proprietary and can only be used with the author's permission.

Screening and assessment tools and information:

- The Health Literacy Tool Shed is an online database of health literacy measures from the National Library of Medicine.
- Health literacy measurement webpage of the Agency for Healthcare Research and Quality:
    - Short Assessment of Health Literacy (SAHL) forms, user manuals for all versions
    - Brief Health Literacy Screening Tool questionnaires and information
- All versions of and information on the Test of Functional Health Literacy in Adults (TOFHLA) forms are available from the Society for Academic Primary Care.
- The Newest Vital Sign Toolkit assessment is available to download from the Pfizer Healthy Living website.

B. Essential Health Information for RSAT Participants

This section outlines specific types of health information that can benefit RSAT clients, discusses strategies for disseminating this information, and offers resources and useful tools. The tables below suggest topics that are important to cover as individuals move through the phases of custody, and they list corresponding resources. Some of these are likely addressed by other elements of rehabilitation programming, but RSAT staff can choose important topics not otherwise addressed and incorporate some of the corresponding resources.

Health Information: Intake and Program Entry

The following chart covers key topics and provides patient education materials and other resources, beginning with wellness tools useful to individuals with drug and alcohol problems when they are taken into custody or begin treatment.

[32] DeWalt, D.A., Berkman, N.D., Sheridan, S., Lohr, K.N., & Pignone, M.P. (2004). Literacy and health outcomes. *Journal of General Internal Medicine, 19,* 1228-1239.

When	What	Educational Materials and Tools
Entry/ intake	**Detoxification/withdrawal**—Substances with high-risk withdrawal syndromes, symptom relief, and self-care. Information for those experiencing post-acute withdrawal symptoms.	• CDC Infographic on Alcohol & Health • CDC Infographic on Alcohol Poisoning • NIDA Drug Facts (see summary handout in appendix)
Entry/ intake	**Accessing institutional health services—** Menu/schedule of medical and mental health services; how to request care, charges/waiving charges, when outside services are required, etc.	• Your Institution's orientation materials • ACLU National Prison Project: Know Your Medical, Mental Health, & Dental Rights
Entry/ intake	**Testing and test results**—Tests routinely administered; the meaning of positive or negative results, when to get tested, other tests and the meaning of results, etc.	• Rapid HIV & Hep C Testing: Know the Facts Video • Sexually Transmitted Diseases • HIV Simple Information Sheet • HIV and Substance Use
Entry/ intake	**Support for dealing with diagnoses/treatment options—**Counseling for HIV and positive test results or hepatitis C diagnosis; treatment options	• After You've Tested Positive—HIV Wellness • Pro-Patient Online Hepatitis C Patient Resource • Hepatitis C Counseling Manual
Entry/ intake	**Institutional health hazards- prevention/risk reduction**—Handwashing, communicable disease risks, such as sharing personal items, syringes, tattooing, Methicillin-resistant Staphylococcus aureus (MRSA), etc.	• Handwashing • Preventing the Spread of HIV • Hepatitis C Brochure for MH and SUDs • MRSA Info and Prevention
Entry/ intake	**PEP and PrEP—**Availability of Post-Exposure Prophylaxis for HIV exposures and information about Pre-Exposure Prophylaxis (PrEP) and availability in the community	• PrEP and PEP Pocket Cards • PrEP and PEP Posters
Entry/ intake	**Depression, mental health, and suicide—** Information on depression and suicide prevention tools	• WHO Prevention Suicide in Prisons and Jails • BOP Clinical Guidelines: Management of Major Depressive Disorder

About the resources: The health information resources listed in the table above mostly comprise handouts and videos for RSAT participants. They are not a substitute for clinical care and are intended for informational purposes only. RSAT programs may wish to work with health services to vet these tools and gain consensus on what may be appropriate to disseminate in RSAT programs. Some handouts can be edited and made more accessible for the intended consumers. Videos are simple and may be easier for RSAT participants to understand than written materials.

Detox and withdrawal information—Comprehensive handouts on withdrawal syndromes that present serious health risks are scarce. However, National Institute on Drug Abuse (NIDA) drug information charts include an overview of withdrawal symptoms. A summary fact sheet adapted from this information is included in the appendix. It also touches on post-acute withdrawal symptoms. The Centers for Disease

Control (CDC) infographics on alcohol, health, and alcohol poisoning offer a concise visual representation of drinking-related health risks.

Accessing institutional health services—Most correctional facilities have orientation materials and handbooks that explain the procedures for accessing health services, any costs, and the conditions for waiving fees. The American Civil Liberties Union (ACLU) brief on health care rights in custody provides guidance on the legal requirements for health care services in prisons and jails.

Testing and test results—Two excellent videos from the Center for Prisoner Health and Human Rights explain rapid testing for HIV and hepatitis C and the meaning of the results. The three patient fact sheets, *HIV Simple Information Sheet*, *HIV and Substance Use*, and *Sexually Transmitted Diseases*, come from HealthReach, the National Institutes of Health (NIH) plain language health information resource. It offers simple handouts on many topics and conditions in several languages. Copies are included in the appendix of this manual.

Support for dealing with diagnoses/treatment options—Project Inform's HIV wellness pamphlet, *After You've Tested Positive,* is for individuals newly diagnosed with HIV infection. Their *Pro-Patient* interactive online consumer resource on hepatitis C explains the risk factors, diagnosis, prevention, and treatment. Text summaries of the information can be printed for distribution. The Harm Reduction Coalition's Hepatitis C Counseling Best Practice Manual organizes critical information for people newly diagnosed.

Institutional health hazard prevention/risk reduction—Handouts on handwashing, preventing the spread of HIV, and Methicillin-resistant Staphylococcus aureus (MRSA) also come from the NIH HealthReach website and from the Health Information Translations site, a project of academic and health care partners that offers materials in many languages. Copies are provided in the appendix. The Substance Abuse and Mental Health Services Administration (SAMHSA) publication *Take Action against Hepatitis C: For People in Recovery from Mental Illness or Addiction* is in a "comic book" brochure format that can be downloaded and printed.

Pre-and post-exposure prophylaxis—Pocket cards and posters from Project Inform can be downloaded in Spanish and English, or quantities can be ordered free of charge.

Depression and suicide—Resources in this section may be helpful for RSAT staff. *World Health Organization—Preventing Suicide in Prisons & Jails* has a wealth of information from correctional systems worldwide. There is also a link to *BOP Clinical Guidelines: Management of Major Depressive Disorder.*

Health Information: During Treatment in RSAT Programs

The next chart suggests topics and corresponding resources for information that can be covered during core treatment phases of RSAT programs and release planning. Materials can be used to inform participants and/or to initiate group discussions.

When	What	Educational Materials and Tools
Treatment	**Women's health topics—**Women, SUDs and pregnancy; alcohol and drug-related health risks for women; trauma, abuse, and domestic violence	• Alcohol-Free Pregnancy • Substance Use in Women and Men Infographic • Domestic Violence Fact Sheet • Recovering Woman's Guide to Coping with Childhood Abuse Issues
Treatment	**Psychiatric medication, medication interactions, and MAT—**Information on medications for mental health conditions, medication-assisted treatment, multiple drug interaction checkers, and medication safety	• FDA OTC and Prescription Meds Safety • NIMH Psych Medication Information • Harmful Interactions: Mixing Alcohol with Medicines • Medscape Drug Interaction Checker • Shared Decision Making for MAT
Treatment	**Common mental health conditions—** Easy-to-understand information and tips on mental health conditions common among recovering individuals	• Mental Health Brochures and Fact Sheets • ADHD Fact Sheet for Patients • Adult ADHD Brochure • PTSD and Addiction
Treatment	**Recovery self-management and wellness**—Mental health wellness and recovery management, nutritional information, information on prescription drug use in recovery and smoking cessation	• Wellness Recovery Action Plan • Nutrient Deficiency Risk Questionnaire • Taking Medicines Safely after Alcohol or Drug Abuse Recovery • Smoking Cessation in Recovering Alcoholics
Treatment	**Culturally responsive health information—**Resources for Native American/Alaska Native populations, Latinos/Hispanics, and African Americans on behavioral health topics; substance use among LGBT communities\	• Black and African American Communities and Mental Health • Native American Behavioral Health Topics • Hispanic/Latino Communities and Mental Health • Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals • One Sky Center

About the resources: Many of these resources consist of handouts for RSAT participants. Copies of the shorter fact sheets and handouts are included in the appendix for easy duplication. All items in the appendix are in the public domain and can be duplicated freely for non-commercial use. RSAT program staff know the topics that are most relevant to the populations they serve. This chart of suggested topics and the corresponding resources does not represent all health-related issues programs may wish to highlight, nor are they all required in every program.

Women's health topics—The *Alcohol-Free Pregnancy* downloadable brochure is from the CDC. It has information regarding alcohol use during pregnancy. The *Substance Use in Women and Men* infographic is from NIDA, and the *Domestic Violence Fact Sheet* is from the American Academy of Family Physicians. Copies of all handouts in this section are included in the appendix, except the SAMHSA booklet, *Helping Yourself Heal: A Recovering Woman's Guide to Coping with Childhood Abuse Issues*, which is available online.

