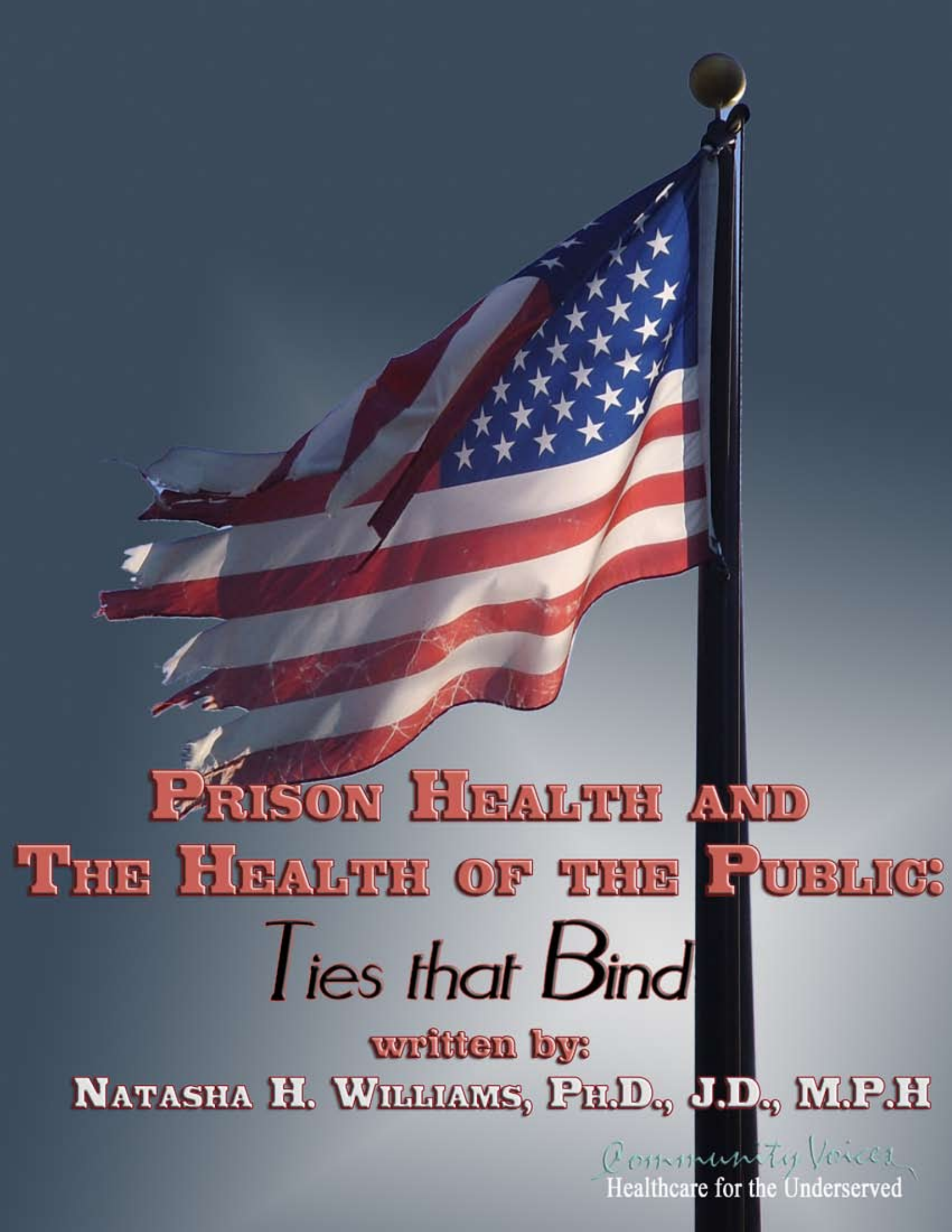

Prison Health and The Health of the Public:

Ties that Bind

written by:
Natasha H. Williams, Ph.D., J.D., M.P.H

Community Voices
Healthcare for the Underserved

Community Voices

Community Voices: Healthcare for the Underserved is working to make health care available to all. With eight sites across the country and managed by the National Center for Primary Care at the Morehouse School of Medicine, Community Voices is helping to ensure the survival of safety-net providers and strengthen community support services. Launched in 1998 by the W.K. Kellogg Foundation, the sites are part of a national effort to sort out what works from what does not in meeting the needs of those who receive inadequate or no health care.