Psychiatric medication, medication interactions, and MAT—The U.S. Food and Drug Administration (FDA) brochure *Medication in My Home* explains how to read medication labels, as well as safe storage and use; the National Institute of Mental Health (NIMH) has online information on most psychiatric meds; the National Institute on Alcohol Abuse and Alcoholism brochure, *Harmful Interactions: Mixing Alcohol with Medicines* can be downloaded in English and Spanish. Medscape's Multiple Drug Interaction Checker is an online tool for identifying interactions between several medications, and SAMHSA's *Decisions in Recovery: Treatment for Opioid Use Disorders* has comprehensive plain language information on MAT that can be downloaded as a printable PDF or accessed as an online interactive tool.

Common mental health conditions—The NIMH webpage on mental health conditions has fact sheets and brochures on most psychiatric disorders; a brochure for adults with ADHD and a fact sheet on ADD is from the CDC. The DualDiagnosis.org webpage, *Post Traumatic Stress Disorder and Addiction*, has information and resources on PTSD and integrated treatment approaches.

Recovery self-management and wellness—The Wellness Recovery Action Plan (WRAP) website has information about WRAP workshops and books for mental health recovery self-management and wellness planning. The *Nutrient Deficiency Risk Questionnaire* checks that daily diets are balanced; *Smoking Cessation in Recovering Alcoholics* and *Taking Medications Safely after Alcohol or Drug Abuse Recovery* are both from the American Academy of Family Physicians. Copies of these easy-to-understand tools are included in the appendix.

Culturally responsive health information—Links to Mental Health America's webpages on issues for African American and Hispanic/Latino communities offer culturally specific information. There is a link to the SAMHSA publication, *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* The One Sky Center is the Native American/Alaska Native national resource center for health education and research, and Native American behavioral health topics are listed on the National Library of Medicine's American Indian Health portal.

RSAT programs can select the handouts, tools, and topics they deem important and useful to their client population. They may wish to provide easily understood printed information on a variety of topics to all RSAT clients or only upon request to participants with specific needs, and these programs may wish to introduce some of the relevant materials in group sessions. These charts offer a wide variety of topics and choices for integrating wellness and health education into programming.

C. Overdose Prevention

Unfortunately, overdose prevention education is not just a topic that is a relevant to release planning, since drug use is a reality in most correctional facilities. In general, controlling drug supplies is like a game of Whack-a-Mole. As soon as we reel in the supply of one illicit drug, another one pops up to take its place. This may be especially true in custody settings. Even the most vigorous and expensive efforts to prevent drugs from entering prison environments have shown only a limited effect. Continued drug use

in prison is usually associated with high-risk behaviors, including HIV and hepatitis transmission due to sharing injection equipment. It is also increasingly associated with overdose and death.

Current issues with contraband buprenorphine have also frustrated correctional treatment professionals, administrators, and security staff. Although these issues are daunting, buprenorphine overdose fatalities are extremely uncommon. At the same time, opioid overdoses in custody have been reported in many jurisdictions. Drug overdoses are among the leading causes of death in California state prisons, according to a 2016 report by a federal court-appointed receiver who oversees the system because of a long-running lawsuit over inmate health care.[33] It may well be that buprenorphine use in prisons is fueling the demand for more dangerous opioid drugs that have a greater overdose potential.

However, the risks in custody pale in comparison to post-release overdose risks and the fatalities that result. The proliferation of non-pharmaceutical fentanyl has created incredibly dangerous post-release environments for re-entering individuals with OUDs. Those with a period of abstinence under their belt are at a heightened risk. Even those with the best intentions of staying clean are afforded no margin of error and can pay for a single mistake with their life.

The following overdose prevention and harm and risk reduction strategies are critical to release planning but may also be an appropriate component of in-custody treatment programming. Naloxone administration is now a standard part of correctional health care and risk mitigation, and although it is an essential tool, use of naloxone alone is not sufficient. This section explores some of components of a comprehensive overdose prevention strategy and offers relevant resources:

- Harm and risk reduction education
- Safer drug use information
- Public health community alliances
- MAT and opioid replacement therapy
- Post-release SUD treatment continuity of care, coverage, and access
- Naloxone provision and administration training
- Overdose prevention release planning and linkages
- Syringe exchanges
- Overdose risk assessments
- Family outreach and involvement
- Drug testing and monitoring
- Trauma-informed approaches and integrated trauma and SUD treatments

[33] Analysis of 2014 Inmate Death Reviews in the California Correctional Healthcare System," by Kent Imai, M.D. (July 30, 2015); www.cphcs.ca.gov; www.theguardian.com

Harm and Risk Reduction and Safer Use Education

Harm reduction programming in the U.S. evolved out of early efforts to contain the spread of HIV when the only response was to prevent new infections, since treatment was not yet available. In other parts of the world, harm reduction efforts continued to evolve and encompass other high-risk substance use behaviors. Syringe exchange programs were introduced in the Swiss prison system in 1992, with Germany following suit in 1996 and Spain in 1997. These countries have reduced HIV and hepatitis transmission and increased referrals to treatment in their prison systems.[34]

MAT with opioid agonist medications (methadone and buprenorphine) reduces overdose risk by almost 90%.[35] Reductions in both post-release overdose fatalities and recidivism are achieved by programs that initiate opioid replacement therapy in custody or prior to release. A few of these types of programs have started to appear in U.S. correctional facilities, but they are more common in prison systems in other countries. Research from the Swiss correctional system estimates MAT participation results in a fourteen-fold risk reduction of post-release overdose death rates.[36]

RSAT staff are hardly able to set up needle exchanges or methadone programs in their facilities. However, they can include videos and handouts on reducing post-release overdose risks, including safer use guidelines. The following 10 safety measures can be delivered in the context of relapse prevention as a failsafe rather than a license to use:

1. Never use alone.
2. Never use behind a locked door—seconds count.
3. Never mix substances (including alcohol).
4. Know your source—use carefully when you don't (a test shot or dose).
5. Be mindful of your tolerance—start low and go slow after periods of abstinence.
6. Locate overdose prevention emergency services near you.
7. Never share equipment, pipes, tie-offs, or water.
8. Have naloxone on hand.
9. MAT can help you stay alive and free.
10. If you use a syringe that has been used, rinse it twice with bleach then water.

Harm reduction and safety education resources:

- *Eight Opioid Overdose Prevention Tips*—10-minute video from the Southeast Harm Reduction Project
- *The DOPE Project: Be a Lifesaver*—pamphlet from Drug Overdose Prevention and Education Project

[34] Harm Reduction Coalition (2007). Syringe Exchange Programs in Prisons: The International Experience; World Health Organization. (2004) Reduction of HIV transmission in prisons. In: Evidence for Action Policy Brief. Geneva: WHO, UNAIDS, UNODC.
[35] World Health Organization (2010). *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence.*
[36] Thierry Favrod-Coune et al., *Opioid Substitution Treatment in Pretrial Prison Detention: A Case Study from Geneva, Switzerland*, 143 Swiss Med. Wkly, 1, 1
(2013).

- Syringe Sterilization Harm Reduction Procedures—NIDA, 2000 (see appendix for handout)

Overdose Risk Assessment

There are several factors associated with the risk of opioid overdose, although the development of formal overdose risk assessment is in its infancy. Some of the known risk factors include the following:

- injecting heroin;
- a history of previous non-fatal overdose;
- a longer history of injection drug use;
- high levels of drug use or intoxication;
- high levels of alcohol use;
- a low tolerance due to a period of incarceration or period of recovery;
- a history of using combinations of drugs, including benzodiazepines or alcohol;
- depression, feelings of hopelessness, or suicidal thoughts;
- higher-risk injection behaviors, such as sharing or using used equipment; and
- HIV positive or other chronic health problems.

Recently, an overdose risk assessment was developed and tested using U.S. Veterans Health Administration data.[37] *The Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression* (RIOSORD) identifies high-risk patients who are most likely to benefit from risk reduction education, monitoring, and provision of rescue naloxone to family members or caregivers in the event of an emergency. In a retrospective study of fatal and non-fatal heroin overdoses, the biggest single factor that differentiated the fatalities from non-fatal overdoses was the use of opioids in combination with sedatives or alcohol.[38] This index includes items that pertain to health conditions that can elevate overdose risk, and it is geared toward prescription opioid users. Overdose risk assessment may soon become a standard weapon in the battle to reduce opioid fatalities. Until that time, the resources below can help RSAT staff better identify individuals approaching release that need a strong overdose risk mitigation plan, beginning with alerting the individuals themselves that they are at a high risk of overdosing after release.

Overdose risk reduction/assessment resources:

- *Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression* (RIOSORD)
- *Preventing Overdose, Third Edition*—briefing paper on the causes, risk factors, responses, and key elements of prevention

[37] Zedler B et al. LB010. "Validation of a Screening Risk Index for Overdose or Serious Prescription Opioid-Induced Respiratory Depression." Presented at: AAPM 2015. March 19-22, 2015; National Harbor, Maryland.
[38] Dietzea, P. et al. (2006). When is a Little Knowledge Dangerous? Circumstances of recent heroin overdose and links to knowledge of overdose risk factors. Alcohol and Drug Dependence, Vol. 84 No 3, pp 223-230.

- *Preventing Overdose: Risk Factors*—a 5-minute video from the Cambridge Harm Reduction Program

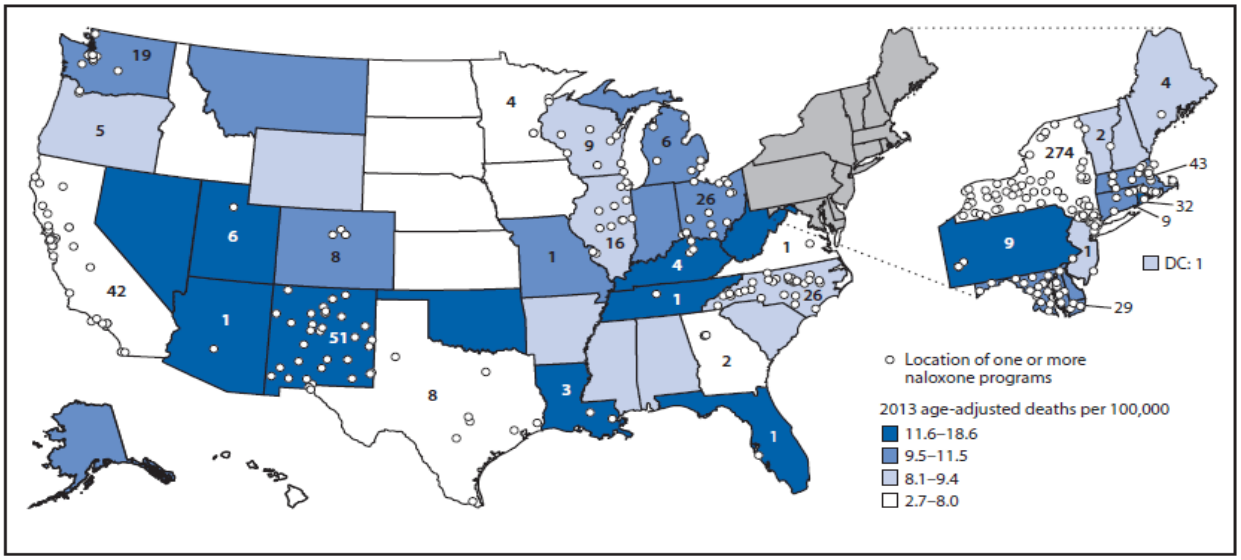
Naloxone Provision, Overdose Prevention Education, and Administration Training

Naloxone intermuscular injection kits, nasal administration kits, and auto-injectable naloxone EpiPens are used to reverse the symptoms of opioid overdose. They are increasingly available, especially in the regions hardest hit by the opioid epidemic. Many state and county correctional departments have implemented naloxone distribution and/or training initiatives. Some, like Rhode Island, have brought in a community agency to educate incarcerated populations about naloxone and preventing overdoses. Vermont and other states are now equipping parole officers with naloxone kits. Although it is beyond the scope of this manual, RSAT programs interested in establishing comprehensive programs in their facilities have models they can use that were developed by many prisons and jails across the country, including six New York state prisons; the San Francisco County Jail; several Colorado jails; and facilities in Washington, Maryland, Ohio, and Connecticut.[39]

Public health departments, pharmacies, health care facilities, substance use treatment facilities, and community-based organizations that serve persons who use drugs, including current or former opioid users, and other potential witnesses to overdoses are providing naloxone kits to laypersons and reporting many overdose reversals by bystanders.[40]

In advance of implementing its National Drug Strategy, Scotland began piloting naloxone take-home prison programs. Today, efforts have evolved into a national policy with a peer trainer workforce, making Scotland a model for harm reduction best practices with prison populations. The latest data show that, in a few short years, Scotland cut post-release overdose fatalities in half.[41]

[39] San Diego Union Tribune, March 22, 2016. Heroin overdose antidote offers hope for vulnerable inmates by Sadie Gurman.
[40] CDC (2015) MMWR Weekly. Opioid Overdose Prevention Programs Providing Naloxone to Laypersons — United States, 2014. June 19, 2015 / 64(23);631-635.
[41] Info. Servs. Div., Nat'l Servs. Scot., National Naloxone Programme Scotland – Naloxone Kits Issues in 2013/2014 and Trend in Opioid-Related Deaths 13 (2014), *available at* https://isdscotland.scot.nhs.uk/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2014-10-28/2014-10-28-Naloxone-Summary.pdf?12183779479.



Number and location of programs dispensing naloxone kits to laypersons and age-adjusted 2013 overdose rates

One take-home message from the videos from Scotland and from the Rhode Island prison program is the importance of a peer-driven element. RSAT programs wishing to explore similar activities can start by building alliances with community naloxone distribution organizations and public health stakeholders.

Naloxone provision and administration training resources:

- *Overdose: Everything You Need to Know*—overdose prevention booklet from ExchangeSupplies.org, UK; available online at no charge; a simple guide for recognizing the signs of an overdose, calling for emergency services, and keeping someone alive until the ambulance arrives
- Tip sheets from the New Mexico Department of Health:
  - *Overdose Prevention and Rescue Breathing in 20 Minutes or Less*
  - *Narcan Nasal Administration and Rescue Breathing Instructions*
- *Reducing Opiate Overdose Deaths*—a 3-minute video from the Scottish government highlighting the peer-driven aspect of their naloxone distribution program
- *Staying Alive on the Outside*—a 7-minute video from the Center for Prisoner Health and Human Rights featuring re-entering individuals talking about post-release overdose fatality risks and relapse experiences; highlights training footage with supporters and family members learning to administer naltrexone; justice professionals who train parolees to administer naloxone discuss harm reduction programs and policies

Public Health and Community Alliances, Release Planning, Linkages, and Continuity

RSAT programs tend to work hard to arrange continuing care and to link graduates to community treatment programs, primary care providers, and other services. Many individuals who use drugs do not trust institutions and avoid providers they perceive as

strangers. Experience shows that a warm hand-off or pre-release in-reach contact with staff from community agencies makes a difference. This is important to RSAT participants because of the intersecting layers of stigma they experience. Many have had interactions with health service providers that were not particularly welcoming. Their reluctance is often rooted in experiences that have amplified their distrust.

In the case of post-release linkages with local harm reduction and overdose prevention resources, it is important to dismantle any barriers of this nature. Fortunately, this is usually not too difficult since harm reduction agencies tend to specialize in outreach to disenfranchised populations. They are usually staffed by people who abstain from judgement, often have a strong peer-led orientation, and are closely allied with recovery community organizations in many areas. RSAT staff can support re-entering clients by locating local community overdose prevention organizations, arranging in-reach activities, distributing their literature or contact cards, and including overdose prevention planning as part of release preparation. Even if RSAT programs integrate overdose prevention education into treatment activities, the issue warrants revisiting during pre-release planning.

One of the links in the following Module II Resources section is for a state-by-state directory of harm reduction agencies and resources. With the rapid expansion of overdose prevention, this list may not include all local efforts. There is also a link to the North American Directory of Syringe Exchange Programs. Other places that may have information about local efforts regarding communities of release include health departments, fire departments, the single state agency for alcohol and drug services, and local police departments. RSAT participants should have the local numbers of these agencies before their release.

Finally, the fear of arrest can deter people from calling for help when there is an overdose emergency. The Law and Policy Atlas link in the Module II Resources section identifies good Samaritan laws by state and details the protections the laws afford. As of December 2016, a total of 37 states had laws that grant some level of immunity to people who call for emergency naloxone administration in the event of an opioid overdose. However, each law is different. A few of them offer protections from probation and parole violations, whereas others protect from possession charges but not from charges related to paraphernalia. It is best to find out the exact provisions of the statute that applies in communities of release. The Law and Policy Atlas also lists state laws pertaining to naloxone prescription requirements and administration by laypeople.

Module II Review

- Health literacy levels among the general population are inadequate for most Americans. Complicating factors for custody populations with SUDs include lower levels of reading comprehension and higher rates of learning disabilities and certain mental health conditions that can affect concentration.
- RSAT participants need to develop a variety of skills and competencies to benefit from health coverage and to navigate the health care system upon re-entry. They include basic computer skills, an understanding of the health care system, health insurance literacy, and communication skills.
- Screening for health literacy helps identify RSAT participants who are likely to need help understanding health information and obtaining services upon re-entry. Several simple screening tools are available. Health information resources are also available that offer clear, understandable materials relevant to RSAT participants entering treatment, during program completion, and prior to release.
- Naloxone administration is an emergency measure that can reverse an opioid overdose and save lives, but it is only one component of a comprehensive overdose prevention strategy. The custody population is at very a high risk of post-release overdose fatality, and overdose prevention plans should be a part of pre-release planning.
- The re-entry environment is dangerous in many parts of the county due to an influx of potent illicit opioids. Harm reduction and safer drug use information save lives and reduce the spread of HIV and hepatitis. Many harm reduction agencies, syringe exchange programs, and recovery community centers offer overdose prevention training and naloxone administration.
- Prison-based naloxone take-home programs have been implemented in a few jurisdictions across the U.S. Good Samaritan laws that protect people from arrest when they call for emergency naloxone to prevent an overdose and laws on naloxone distribution and administration differ from state to state. RSAT staff can look up the laws in communities where program graduates are planning to re-enter.