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"...O'er the land of the free and the home of the brave." - Francis Scott Key

Introduction – A Hard Look at the Health of Our Prisoners

The word "genocide" evokes images of horrors in other lands – of the Holocaust or deaths in Bosnia, of Rwanda and now Darfur. All too often, in the aftermath of these atrocities, voices the world over will condemn the sluggish responses that allowed killing fields or gas chambers, the inattention or the apathy that ultimately permitted "deliberate and systematic destruction of a racial, political, or cultural group." (Merriam-Webster, 2006)

In our nation, the sad saga of the Trail of Tears is an example of systematic destruction closer to home. The forced removal of Cherokee Indians from their North Carolina homelands in 1838, and the attendant condemnation to illness and poverty and premature death, did not happen by chance. Laws were enacted, public policies enforced, and resources committed – even here, in the "land of the free." And however mindful we may be in the 21st century of the cruelty and injustice of the past, the people lost and families destroyed will never be recovered. The best we can hope for is that understanding the consequences of past errors will prevent similar catastrophes – that the overwhelming shame and sadness engendered by genocidal policies will rouse us to demand respect for humanity from our leaders and governments.

Yet when we consider the plight of prisoners in the U.S. criminal justice system, the world could rightly question how well we have learned from the mistaken paths of our history. ***Nearly 2.2 million men and women are incarcerated in prisons and jails in the United States (Harrison and Beck, 2006), and a growing body of evidence points to levels of ill health and inadequate treatment that suggest a willful disregard of prisoners' basic human rights.*** Many convicted of crimes in this country enter their cells infected with HIV/AIDS, hepatitis, or tuberculosis. Many more suffer from undiagnosed or untreated mental illness. Oftentimes, prisoners have poor oral health, dental cavities, and gum disease. And a great many live with

chronic conditions – especially diabetes and hypertension. Whatever the length of individual sentences, taken as a group prisoners are more likely to suffer serious illness and premature death because of the inadequate care most receive during incarceration. And those risks are compounded by the many systemic barriers to receiving needed health services once they are released.

At the present, health care provided in the hundreds of correctional facilities across the United States varies greatly – in part because there is no accepted standard of care for prisoners. Dr. Robert Greifinger, health care policy and quality management consultant, notes a range of health programs that spans those "considered excellent to those that are shameful, not only in terms of what we do to the individuals but shameful in terms of the risks we expose our staff to and the risks to the public's health" (Commission on Safety and Abuse in America's Prisons, 2006, p. 38). In general, overcrowded conditions and lack of resources to deliver adequate care aggravate prisoners' existing medical conditions. Chronic illnesses such as hypertension, diabetes, asthma, and heart disease require regular monitoring and consistent care to keep the diseases from escalating to crisis levels. Poor oral health can complicate and compound the ill effects of diabetes and cardiovascular disease (Treadwell and Formicola, 2005). With longer prison sentences, more men and women are growing old in prisons and developing the diseases of the elderly (respiratory illnesses, Alzheimer's disease, cardiovascular disease, arthritis, ulcer disease, mental health problems, and cancer). And as prevalent as these conditions are in the general inmate population, they appear to be more concentrated among older prisoners (Anno, et al, 2004).

Once released, many former prisoners have no access to health insurance and, thus, no entrée to health services. Added to that, ex-offenders often return to the communities with the fewest resources – cities, towns, and neighborhoods that are already poor, overburdened, and with limited health resources. The effect is to exacerbate health disparities already present. And the implications for public health cannot be walled off or isolated to particular communities or neighborhoods. On the contrary, the unmet health needs of people in jails and prisons can threaten the well-being of their families, communities, and society as a whole.