Module II Resources

Release planning resources:

- *List of Harm Reduction Service Providers by State*
- *Overdose Prevention Tips Worksheet* by the Harm Reduction Coalition
- *When Seconds Count Card* from the American Society of Anesthesiologists/ONDCP

On overdose symptoms and emergency prevention steps:

- *Opioid Overdose Prevention*—an outstanding 7-minute video from Prisonerhealth.org with clips of formerly incarcerated individuals in recovery discussing the increased risk of death by drug overdose during re-entry due to a loss of tolerance; touches on harm reduction, prevention, emergency response, and myth-busting
- *Worth Saving*—a 10-minute video that follows two drug users through San Francisco's groundbreaking Drug Overdose Prevention and Training (DOPE) program that teaches the signs of drug overdose and basic CPR needed to save lives; in conjunction with the city's Department of Public Health, the DOPE project prescribed Narcan directly to drug users

Other overdose prevention resources:

SAMHSA Opioid Overdose Prevention Toolkit—Updated 2016

Harm Reduction Coalition: Online Training Institute

SAMHSA—How to Use Methadone Safely

CDC Injury Prevention: Opioid Overdose Data

- Includes reports on drug overdose data
- New CDC guidelines on opioids for chronic pain
- Information on prescription drug monitoring programs
- Prevention, prescribing, and Narcan administration laws and measures by state

The Policy Surveillance Program at Temple University Law School: Law Atlas Project

- Search Good Samaritan Overdose Prevention Laws by state
- Search Naloxone Overdose Prevention Laws by state

Syringe exchange information:

Kentucky Harm Reduction and Syringe Exchange Program (HRSEP): Guidelines for Local Health Departments Implementing Needle Exchange Programs—Kentucky Public Health, 2015

North American Syringe Exchange Network (NASEN) Directory of Syringe Exchange Programs

Get Out of Jail Free Card—HarmReduction.org reminder about decreased tolerance

Module III—Continuing Care, Recovery, and Wellness Self-Management

A. Navigating Re-Entry Health Coverage Options

B. Accessing Affordable Care Options

C. Communicating with Providers and Safeguarding Recovery

Review

Resources

Learning Objectives

After completing this module, participants will be able to

- locate enrollment assistance for re-entering RSAT participants eligible for Medicaid,
- identify other benefit programs and low-cost health care options for re-entering RSAT participants, and
- name at least one tool RSAT participants can use to improve health communication.

Module III—Continuing Care, Recovery, and Wellness Self-Management

A. Navigating Re-Entry Health Coverage Options

Most re-entry planning efforts for RSAT clients include a strong continuing care component since we have known for a long time that SUD treatment in custody with follow-up community care is more effective that either alone. Care continuity also plays a critical role in preventing overdose and maintaining treatment gains, especially for those with CODs. When health coverage is available for continuing care, RSAT graduates are more likely to obtain the ongoing recovery support they require. In many states, enrollment efforts have been a release planning priority, and immediate coverage for recovery support services and medications upon release has helped individuals with SUDs succeed in the community.

Outreach and Enrollment Assistance

RSAT programs can help clients take advantage of resources dedicated to outreach and enrollment assistance to increase the health literacy/insurance literacy among newly enrolled individuals. Since 2013, federal and state funding has gone to community-based organizations to educate, inform, and assist hard-to-reach subgroups of uninsured and newly eligible individuals. Introducing the re-entry population to some insurance literacy basics before they are released can help individuals take advantage of the assistance these agencies offer.

The objectives of assistors include enrolling the uninsured and increasing the health literacy and health insurance literacy of newly covered individuals. Some assistor agencies have specified the custody population and re-entering individuals as a priority. All navigators/assistors (state or federally funded) are mandated to carry out certain duties that include conducting public education activities, explaining coverage options to consumers, and facilitating the selection of and enrollment in a qualified health plan. They are also charged with outreach to underserved or uninsured subgroups through culturally appropriate means.

Currently, 34 states have federally facilitated or state and federal/partnership health insurance marketplaces that support local agencies experienced with working with underserved subgroups to help with enrollment and assistance. A smaller number of states (13) have opted to develop their own state-run insurance exchanges, and a few states have hybrid models of state-run exchanges with federally supported components (4). They all have outreach, education, and enrollment assistance programs. Some state-based insurance exchanges have dedicated significant resources to making assistor services widely available. For example, California's state-based marketplace offers more than 500 "storefront" assistor locations with a workforce of more than 4,000. A search of Colorado's database of assistance sites yielded 366 results.

Below is an explanation of the different types of assistors:

- **Navigators**—Navigators receive extensive training from the Center for Medicare and Medicaid Services (CMS) and are responsible for providing unbiased

information about public and private health insurance programs in a culturally competent manner. They regularly report on their outreach and consumer education activities.

- **Non-navigator assistors** (in-person assistors)—They serve a similar function, providing in-person assistance and informing consumers about coverage options, but the funding for these assistors is more flexible. Many states opt to train the staff of existing community-based agencies to carry out in-person assistor duties.
- **Certified application counselors (CACs)**—CMS designates organizations to certify counselors who perform these functions. CACs complete pre-service training and receive ongoing in-service training. They comply with privacy and security standards but have fewer reporting requirements.
- **Brokers, agents, and contracted assistors**—Brokers usually act on behalf of the consumer and are compensated by insurers or consumers. Agents are compensated by insurers. Some states contract with brokers or agents to act as "navigators." They may be required to forgo compensation or abide by other guidelines that mitigate potential conflicts of interest.

A few correctional model programs have either trained staff as assistors or have trained assistors from other state or community agencies working with pre-release individuals to enroll them in health benefit programs. Some jurisdictions link re-entering individuals with assistors upon release, and there are advantages to doing so. Assistor organizations can offer more than just enrollment help to justice-involved populations. They often meet in-person with newly eligible individuals at local community agencies, such as drug treatment programs or transitional housing agencies.

In addition to enrollment help and public education activities, assistor organizations are charged with improving health plan utilization and retention. This can involve linking individuals to other benefit programs for which they may qualify, making referrals to appropriate services, follow-up contact with beneficiaries to see whether they are using their coverage to access services, helping them overcome any barriers they encounter, and facilitating re-enrollment so that coverage is maintained. All these assistor services can help newly covered justice-involved individuals obtain treatment for mental health conditions and SUDs, as well as other medical conditions.

Research has verified that most people who need enrollment assistance prefer in-person help. The re-entering population and other justice-involved individuals are like other new beneficiaries who prefer to turn to a person or organization in their community that specializes in helping underserved groups. RSAT graduates not yet enrolled in health plan upon release should have an appointment with an assistor or a contact at a local agency. They also need Help Desk numbers and contact information for state or county Medicaid offices and/or relevant MCOs.

Health Insurance Literacy—Educational Resources

Fortunately, there are plenty of plain language materials, short videos, and easily understood brochures available to RSAT programs and clients. Like the assistor workforce, both state and federal insurance exchanges are tasked with improving the health insurance literacy of those new to coverage. Health insurance marketplaces are

good resources for clear health insurance consumer information. There are differences in enrollment pathways, service delivery mechanisms, and benefit package(s) offered by various state Medicaid plans. The advantage of using locally produced educational materials is that they explain the processes for your state's Medicaid program. For example, many states have more than one managed care plan and offer information on all contracted managed care plans.

There are also some good health insurance literacy tools available from federal sources that introduce key concepts. RSAT programs can make use of some of the materials below. There are several short videos that explain important topics and terms, which may be easier to understand than written material.

About justice populations and health insurance:

- CDC Correctional Health webpage—information and materials on relevant health topics
- Health Coverage and Care for the Adult Criminal Justice-Involved Population—issue brief from the Kaiser Family Foundation
- State Medicaid Eligibility Policies for Individuals Moving into and Out of Incarceration—issue brief from the Kaiser Family Foundation

Basic health insurance videos for consumers:

- Health Insurance Explained: The YouToons Have It Covered—a series of short videos from the Kaiser Family Foundation in English and Spanish that answers basic questions such as "What is a provider network?" and "What is a deductible?"
- CDC YouTube Channel—offers many videos, including the *Coverage to Care* series—11 short videos on topics such as: finding a primary care provider and making an appointment
- *How Does Health Insurance Work?*—a 5-minute video from eHealth
- *Understanding Your Health Insurance Costs*—a 5-minute video from *Consumer Reports*

Handouts and pamphlets:

- *Understanding the Health Insurance Marketplace if You're Incarcerated*—a printable CMS brochure (in English or Spanish)
- *From Coverage to Care: Road map to Better Care and a Healthier You* – Printable brochure from CMS outlining the basics for newly covered beneficiaries
- Glossary of Terms from Healthcare.gov
- Tips to Get Started in the Health Insurance Marketplace—four Healthcare.gov tips about health insurance marketplaces

B. Accessing Affordable Care Options

Prior to the Affordable Care Act (ACA), substance use treatment services were funded through a combination of federal block grant funds, state/local funding, and Medicaid reimbursement. Medicaid does not cover SUD treatment services in every state, nor have all states expanded Medicaid eligibility. It is important to identify other health care options that may be available to re-entering individuals. This section has information on potential health care resources for those without coverage, low cost options for health care services, and cost-saving measures for prescribed medications.

Medicare

Re-entering individuals without any type of disability who are approaching age 65 may be eligible for Medicare Part A and/or Part B. Medicare Part A covers inpatient hospital care, and Medicare Part B covers most outpatient treatments. People approaching age 65 will have a seven-month initial enrollment period to sign up for these benefits. They should sign up to avoid gaps in coverage or late enrollment fees. They will not be automatically enrolled in Medicare. The initial enrollment period

- begins three months before the month they turn 65,
- includes the month they turn 65, and
- ends three months after the month they turn 65.