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In a worst case scenario, untreated or overlooked illness in a prison population can expose whole communities to the risk of epidemic. As an example, a multi-drug resistant strain of tuberculosis that surfaced in New York City in 1989 was linked to inadequate treatment in prisons and jails (Commission on Safety and Abuse in America's Prisons, 2006; Mauer, 1999; and National Commission on Correctional Health Care, 2002). It also appears that the network of relationships interrupted by incarceration may be the conduit for ready transmission of diseases and conditions prevalent in prisons when prisoners are released. ***Many correlate the catastrophic rise in HIV cases among African American women with the return of HIV-positive men after release from prison (Adimora, Shoeblack, and Doherty, 2006; Clemetson, 2004).*** While incarcerated, inmates

may engage in high-risk sexual behavior either consensually or by force. When they return to their communities, ex-offenders often resume relationships and unwittingly "bridge lower-risk community partners to higher-risk contacts developed in prison" (Adimora, et al, 2006, p. 44).

Dire examples like these represent tangible health threats we can measure, track, and document. Less well understood are the intangible effects of inadequate health care on prisoners and their loved ones or on the way poor health translates into fewer options for employment and for productive contributions to family life and community. As we take an unflinching look at the current prison population, its health status, and the implications for public policies, let us keep in mind that men and women confined to prisons and jails are not held in a vacuum. ***Even under lock and key, they remain parents, husbands, wives, daughters, sons, and neighbors who will return to their homes once released. As such, their health is inextricably linked to the health of our society.***

"Oh say can you see...?"
- Francis Scott Key

The People in Our Prisons and Jails

At the end of 2005, there were nearly 2.2 million men and women incarcerated in jails and prisons in the United States – the rough equivalent of one out of every 136 U.S. residents behind bars. Of those inmates sentenced to at least one year in prison, 547,200 were African American males representing 40 percent of this population, compared to 35 percent for whites and 20 percent for Hispanics. ***Moreover, African American males ages 25 to 29 had the highest incarceration rate when compared to other racial and ethnic groups.*** In 2005, 8.1 percent of African American males in this age group were incarcerated, compared to 2.6 percent Hispanic, and 1.1 percent white. (Harrison and Beck, 2006)

The same data show that women represented 7 percent of all prisoners, an increase from 6.1 percent in 1995. Even so, men were at least 14 times more likely than women to be incarcerated in state and federal prisons. And racial and ethnic disparities appear to be consistent among both women and men. ***Data indicate that African American women are more than twice as likely as Hispanic females to be incarcerated*** and three times as likely as white women to be imprisoned. (Harrison and Beck, 2006)

Rather than mirroring the general population, the proportion of people of color in U.S. prisons and jails mirrors economic and educational disparities in society as a whole. Many did not follow the path to prison of their own volition; they were pushed onto this pathway (Williams, 2006). But the ripple effect on communities economically and socially is significant – in particular because many of those in prisons are parents.

In 1999, there were over 700,000 parents incarcerated in state and federal prisons. Data from 1997 indicate that ***prior to incarceration over 70 percent in both state (70.9 percent) and federal prisons (73.5 percent) were employed, taxpaying citizens.*** These wage-earning men and women were parents to at least 1.5 million minor children – most of them (58 percent) under the age of 10 with an average age of 8. (Mumola, 2000)

Looked at another way, this data indicates that only two percent of the 72 million children in the United States had an incarcerated parent. Yet according to analysis by the Bureau of Justice Statistics, ***"black children were nearly 9 times more likely to have a parent in prison than white children and Hispanic children were 3 times as likely as white children to have an inmate parent" (Mumola, 2000, p.2).*** Unfortunately, that is where

available data about incarceration and families ends. At present there is limited research exploring how having a parent in prison might affect children – their mental health, their resilience, or their future well-being – in particular the potential for their relationship to the criminal justice system as a result (Travis and Waul, 2003).

A trend toward more punitive practices in criminal justice – including mandatory sentencing, increased sentences for drug offenses, and the elimination of parole by many states – has resulted in inmates serving longer sentences and beginning to grow old in prison. Between 1992 and 2001, the number of inmates age 50 or older increased 172.6 percent, representing almost 8 percent of the prison population in 2001 (Anno, et al, 2004*)*. This graying of the prison population impacts both health care needs and possibilities for re-socialization. As with the general population, the prevalence of chronic diseases associated with aging (such as diabetes, heart disease, and hypertension) increases among inmates as well. In addition, extended separation from home makes it almost impossible for ex-offenders to reestablish meaningful relationships with family, children, and community.

Lack of health insurance upon release compounds health consequences for the prison population. Since the United States does not guarantee coverage for the poor and unemployed or underemployed, many of these individuals face limited health care options. For example, a person working a low-wage or minimum wage job with no insurance may not be able to sit in an emergency room for hours to wait to be seen by a physician. For the hourly worker, time is money and most cannot afford to sacrifice those precious hours of pay. Missed hours of work represent food, clothing, and housing – essentials for survival for the worker and his or her family. Moreover, some jobs may not allow employees to take time off for medical care, forcing the low-wage ex-offender to choose between his or her health and a paycheck.

The inability to secure or maintain a job because of health issues may set in motion a sequence of events that leads back to prison. Unable to find employment, get housing, pay for medication, and re-establish family and community relationships, an individual may opt to return to the activities that led to confinement, thus perpetuating a vicious cycle of incarceration and release. The effect is to create a population of people condemned to either hard-scrabble existence or repeated sentences. Resources must be provided to those re-entering society through pre-release planning and once they return home to eradicate this destructive cycle.

More Prisoners, More Serious Health Care Needs

The U.S. domestic War on Drugs had a staggering effect upon the prison system from the 1980s onward. Between 1986 and 1991, the number of state prison inmates incarcerated for drug offenses rose from 9 percent to 21 percent. In the federal system, the drug offender population rose from 25 percent in 1980 to 61 percent in 1993. Overall, the prison population increased from 329,821 in state and federal prisons in 1980 to a stunning 1,053,738 in 1994 (Brown, 1997).

During this period, disparities in who went to prison and for how long became more pronounced. ***While numbers of white inmates increased 163 percent, the roll of black prisoners more than doubled (to 217 percent) (Brown, 1997). Once arrested, African Americans served longer sentences than their white counterparts, with the average sentence for an African American drug offender in federal court of 89 months compared with a white offender at 70 months (Cole and Littman, 1997).***

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With increased incarceration of drug offenders came prison overcrowding and exposure to HIV and tuberculosis. The extensive health care needs of the swollen prison population brought about near collapse of the prison health care system. As the infection rates of HIV/AIDS, tuberculosis, and other diseases increased among the inmate population, the cost of intensive health care services also increased.

Based on the latest available data, researchers estimated that "correctional systems spent approximately $2 billion in 1994 on inmate health care, an increase of 33 percent over spending in 1993" (McCorkel, et al, 1998, p. 1086).

Communicable and Chronic Diseases

The prevalence of communicable and chronic diseases among prisoners during incarceration and upon release is one way of gauging both the severity of medical conditions and the extent of unmet health care needs. In 1997, approximately 107,000 to 137,000 incarcerated individuals had at least one sexually transmitted disease (STD) – syphilis, gonorrhea, or Chlamydia – and among those released were an estimated 465,000 cases. Moreover, 36,000 inmates had hepatitis B, over 300,000 had hepatitis C, and 130,000 had latent tuberculosis infection. Of prisoners released in 1996, 155,000 had hepatitis B infection, approximately 1.4 million were infected with hepatitis C, and 566,000 inmates had latent tuberculosis infection. In addition, 8.5 percent of inmates suffered from asthma, an estimated 4.8 percent from diabetes, and more than 18 percent from hypertension (National Commission on Correctional Health Care, 2002). **Inmates with infectious diseases not only pose a risk to themselves but also other inmates, correctional personnel, and their families when they return home (Commission on Safety and Abuse in America's Prisons, 2006).**

The failure to provide prisoners with comprehensive medical care fuels public health crises both inside and outside of the correctional facility. Ideally, since those with chronic diseases are in poor health status, lack health insurance, and generally do not have a continuum of care upon release, the correctional facility has the opportunity to provide health care that will stabilize and treat the inmate's condition prior to release. As researchers have concluded, "It is time for public health to go to jail" (Community Voices, 2005, p. 10).