If people become eligible for Medicare while they are in jail or prison: It is best to enroll in Medicare Parts A and B while they are incarcerated, even if they remain in prison for a while. Although Medicare won't cover care costs while they are incarcerated, signing up when they become eligible ensures Medicare will pay for care immediately upon release. There is not usually a premium required for Part A, but to keep Part B coverage they need to continue paying Part B premiums ($134 per month in 2017) while in custody. It may be worth it to do this because coverage will be in effect on their day of release. Also, missing the initial enrollment period can result in a long waiting period after release until they can re-enroll and before coverage takes effect. It can mean fees or lifelong higher premiums.

To enroll in Part A and Part B while incarcerated, they should send a signed and dated letter to Social Security that includes their name, Social Security number, a clear statement that they want to enroll, and the date that coverage should be effective. They should keep a copy of the letter and a copy of the envelope or send the letter by certified mail with a return receipt.

If people were on Medicare before entering jail or prison: Medicare Part A will be suspended during incarceration but will resume upon release. Medicare Part B may be affected by incarceration. If premiums are paid during incarceration, benefits resume upon release. If they don't continue paying part B premiums, they must reapply for Medicare Part B. Before benefits can start, they must pay back all the premiums they missed while incarcerated. People who were receiving Social Security disability payments prior to incarceration may have had Medicare premiums deducted from their check. They will have to pay premiums themselves while in custody. If they do not and have to re-enroll upon release, it can mean long waiting periods and higher premiums.

People should not pay for a Medicare Advantage or Medicare Part D while incarcerated. Visit www.ssa.gov or call (800) 772-1213 for more details.

State Health Insurance Assistance Programs (SHIPs): SHIPs help Medicare beneficiaries with one-on-one insurance counseling and operate in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. Older justice-involved individuals who are nearing Medicare eligibility can take advantage of these services. The SHIP website includes a locator to find state SHIP programs that can help: https://www.shiptacenter.org/.

Social Security

Supplement Social Security Income (SSI) and Social Security Disability Insurance (SSDI) are both programs that provide disability benefit payments. They are not paid while beneficiaries are incarcerated (this includes detention centers, halfway houses, work release centers, boot camps, etc., but not necessarily home confinement).

If people were receiving SSI before entering prison or jail: The benefits are suspended after one full calendar month in custody and are terminated after 12 full months in custody. If incarcerated for more than 12 consecutive calendar months, they must reapply upon release.

If people were receiving SSDI before entering prison or jail: They can continue receiving benefits until they are convicted of a criminal offense. If they are in jail awaiting trial, SSDI continues until they are convicted. Then benefits are suspended after they have served 30 continuous days. They can be reinstated the month following release by contacting the local Social Security office with official release papers and requesting reinstatement.

Applying for SSI benefits before release: People in custody can apply for SSI benefits before their expected release date from prison or jail. Applications are processed under the pre-release procedure for people in jails or prison if they are likely to meet the SSI eligibility criteria upon release.

Many correctional systems have pre-release agreements with local Social Security offices. Under these agreements, institutions notify local SS offices when an individual who is likely to be eligible for SSI is approaching release, sends relevant medical records, and keeps the office informed about the release plans. Social Security processes these claims or reinstatements as quickly as possible and notifies the institution regarding eligibility determinations, with the applicant's permission. The details of the procedure are available online at https://www.ssa.gov/ssi/spotlights/spot-prerelease.htm. There is also a pamphlet available on benefits and incarceration from Social Security that can be ordered or viewed online: What Prisoners Need to Know.

Information on other relevant Social Security programs: Social Security also provides benefits to eligible individuals with HIV/AIDS. Information on Social Security for HIV is available at https://www.ssa.gov/pubs/EN-05-10019.pdf.

SOAR resources: The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance Center. SOAR is dedicated to ensuring eligible individuals with disabilities apply for and obtain benefits. Applying for disability benefits is a difficult and

complicated process. Nationally, only about 28% of applications are approved when they are initially submitted. The approval rate of initial applications from individuals experiencing homelessness who have no one to assist them is even lower—only 10% to 15%. The remaining applicants must appeal the initial decision and obtain approval of their application for benefits through a lengthy appeals process that can take more than a year and sometimes involves retaining an attorney.

The SOAR program provides technical assistance to criminal justice agencies and accepts applications for the Criminal Justice Technical Assistance Program from agencies that have not already participated in the federally sponsored initiative. The SOAR website offers information and resources such as these:

- SOAR Technical Assistance Opportunity for Criminal Justice Programs
- Living Arrangements: Residing in an Institution
- Working with Justice-Involved Persons

Veterans' Benefits

The U.S. Department of Veterans Affairs (VA) provides specific assistance and health care for veterans re-entering after incarceration and for justice-involved veterans.

If people were receiving VA disability benefits before entering jail or prison: VA benefits could be limited or even suspended during incarceration. VA disability compensation payments are reduced if a veteran is convicted of a felony and imprisoned for more than 60 days. Veterans who are rated as 20% or more disabled are limited to the 10% disability rate. For a veteran whose disability rating is 10%, the payment is reduced by one-half. Once a veteran is released from prison, payments may be reinstated. All or part of the compensation not paid to an incarcerated veteran may be apportioned to the veteran's spouse, child or children, and/or dependent parents based on individual need.

Disability benefits are not reduced for veterans in work release programs, residing in halfway houses (also known as residential re-entry centers) or for those under community supervision. People can apply to restart benefits when they are 30 days or less from release. They should inform the VA of their scheduled release date. The VA must be notified within one year of actual release. If there was an overpayment (full benefits paid for more than 60 days after date of incarceration), the recipient must repay the amount of the overpayment before benefits can begin again.

VA programs for justice-involved veterans:

- Health Care for Re-Entering Veterans (HCRV) is designed to help incarcerated veterans successfully reintegrate back into the community after release. A list of regional HCRV specialists is available at https://www.va.gov/homeless/reentry.asp#contacts. The program offers the following:
    - outreach and pre-release assessment services for veterans in prison;
    - referrals to and linkages with services, including substance use, mental health, and employment services upon release; and

    - short-term case management assistance after release.

- The Veterans Justice Outreach Program (VJO) initiative is designed to ensure eligible justice-involved veterans receive timely access to VA health care, specifically mental health and substance use services (if clinically indicated), and other VA services and benefits as appropriate. A list of regional VJO specialists is available at https://www.va.gov/homeless/vjo.asp.

Federally Qualified Health Centers (FQHCs)

FQHCs are a particularly important re-entry resource in states that have not expanded Medicaid eligibility. The Health Resources and Services Administration (HRSA) FQHC locater identifies the nearest health center anywhere in the United States. FQHCs provide primary health care services to uninsured and medically underserved individuals and areas regardless of their ability to pay. They may also offer dental services, pharmacy services, behavioral health care, transportation, and/or case management. Since the passage of the Affordable Care Act, FQHCs have been encouraged to integrate behavioral health services. Most now provide mental health services, and at least half of all FQHCs offer SUD treatment.

There are many different types of community health centers that are certified as FQHCs. They include rural health centers, migrant health centers, and health care centers for people experiencing homelessness. FQHCs not only accept Medicaid and Medicare, they are also eligible to receive funding that offsets the cost of care for the uninsured and can apply for funds to hire enrollment assistors. Some community health centers can accept Medicaid and Medicare reimbursement but do not receive other grants to offset caring for the uninsured. These are known as FQHCs "look-alikes."

All FQHCs and look-alikes are an important resource for re-entering individuals in need of health care services. They are required to include 50% consumer representation on their board of directors and to deliver culturally appropriate services to the communities they serve. Because they operate in rural and medically underserved areas, they are sometimes the only comprehensive health care providers in certain communities. RSAT staff can use the FQHC locator to find centers that serve communities of re-entry for RSAT graduates.

Examples of federal health care resources:

- Health Care for the Homeless Program—This program is a major source of care for people experiencing homelessness in the United States. It serves patients who live on the street, in shelters, or in transitional housing. These programs are a specific type FQHC that are required to direct outreach efforts and provide services to meet the needs of this population. They are also required to offer substance use services.
- Indian Health Service—They coordinate federal health services to American Indians and Alaska Natives. The website offers information about the specific provisions of the Affordable Care Act and other targeted health programs that apply to Native Americans and Alaska Natives.
- CMS and the Tribal Affairs Office—a contact list of federal CMS and Tribal Affairs staff and regional CMS Indian Health Contacts

- Health Homes—The “Health Home” model uses a care manager to coordinate communication among interdisciplinary providers serving patients with multiple conditions, especially those dealing with chronic physical and behavioral health problems. Their networks must include mental health and substance use disorder treatment capacities. The link takes you to a list of Health Homes that address care coordination for justice-involved individuals.

Lowering the Cost of Prescription Medications

Some FQHCs offer pharmacy services through a discounted drug cost program. This is only one way to obtain prescription drugs at a lower cost. There are several different types of prescription assistance programs (PAPs) that can help defray costs. Some of them also offer useful resources aimed at increasing health literacy for consumers of prescription drugs and helping them obtain medications they need at the lowest possible cost. Different types of programs include the following:

- **Need-based programs:** Low income applicants qualify for this type of assistance if they do not exceed the specified earning limits. These programs vary in the ways they determine eligibility; some consider income and assets as well as the applicant’s existing coverage.
- **Drug company sponsored programs:** Nearly every drug manufacturer offers some level of assistance to people who cannot afford their medications. The degree of assistance available and the process for determining who qualifies can vary.
- **Consumer discount programs:** These programs usually offer a discount card or coupons. Some are accepted at affiliated pharmacies, whereas others are accepted everywhere. Enrollment is often free, but they may not offer discounts on all drugs.