Oral Health

The people incarcerated at disproportionately high levels are also those most often in need of oral health care. In the general population, **African Americans, Hispanics and Native Americans are less likely to have visited a dentist within the past year and more likely to have untreated dental caries than white counterparts;** African American males also have the highest incidence of oral and pharyngeal cancer (Satcher, 2003). In prison, the same conditions prevail. Whites had fewer decayed teeth than black inmates and the number of missing teeth increased with age (Mixon, et al, 1990).

Unfortunately, having missing teeth is becoming a telltale sign of having been incarcerated. Poor oral health has serious health implications leading to nutritional problems, and complicating chronic conditions such as diabetes, cardiovascular disease and oral cancers. Equally important, poor oral health constrains social, professional, and personal relationships. A person with missing teeth or in poor oral health is less likely to be hired for a job. And for someone ill or in pain from a cavity, impacted tooth, or oral cancer, searching for a job is almost impossible. Though no direct correlative studies have been conducted, African American men have the highest death rate from oral cancer (Ahluwalia, et al, 2005).

...people in prisons are more likely to die of AIDS than other Americans...

HIV/AIDS

In 2004, there were an estimated 23,046 people incarcerated in state and federal prisons who were known to be infected with HIV. Of known cases, 21,366 state inmates and 1,680 federal inmates were HIV-positive. In addition, there were 5,483 confirmed AIDS cases among inmates with 4,842 in state prisons and 641 in federal prisons. The rate of confirmed AIDS among the prison population was 3 times higher than in the U.S. general population. Almost 3 percent (2.6 percent) of all females in state prison were HIV positive compared to almost 2 percent (1.8 percent) of males. (Maruschak, 2006)

Equally disconcerting is that people in prisons are more likely to die of AIDS than other Americans – their rate is 1.5 times that of the general population between the ages of 15 and 54 in 2003. Maruschak (2006) estimates that among prisoners, 1 in 13 deaths could be traced to AIDS-related causes; in the general population, the figure would be closer to 1 in 23. At least two-thirds of AIDS-related deaths were among black inmates. In fact, Maruschak found that black inmates in state prisons were about "2½ times more likely than whites and 5 times more likely than Hispanics to die from AIDS-related causes" (2006, p. 9).

Considering that only a handful of U.S. state and federal prison systems conduct mandatory screening of inmates, these estimates are probably low (Braithwaite, et al, 1996). **But inmates clearly have higher rates of HIV/AIDS than the general population and a greater likelihood of dying from the disease – a stark reality seldom remarked upon by public health officials, the public, or policymakers.** Yet understanding what we now do about how to manage HIV/AIDS as a chronic illness, the death rate of prisoners is unnecessarily high and brings to light disparities between care inside of prison walls and in society as a whole.

To reverse this trend, prisoners need a continuum of care and counseling not only while they are incarcerated but

also once they return home. Since many inmates do not have insurance or the reinstitution of their Medicaid benefits has been delayed because the process can take weeks to months - if they are eligible at all - they do not have medical care or medication. Pre-release planning to manage HIV/AIDS could ensure that networks for payment and facilitated access to services be in place prior to an individual's return to the community. Outreach workers collaborating with parole and/or probation officers could mediate this process.

Mental Health

Incarcerated inmates suffer from many mental health conditions. Data from 1997 indicate inmates in state prisons had schizophrenia and another psychotic disorder (2 to 4 percent), anxiety disorder (22 to 30 percent), post-traumatic stress disorder (6 to 12 percent), major depression (13 to 19 percent), bipolar disorder (2 to 5 percent), and dysthymic disorder or chronic low-grade depression (8 to14 percent). For those incarcerated in federal facilities, the prevalence of these mental health conditions are lower with approximately 2.5 percent suffering from schizophrenia or another psychotic disorder; 13 to16 percent with major depression; 1 to 3 percent with bipolar disorder; 6 to 12 percent with dysthymia; 18 to 23 percent with an anxiety disorder; and 4 to 7 percent with post-traumatic stress disorder. Of inmates in jails approximately 1 percent had schizophrenia or another psychotic disorder; 8 to 15 percent had major depression; 1 to 3 percent bipolar disorder; 2 to 4 percent dysthymia; 14 to 20 percent an anxiety disorder; and 4 to 9 percent post-traumatic stress disorder. (National Commission on Correctional Health Care, 2002)