Examples of need-based prescription assistance programs:

- Rx Outreach—This program offers individuals who qualify a nonprofit mail order pharmacy service. It provides many types of prescription drugs to low income individuals at a significant discount. The income limits for eligibility are somewhat higher than other need-based programs. The website explains eligibility, how the program works, how to see if they supply the drugs you need, and how to communicate with prescribers about writing and submitting prescriptions and renewals. Prescriptions may be written with refills available for up to one year. Many drugs can be purchased for $20 for a 180-day supply. For more information, visit www.rxoutreach.org or call 1-888-RXO-1234 (796-1234), Monday through Friday, 7:00 a.m. to 5:30 p.m. Central time. Link to print out paper applications: http://rxoutreach.org/wp-content/uploads/current/AppOnly.pdf
- Needy Meds—This is a nonprofit organization that provides a free prescription drug discount card to eligible individuals. It also offers a lot of other information and tools, including help locating low cost services and providers, and information on government programs including Medicaid and Medicare. It has a very helpful state-by-state list of locally sponsored assistance programs, which

includes medical equipment loan programs, supports and benefits for people with HIV, assistance and counseling for Medicare beneficiaries, and more.

Examples of drug company sponsored programs:

- Partnership for Prescription Assistance—This program is sponsored by the drug industry's primary trade group, the Pharmaceutical Research and Manufacturers Association. The website claims affiliations with 1,300 national and local organizations that help spread the word about assistance programs and enroll people who qualify. It can link individuals to 475 public and private prescription assistance programs, including 180 sponsored by drug companies.
- Renckitt Benkheiser Here to Help Program—This program provides free Suboxone for up to 12 months to U.S. citizens age 16 or older. People without coverage can apply if their earnings are within the income limits (about $2,500 a month or less for a single person). The application has a section for the prescriber. They can only see three patients at a time who are receiving this assistance. They also offer a discount card program for eligible patients who have insurance or for uninsured patients who do not qualify for the Here to Help program. It covers up to $75 a month toward co-pays for new patients with coverage and a larger proportion of the costs for uninsured patients (a maximum savings of $230 per month). Link to savings cards: http://www.suboxone.com/treatment-plan/savings-card?cid=subx
- Alkermes Vivitrol Co-pay Assistance Program—Patients 18 years or older can apply for the Vivitrol Co-pay Savings Card if they are uninsured or have commercial insurance. The co-pay program does not accept applications from patients who are covered by any government or public health benefit program. Alkermes also offers patient support through their Touchpoints website, including a program where needy patients can apply to receive Vivitrol at no cost. Link to application: https://www.vivitrol.com/Content/pdf/Standard_Enrollment_Form.pdf

Examples of discount programs:

- GoodRx—This program offers a free prescription drug discount card or a free app you can download that functions like a discount card but with enhancements, such as a mapping tool that compares medication prices at nearby retail pharmacies. It is as decent "shopper's tool" and can result in significant cost savings.
- Pharmacycard.org—This program offers a free prescription drug discount card accepted at participating pharmacies. It has a drug price and pharmacy finder that allows you to look up any medication to see if a discount is available.
- HelpRx.info—This program offers a free prescription drug discount card accepted at participating pharmacies, a searchable database, manufacturer's coupons, guides, resources, and useful information on specific medicines and conditions. It includes a section on SUDs that offers coupons for buprenorphine and disulfiram (Antabuse), as well as information on overdose prevention and drug safety.

C. Communicating with Providers and Safeguarding Recovery

One of the most challenging aspects of a visit to a primary care physician or other health provider is being able to ask questions and communicate comfortably during visits or exams. This is especially difficult when patients are seeing a provider for the first time. This experience can be intimidating for newly released individuals with SUDs. At the same time, it is important for people in recovery to inform their health care providers about their substance use history, talk with them about their prescribed medications, and safeguard their recovery from the risks those medications may present. Health care providers differ with their experience and knowledge when it comes to treating patients with an addiction history. Some are very good at suggesting alternative treatments or medications and are familiar with the medications approved to treat opioid and alcohol use disorders, whereas others may have limited experience treating recovering individuals, may not be familiar with common problems and are unaware of how some prescribed medications may affect people in recovery.

There is also a difference between the way almost any substance can be used to get high in a custody environment and the way a medication prescribed for a legitimate health issue to an individual in recovery can trigger urges to use more than the recommended dose or cravings for alcohol, opioids, or other substances. This section provides information and resources to improve patient/provider communications about these issues and to educate providers and people in recovery about these important issues beginning with the most challenging—pain management.

Pain—In March 2016, the CDC released updated guidelines for prescribing opioids for chronic pain. The guidelines are based on research on the increases in opioid prescription practices that helped create the opioid epidemic and the diminishing benefits of long-term use of opioids for pain management. The new guidelines emphasize providing patients with information about the risks involved and giving them an informed decision-making role in working with providers. Opioids are very effective for short-term management of acute pain but carry the risk of dependency and the side effect of increased tolerance, even in these situations. Pain management for patients receiving MAT for an OUD and for patients in recovery is a specialized field that requires a practitioner with both pain management and addiction medicine training. The SAMHSA Treatment Improvement Protocol, Managing Chronic Pain in Adults with or in Recovery from SUDs is a helpful tool for patients, counselors, and medical practitioners. The FDA has also developed a good consumer guide on the topic: *What to ask When You are Prescribed Opioids—New FDA Consumer Information*. A few take-home points RSAT programs can highlight for clients are as follows:

- Complete absence of pain is probably not a realistic expectation. Pain management goals include making pain levels tolerable, interrupting pain when it becomes severe, and employing a combination of pain relief approaches.
- Recovering individuals need to consider the risks and benefits of pain management approaches. If opioids are required, how long and what type of opioid medications can be used safely may vary among recovering individuals. They all present some degree of risk, but high levels of unmanaged pain can also present risks.

- Decisions to use pain medications can be made in conjunction with agreements about monitoring and safeguards patients and providers can put into place to reduce the risks.

Sleep—The incidence of insomnia and sleep disturbances among people with alcohol use disorders and histories of dependence on other substances is high. There is also a relationship between ongoing sleep problems and risk of relapse. Treating Sleep Problems of People in Recovery from Substance Use Disorders is a SAMHSA publication for providers on sleep disturbances among people withdrawing from substances and initiating recovery that explains these issues and offers strategies for improving sleep. Sleep problems are also an issue for people with trauma-related disorders and chronic pain, which commonly co-occur among individuals with SUDs. There are many options for individuals with sleep problems. Some of them include medications that do not have sedative-hypnotic properties, such as the use of antihistamines, over the counter preparations, and off-label use of other medications with low abuse potential. There are also several behavioral treatments, and maximizing the use of non-medication options is an important element of treating sleep problems of recovering individuals.

Anxiety—Many of the same considerations apply to anxiety problems, which are common among recovering individuals. The use of tranquilizers or benzodiazepines is controversial for several reasons. First, this class of medications does not play well with others. There are significant risks when they are combined with opioids or alcohol, which are amplified when combined with both. Benzodiazepines are for short-term treatment of acute anxiety but are often prescribed for sleep problems, depression, and for long-term management of anxiety problems. This can lead to physical dependency and a withdrawal syndrome that can be dangerous. Some individuals in recovery from alcohol problems feel these medications trigger alcohol cravings, and the potential for cross-addiction is high. Non-medication treatment options for anxiety include cognitive-behavioral therapies that have outperformed medications in research studies on treatments for certain anxiety disorders. Some antidepressant medications also have a positive effect on anxiety symptoms for some individuals and have very low potential for misuse or dependency.

Other mental health issues—There are several medications for depression and other serious mental health conditions that have low or no abuse potential and are helpful to people in recovery who have CODs. However, it is difficult to predict who will respond to what medications. Often, a period of trial and error is the only way to determine what works for an individual. Starting a new medication or changing medications can be a stressful undertaking for individuals in recovering from CODs. All medications have side effects ranging from mild to very unpleasant. People must be prepared at the outset to go through the adjustment period with a new medication and put up with side effects only to find the medication does not work for them or that it only provides partial relief of symptoms. In the case of depression, these experiences are more common than experiencing complete relief from an antidepressant medication. At the same time, the benefits of psychiatric medications often outweigh the risks for many people. RSAT clients can be prepared to discuss medication as an option should they develop depression or another mental health condition that can be treated with medication. If

they are already taking psychiatric medications, the ability to discuss continuing medication management issues with community providers can help during the transition from correctional to community-based care.

Explanation of Medicaid Terms Applied to Medications

The following list of terms explains relevant definitions that apply to Medicaid and other health plan coverage criteria and restrictions. Public and private health plans frequently place restrictions on coverage for MAT, some of which are generally not placed on coverage for other medications. It is important for RSAT participants seeking MAT or other treatments that involve ongoing use of medications upon release to understand how to work with providers within these limitations to make sure all allowable treatment costs of are covered.

Medicaid fee for service plans—State Medicaid pays for services through either fee-for-service or managed care arrangements. Each state can set their own Medicaid reimbursement rates for services as long as they fall within federal guidelines. Some ways states determine rates for services include the following:

- a review of the cost of a service for commercial payers in the private market, or
- a percentage of what Medicare pays for an equivalent service.

Medications for OUDs are frequently covered by fee-for-service arrangements. This is because Medicaid discounted rates for prescription drugs are obtained through drug company rebates. Medicaid managed care plans were once excluded from rebate programs, so states carved out pharmacy benefits from managed care and left them as fee-for-service benefits.

Categorically needy and medically needy populations—Federal Medicaid requirements designate categorically needy populations that state mandatory to cover. States may extend Medicaid benefits to additional groups they designate as medically needy.

Medicaid managed care—delivers services through contracted arrangements between state Medicaid agencies and MCOs. They accept a set monthly payment per member. At least 70% of Medicaid beneficiaries are now enrolled in managed care plans. Some states offer eight or more different managed care plans that vary in benefits they offer. Some states require consistent coverage for specified services from MCOs; other states allow flexibility and only require contracted MCOs to offer plans that meet federal standards and adhere to various quality assurance and performance benchmarks.

Utilization controls—measures designed to manage the costs of health care services. Several different types of controls are referenced in this review.

- **Negotiated reimbursement rates**—State Medicaid agencies have different ways of determining the rate for reimbursement of a service. Some use a *per diem* or daily rate. Other types of negotiated rates: *percentage of cost, capitated fee,* and *cost-based or prospective cost rates*.
- **Pre-approval or prior authorization**—refers to needing permission for a specific service before the plan agrees to cover it. Providers/prescribers usually submit pre-authorization requests. Medicaid managed care plans often require that these

requests come from primary care providers.

- **Dosage limits**—the maximum dosage of a medication that a health plan will cover. Some dosage limits do not correspond to clinical guidelines. They also fail to account for biological conditions that can influence drug metabolism. For example, pregnancy and certain drugs prescribed for other medical conditions can require dosage adjustments. “Dosage limits” are also applied to counseling, outpatient, and residential treatment services. For example, counseling might be limited to 36 sessions per year or residential treatment to 30 days.
- **Lifetime limits on methadone and/or buprenorphine**—limits on how long a plan will pay for medications that are seldom applied to medications for other chronic conditions (asthma, hypertension, depression, etc.), but some state Medicaid programs limited MAT to 24 months.
- **Frequent reauthorization requirements**—refers to needing permission to continue to get prescribed medication. Criteria may become more demanding with each reauthorization.
- **Prescription refill limits**—are limits on the number of refills a plan will cover. They are not typically imposed on medications for other chronic conditions or when buprenorphine or methadone are prescribed for pain management, but they apply when used to treat opioid addiction.
- **Pre-authorization requires documentation of counseling**—requirement to ensure a beneficiary is receiving counseling before it covers medication. Sometimes details of counseling sessions or progress notes are required.
- **Requiring documentation of having a disorder for a specified time**—refers to documenting a problem an individual has had often for a year or more. This is sometimes waived for individuals recently released from prison or jail and for pregnant women.
- **Step therapy or fail first criteria**—is a requirement for documentation that other therapies have been attempted but were ineffective before a treatment is covered.
- **Dictating specific clinical approaches**—for example, requiring a provider introduce a plan to taper people off a medication as soon as they are stabilized or dictate a tapering schedule.

Preferred drug list (PDL) and formulary—Typically, preferred drug lists comprise medications that health plans routinely cover. Formularies are broader lists of all medications, preferred and non-preferred, with notations that indicate higher co-pays, pre-approval criteria, dosage or duration limits, and other coverage restrictions.

Module III Review

- RSAT programs can help graduates enroll in health benefits prior to release or upon release. Linking clients to health enrollment assistor agencies can provide them with in-person application assistance, help understanding health information, referrals to local providers, and follow-up to make sure they are using their benefits.
- There are many videos and written materials available that explain basic health insurance terms and the way coverage works. Newly covered individuals need this background information to utilize the benefits they obtain, find covered services, and understand the out-of-pocket expenses involved.
- RSAT staff can also familiarize participants with other health care programs they may qualify for, aside from Medicaid. These include Medicare, veterans' health programs, Social Security, and primary care and behavioral health services from FQHCs.
- Prescription drug costs can be reduced through assistance programs that offer need-based programs or discount cards. Drug manufacturers also offer assistance programs to patients who qualify. Medicaid and other insurance plans sometimes place restrictions on the medications they cover. It is important for RSAT clients to understand these requirements.
- Recovering individuals need to be able to make informed decisions regarding the risks and benefits of certain prescribed medications. When they are prepared to communicate with physicians and providers about these issues, they can take an active role in making decisions that safeguard their recovery.

Module III Resources

Resources Included in the Appendix

RSAT programs can contribute to the health and wellness of clients, reduce the harms and risks they face upon re-entry, and increase access to appropriate care by integrating any of the elements of health literacy outlined in this manual. The appendix includes links to printable educational resources that support these efforts and copies of many of the handouts mentioned in text, which can be duplicated freely.

Appendix

Harm Reduction Handouts

1. **When the Seconds Count**—OD prevention card from the American Society of Anesthesiologist: https://www.asahq.org/WhenSecondsCount/resources.aspx
2. **Overdose Prevention Tip Sheet**—Harm Reduction Coalition: http://harmreduction.org/wp-content/uploads/2012/11/HRC_ODprevention_worksheet9.pdf
3. **Overdose Prevention and Rescue Breathing in 20 Minutes or Less**—New Mexico Department of Public Health: https://nmhealth.org/publication/view/help/1706/
4. **Narcan Nasal Administration and Rescue Breathing Instructions**—New Mexico Department of Public Health: https://nmhealth.org/publication/view/help/1712/
5. **Syringe Sterilization Harm Reduction Sheet**—Adapted from the NIDA Community-Based Outreach Model: A Manual to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users

Highly Recommended Resources

Public domain health information brochures available online to download and print.

1. **After You've Tested Positive**—HIV Wellness Booklet from Project Inform**:** https://www.projectinform.org/pdf/hivhealth1.pdf
2. **Alcohol-free Pregnancy**—FASD Prevention Brochure from the CDC: https://www.cdc.gov/ncbddd/fasd/documents/FASDBrochure_final.pdf
3. **Medicines in My Home**—Excellent booklet from the FDA: https://www.fda.gov/downloads/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/understandingover-the-countermedicines/ucm094872.pdf
4. **Helping Yourself Heal: Recovering Woman's Guide to Coping w/ Child Abuse Issues**—from SAMHSA**:** http://store.samhsa.gov/shin/content/SMA12-4132/SMA12-4132.pdf
5. **Harmful Interactions: Mixing Alcohol and Medicines**—Brochure from NIAAA: https://pubs.niaaa.nih.gov/publications/Medicine/Harmful_Interactions.pdf
6. **Could I Have ADHD? Finding an Answer to ADHD as an Adults**—Booklet from NIH: https://pubs.niaaa.nih.gov/publications/Medicine/Harmful_Interactions.pdf
7. **Overdose: Everything You Need to Know**—Easy to read booklet from Exchange Supplies: http://www.exchangesupplies.org/pdf/HRDVD6.pdf

Health Information Handouts and Tools

1. Short Assessment of Health Literacy
   https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy/sahl-e-form-user-guide.pdf
2. Implementation Guide for the Newest Vital Sign
   http://www.pfizer.com/files/health/2016_nvs_flipbook_english_final.pdf
3. Nutrient Deficiency Risk Questionnaire
   https://erygi42lxye3x93s11zt8kf1-wpengine.netdna-ssl.com/wp-content/uploads/2016/11/nutrient-questionnaire.pdf
4. Alcohol Use and Your Health Infographic
   https://www.cdc.gov/alcohol/pdfs/alcoholyourhealth.pdf
5. Withdrawing from Substances Fact Sheet
   Adapted from the National Institute of Drug of Drug Abuse - Commonly Abused Drug Charts:
   https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts
6. Post-Acute Withdrawal Syndrome Fact Sheet
7. How You Get HIV/AIDS Fact Sheet
   https://healthreach.nlm.nih.gov/files/English_HIVAIDSHowYouGet_Final.pdf
8. HIV/AIDS and Substance Abuse Fact Sheet
   https://healthreach.nlm.nih.gov/files/English_HIVAIDSSubstanceAbuse_Final.pdf
9. Sexually Transmitted Diseases Fact Sheet
   https://www.healthinfotranslations.org/pdfDocs/STDs.pdf
10. Handwashing Fact Sheet
    https://www.healthinfotranslations.org/pdfDocs/HandWashing.pdf
11. MRSA Fact Sheet
    https://www.healthinfotranslations.org/pdfDocs/MRSA.pdf
12. PrEP and PEP Pocket Cards
    https://www.projectinform.org/pdf/prep_pep_poc_cards_new.pdf
13. Substance Use in Women and Men Infographic
    https://www.drugabuse.gov/related-topics/trends-statistics/infographics/substance-use-in-women-men
14. Domestic Violence Handout
    https://www.familydoctor.org/domestic-violence-protecting-yourself-and-your-children/
15. Smoking Cessation for Recovering Alcoholics Handout
    https://www.familydoctor.org/smoking-cessation-in-recovering-alcoholics/
16. ADHD Fact Sheet
    https://www.cdc.gov/ncbddd/adhd/documents/adhdfactsheetenglish.pdf
17. Overdose Prevention Tips Worksheet
    http://harmreduction.org/wp-content/uploads/2012/11/HRC_ODprevention_worksheet9.pdf
18. Overdose Prevention and Rescue Breathing in 20 Minutes or Less
    https://nmhealth.org/publication/view/help/1706/
19. Naloxone (Narcan) Instructions and Rescue Breathing Instructions
    https://nmhealth.org/publication/view/help/1712/

20. Harm Reduction—Syringe Cleaning Handout
    Adapted from the NIDA Community-Based Outreach Model: A Manual to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users. National Institute on Drug Abuse, NIH Publication Number 00-4812
21. Opioid Overdose Resuscitation Card
    https://www.asahq.org/WhenSecondsCount/resources.aspx

Note: All items are in the public domain and may be reproduced for non-commercial purposes. Handouts may be duplicated or downloaded and printed at the links listed on each item.