More recently, James and Glaze (2006) cite Bureau of Justice Statistics from 2005 indicating that ***more than 50 percent of all people in U.S. prisons and jails suffered from a mental health issue (psychotic disorders, major depression, and other conditions) – specifically, 705,600 inmates in state prisons (56 percent), 70,200 in federal prisons (45 percent), and 479,900 in local jails (64 percent). White inmates were more likely to have diagnosed mental health problems than blacks and Hispanic inmates (among state inmates: 62 percent white, 55 percent blacks and 46 percent Hispanics; among jail inmates: 71 percent whites, 63 percent blacks, and 51 percent Hispanics).***

Even though males have higher incarceration rates than females, incarcerated women have higher rates of mental illness than their male counterparts – in state prisons (73 percent of females compared to 55 percent of male inmates), federal prisons (61 percent of females compared to 44 percent of males), and local jails (75 percent of females compared to 63 percent of male inmates). **Of women with mental health issues in state prison, 68.4 percent reported past physical and sexual abuse. (James and Glaze, 2006)**

Many inmates with mental problems also have a co-occurring disorder of substance abuse. James and Glaze (2006) found that 63 percent of state prisoners with a mental health problem also used drugs in the month before their arrest. In general, rates of alcohol or drug abuse and dependence are

high, with local jail inmates at 76 percent, state prisoners at 74 percent, and federal prisoners at 64 percent. Since many people self-medicate with marijuana, hashish, and alcohol, data also suggest that rates of substance use among inmates with mental health problems were high in the month before an offense, specifically 46 percent among state prisoners, 41 percent among federal prisoners, and 43 percent among jail inmates. In addition, about 43 percent of state prisoners, 38 percent of federal prisoners, and 48 percent of jail inmates indicated they had participated in binge drinking in the past. Inmates with mental health problem also were twice as likely to be homeless in the year before their arrest. (James and Glaze, 2006)

In a 2000 Bureau of Prisons analysis examining the co-occurrence of substance abuse disorders with depression and antisocial personality disorder (APD) among federal inmates, researchers noted that "38 percent of the male inmates dependent on one or more drugs had a diagnosis of APD as compared with 43 percent of the drug dependent women. In contrast, women were more likely to have a diagnosis of depression. Seventeen percent of the drug dependent males had a lifetime diagnosis of depression compared with one-third of the drug dependent female inmates" (p.1). These results indicate the need for greater monitoring and assessment for inmates that are dually diagnosed with substance abuse and mental health disorders.

Despite the prevalence of mental health conditions among inmates, many do not receive the treatment they need. In 2005, only 1 in 3 state prisoners and 1 in 6 jail inmates received treatment following admission (James and Glaze, 2006). Beck and Maruschak (2000) cite Bureau of Justice Statistics indicating that in 2000 only 1,394 of 1,558 state public and private adult correctional facilities provided mental health services. Of the facilities for state prisoners, Beck and Maruschak also noted "70 percent of facilities housing state prison inmates screened inmates at intake; 65 percent conducted psychiatric assessments; 51 percent provided 24-hour mental health care; 71 percent provided therapy/ counseling by trained mental health professionals; 73 percent distributed psychotropic medications to their inmates; and 66 percent help released inmates obtain community mental health services" (p.1). Furthermore, 10 percent of inmates were receiving psychotropic medications and less than 2 percent of state inmates were in a 24-hour mental health unit.

As stated earlier, inmates suffer from many mental

conditions including depression, bipolar disorder, and schizophrenia. Some inmates also commit suicide. Mumola (2005), citing data from 2000 through 2002, notes that **white jail inmates were six times more likely to commit suicide than black inmates and more than three times more likely than Hispanic inmates.** In the same analysis, males in local jails were 50 percent more likely than female inmates to commit suicide and violent offenders had a suicide rate three times that of non-violent offenders.

Screening techniques that are effective, culturally sensitive, and accurate must be developed to correctly detect and diagnose mental health problems, especially among African Americans and Hispanics (Borowsky et al, 2000; Baker and Bell, 1999). While incarcerated, those with mental health conditions need treatment regimes that provide for assessment to determine proper treatment modality, extensive case management, and discharge planning upon release. Once they reenter the community, they also need facilitated access to social services, medical services, housing, transportation and employment and linkages to ongoing treatment programs (Welsh and Ogloff, 1998).

Substance Abuse

The extent of drug use and abuse among people in jails and prisons is well-documented and provides another lens to consider the breadth of need for treatment among prisoners. Mumola and Karberg (2006) note that in 2004, 56 percent of state inmates and 50 percent of federal inmates used drugs a month before committing the offense for which they were incarcerated. Writing about state inmates they note: "a third committed their current offense while under the influence of drugs, more than half used drugs within the month of their current offense, and two-thirds used drugs regularly" (p.2). The most commonly used drugs by state inmates a month before their current offense were marijuana (40 percent), cocaine or crack (21 percent), stimulants (12 percent), heroin and other opiates (8 percent), and hallucinogens (6 percent). Of those inmates in federal prisons, 26 percent used drugs at the time of their current offense and 50 percent within a month of their current offense. Of federal inmates, the most commonly used drugs a month before their current offense were marijuana (36 percent), cocaine or crack (18 percent), stimulants (11 percent), heroin and other opiates (6 percent) and hallucinogens (6 percent).

For state inmates, 53 percent to 58 percent of all racial/ethnic groups reported using drugs in the month before the offense. For federal inmates, 58 percent of whites, 53 percent of blacks, and 38 percent of Hispanics reported using drugs in the month before the offense. In federal prisons, Mumola and Karberg (2006) note "men (50 percent) were slightly more likely than women (48 percent) to report drug use in the month before the offense in 2004" (p.3). On the other hand, in state prisons, women (60 percent) were more likely to use drugs in the month before their current offense (56 percent for men). Fourteen

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percent of drug abusing inmates in state prisons were homeless the year prior to admission and 68 percent were employed in the month prior to incarceration.

Thirty-nine percent of recent drug users in state prison reported participation in a variety of drug abuse programs including self-help groups, peer counseling, and drug abuse education programs. However, only 14 percent participated in drug treatment programs with a trained professional. Forty-five percent of federal inmates who were recently incarcerated drug abusers participated in drug abuse programs but only 15 percent received treatment provided by a trained professional (Mumola and Karberg, 2006).

Inmates with substance abuse problems prior to incarceration have a greater risk of contracting a variety of diseases including HIV, multi-resistant tuberculosis, hepatitis B and C, endocarditis, bloodstream bacterial infections, and sexually transmitted diseases (Cole and Littman, 1997). In 1999, the Bureau of Justice Statistics stated that there was a substantial link between drug use and HIV infection. Based on personal interviews with state prisoners, 2.3% of those who said they had ever used drugs were HIV positive as well as 2.7 percent of those who had used drugs in the previous month before their current arrest, 4.6 percent of those had used a needle to inject drugs, and 7.7 percent of those had shared a needle (Maruschak, 1999).

The possible health complications that put incarcerated drug-abusers at risk include liver disease, renal failure, nasal perforation from snorting cocaine or smoking marijuana, and greater susceptibility to strokes and heart attacks from cocaine consumption (McCorkel et al, 1998).

Tearing Down Policy Barriers to Health Care for Inmates

According to the Commission on Safety and Abuse in America's Prisons (2006), there are several policy barriers that prevent inmates from receiving quality health care while incarcerated. These impediments include: inadequate funding of prison health care systems; lack of collaboration and partnerships of the correctional facilities with primary and public health care providers in the community;

lack of consistent screening for infectious diseases; required co-payment by inmates for medical and /or oral health care; and the inability of inmates to receive Medicare and Medicaid while incarcerated. Specifically the report states, "no U.S. correctional institution receives federal Medicaid or Medicare reimbursement for health services provided to prisoners, even though most prisoners would qualify for these benefits and many were enrolled in these programs before incarceration. Medicaid is funded jointly by the federal and state governments, while Medicare is a federal program. Current law prevents the federal government from paying its share" (p.50).