Withdrawing from Substances

(Adapted from NIDA Drug Charts: https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts)

Alcohol Withdrawal - Withdrawing from alcohol can be difficult, uncomfortable and, in some instances, life threatening. Acute alcohol withdrawal can be dangerous and shouldn't be attempted without professional medical guidance and monitoring. Medically supervised detox uses of specific medications to moderate the potentially dangerous physical effects of withdrawal. There are also oral medications to reduce cravings for alcohol that often follow once the initial hurdle of withdrawal has been overcome.

Methamphetamine – Short term effects included increased wakefulness and physical activity; decreased appetite; increased breathing, heart rate, blood pressure, temperature; irregular heartbeat. Long-term use can lead to anxiety, confusion, insomnia, mood problems, violent behavior, paranoia, hallucinations, delusions, weight loss, severe dental problems ("meth mouth"), intense itching leading to skin sores. Withdrawal Symptoms are not usually life-threatening and include depression, anxiety, and tiredness.

Cocaine - Cocaine's effects appear almost immediately and disappear within a few minutes to an hour, depending on the method of use. Long-term effects of cocaine use include being malnourished and movement disorders, including Parkinson's disease, which may occur after years of use. People report irritability and restlessness resulting from cocaine binges, and some also experience severe paranoia, in which they lose touch with reality and hear noises that aren't real. Repeated use of cocaine can cause long-term changes in the brain's reward circuit and other brain systems, which may lead to addiction. Withdrawal is not usually life-threatening unless there are other health conditions. Symptoms include: depression, fatigue, increased appetite and insomnia.

Opioids - People who regularly use heroin or other opioids develop a tolerance, which means it takes higher and/or more frequent doses of the drug to get the desired effects. An OUD (opioid use disorder) can range from mild to the most severe - addiction. Stopping the drug abruptly may cause severe withdrawal symptoms, but they are usually not life-threatening unless there are other health problems. Pregnant women should not withdraw abruptly from opioids without medically supervised opioid replacement medications. A range of treatments including medicines and behavioral therapies are effective, especially combined. Withdrawal symptoms can begin as early as a few hours after last use and include: muscle and bone pain, sleep problems, diarrhea and vomiting, cold flashes with goose bumps, uncontrollable leg movements and severe heroin cravings.

Rohypnol - Possible short-term health effects include drowsiness, sedation, sleep; amnesia, blackout; decreased anxiety; muscle relaxation, impaired reaction time and motor coordination; impaired mental functioning and judgment; confusion; aggression; excitability; slurred speech; headache; slowed breathing and heart rate. Long-term health effects are unknown. When combined with alcohol, rohypnol can be dangerous and results in severe sedation, unconsciousness, and slowed heart rate and breathing, which can lead to death. Withdrawal symptoms can be dangerous, require medical supervision and include headache; muscle pain; extreme anxiety, tension, restlessness, confusion, irritability; numbness and tingling of hands or feet; hallucinations, delirium, convulsions, seizures, or shock.

Sedative, Sleep Medications and Tranquilizers – Barbiturates, benzodiazepines and sleeping pills cause drowsiness, slurred speech, poor concentration, confusion, dizziness, problems with movement and memory, lowered blood pressure, slowed breathing. When used in combination with alcohol heart rate and breathing are slowed down more, which can lead to death. Withdrawal Symptoms can be dangerous and should be medically supervised. Barbiturate and benzodiazepine withdrawal can cause a serious abstinence syndrome that may even include seizures.

Post-Acute Withdrawal Syndrome (PAWS)—symptoms associated with withdrawing from drugs and alcohol that go on for a longer period once a person has gone through an initial period of acute withdrawal. The combination and timing of specific symptoms is different for each person. Physical differences between people, as well as differences in the types of drugs used and the amount and frequency of use all affect each individual's experience of PAWS.

◆ *Mood swings*: The brain of a chronic drug user, including patients taking medications under their doctor's supervision, adapts to a constant supply of a mood-altering substance. When it is removed, periods of mania or depression can occur for no apparent reason while the brain rebalances itself.

◆ *Anhedonia:* Virtually all addictive drugs, and many medications like antidepressants, have the end result of boosting neurotransmitters and neural pathways that make the user feel good. Once they are stopped, it can take time for the brain to produce normal levels of these feel-good chemicals on its own again. Until it does, nothing may seem fun or interesting anymore.

◆ *Anxiety*: For addicts and patients alike, cessation of a drug or medication is a major life change. There can be a great deal of anxiety, and even panic attacks, that accompany this shift. Additionally, withdrawal from drugs such as alcohol and benzodiazepines that chronically inhibit brain activity results in a hyper-excitable, anxiety-prone state when they are stopped.

◆ *Insomnia*: Many drugs and medications affect sleep patterns. Once these drugs are stopped, it can take time to re-establish healthy sleep patterns. Vivid, realistic dreams about using are common, but they are not usually a warning of impending relapse, but simply the compulsion's effect on the mind.

◆ *Cognitive impairment*: This is another symptom of the brain's imbalance. Difficulties thinking clearly and concentrating are usually temporary and not a sign of permanent brain damage.

◆ *Depression and fatigue*: People who stop chronic drug habits or long-term medications have such intense feelings of depression and fatigue that may they fit the criteria for a mental disorder. However, these symptoms are a phase of readjustment in the brain and generally diminish over time.

◆ *Drug cravings*: People with PAWS often have intermittent cravings. Because the most intense physical withdrawal symptoms have subsided, the individual may feel physically healthy but continue experiencing negative psychological symptoms which make the return to drug use seem appealing.

◆ *Sensitivity to stress:* Many people dealing with the effects of PAWS find that their threshold for daily stress is very low. Trivial irritations or setbacks can feel like the end of the world. As new coping skills are learned it becomes easier to deal with normal emotions brought on by stress can take time.

These are some of the most common features of PAWS but not an exhaustive list. Most symptoms are intermittent and come and go over days and weeks. Steps you can take to manage PAWS and improve your wellbeing during recovery include:

- Educating yourself. Becoming aware and educated about both acute and post-acute withdrawal so you know what to expect as you navigate the recovery process.
- Focusing on positive changes and achievements. It is normal to focus on continued difficulties caused by PAWS, you should not lose sight of how recovery is changing your life for the better.
- Stay active. Physical activity helps your body and brain heal more quickly and can reduce anxiety and stress, as well as help you sleep better in the long-term.
- Most importantly, be patient and take it easy on yourself.

These symptoms will subside with time. Patience and understanding are therefore the keys to successfully navigating PAWS and learning how to live a healthy and happy life in recovery.

Harm Reduction - Syringe Cleaning

Whenever possible, the interventionist should demonstrate to drug injectors how to disinfect syringes and other injection equipment. (This may not be feasible when the session is conducted in street settings.) The following materials are required when demonstrating proper disinfection techniques:

- Cup with clean rinse water;
- Container with full-strength household bleach;
- Empty cup;
- Bottle cap (cooker); and
- Demonstration syringe (no needle).

To demonstrate proper needle disinfection, full-strength bleach should be drawn through the submerged tip of the syringe to fill the barrel, and the barrel should be shaken or tapped to agitate the contents for 30 seconds. The interventionist should stress that only full-strength household bleach and clean, unused water should be used for disinfection of needles and syringes. Next, the bleach should be discharged for disposal, or squirted into the cooker if the cooker is also being cleaned. If the back tip of the plunger is used to mix the drug solution, it can be cleaned by immersion in the bleach contained in the cooker. Once completed, this process should be repeated.

After the syringe is disinfected with bleach, clean water should be drawn through the submerged tip of the syringe to fill the barrel, and then the water should be discharged and disposed. When completed, this process also should be repeated. If the cooker is being cleaned, water can be used to flush out any residual bleach, and the back plunger tip can be rinsed off by being dipped into the water in the cooker. It is important for the interventionist to emphasize that water and bleach used to clean injection equipment should never be reused, and that they should be discarded into a sink, toilet, sewer, or discard bottle whenever possible. They are hazardous waste! The interventionist also should emphasize that all injection equipment should be cleaned after each use.

The interventionist may suggest that the participant take the syringe apart (remove the plunger) to improve the cleaning/disinfection of parts that might not be reached through flushing with water and bleach. Next, the participant should be asked to demonstrate his or her proficiency by cleaning the needle and syringe as directed. Playback may be continued until proficiency is achieved. (It is anticipated that at least 90 percent of participants will be proficient by the first rehearsal.)

From: The NIDA Community-Based Outreach Model: A Manual to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users. National Institute on Drug Abuse, NIH Publication Number 00-4812
Printed September 2000