In order to overcome these barriers the Commission recommended the following:

- •Forming partnerships between department of corrections and community health providers to provide culturally competent health services to inmates;
- •Designing a health care delivery system where there is collaboration among medical, correctional and security staff within the facility;
- •Identifying and providing comprehensive treatment for those inmates with mental illness;
- •Screening throughout all prisons and jails for infectious disease based upon a national guideline to ensure a continuum of care once the inmate is released;
- •Repealing state laws that require inmates to pay a co-payment in order to receive medical treatment;
- •Changing Medicaid and Medicare rules that prohibit correctional facilities from receiving federal funds for the health care of inmates that may be eligible; and
- •Making Medicare and Medicaid benefits available to eligible inmates immediately upon release.

In addition to the Commission's recommendations, it is imperative to provide coverage, either through Medicaid or some other form of public coverage as a part of a national access program.

Why We Must Act Now

Implementing the Commission's recommendations would represent a bold step toward improving the treatment and care of men and women in prisons and jails for those going home. But in order to truly improve the health of prison populations, we must address the stigma of incarceration as well because, although it is seldom spoken aloud or acknowledged, the underlying belief that those convicted of crimes do not deserve comprehensive health care is the most solid barrier to improving health services to prisoners. Perhaps that is because, although all Americans are laden by the social, economic, and health consequences of incarceration, some groups are more burdened than others. African American communities – and men in these communities, statistics show – bear the heaviest burden of all. This gives some in our society cover to ignore cruel inequities. 'Why should we care?' these voices ask blandly. 'Why should inmates have better health care than law-abiding Americans?'

...tackling prison health care is not only the right thing to do, the the smart thing to do- because to do otherwise puts our viability as a society at stake.

The answer is two-fold: First, ***the cost to incarcerate one individual for one year was almost $23,000 in 2001 compared to $5,700 for one year at community college (Bureau of Justice Statistics, 2004; U.S. Department of Education, 2006). Taxpayers want the greatest return on their valuable tax investments. Under the current criminal justice systems, the costs to taxpayers will only rise as the likely return diminishes.*** By contrast, paying attention to serious health issues during and after incarceration is an investment that can only benefit public health. Secondly, even though the logistics may be complicated, the reason is simple – ***because we must*****.** Health care is a basic human right for those in prison, just as it is for those of us on the outside, whatever current payment systems may indicate to the contrary. As we formulate national health objectives for 2020, it is important ethically and morally to give priority to the most vulnerable – among them, people in prisons and jails. It is unthinkable that we in the richest nation in the world, the self-proclaimed "land of the free," would stand idly by watching people suffer and die from preventable diseases and conditions. **So, although standards and practices to protect and treat prisoners are a first step, sufficient human caring must be part of policy as well.** To do otherwise is to endorse a form of genocide, albeit hidden behind bars in American jails and prisons.

Looked at from another angle, tackling prison health care is not only the right thing to do, but the smart thing to do – because to do otherwise puts our viability as a society at stake. **If we do *not* act, the public health crisis and health care costs that will emerge – which we are beginning to witness with the skyrocketing HIV rates in African American women – will decimate our health care system, our communities, and mortgage future generations.** Prison health and the public's health are intertwined. What we need is immediate and determined action to address social institutions broken almost irretrievably. In making our laws and practices more humane and more just, we will demonstrate that the hard lessons of past and contemporary history have not been wasted.

".. in the world,... the health of each one member rises & falls with the health of all others." – Laurie Garrett

Where to Improve the Health of Those Coming Home

What policymakers and practitioners must do to stop the unnecessary human suffering and death caused by incarceration for health public and social justice reasons, and to end the alienation that is magnified by factors such as race, gender, and poverty:

Expand Health Care Coverage – Provide health care coverage for comprehensive primary health care that includes mental health care, substance abuse treatment on demand, and

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oral health care that includes all African American, Latino, and other poor men, as well as white men who are age 18 or over. Individuals leaving jail or prison must have insurance cards in their possession as a part of the discharge process, be referred to a specific community-based provider, and networked with a community outreach worker because coverage alone does not equate to accessible quality health care. The outreach worker who must be employed by the health care system or a community-based not for profit, must be paid a salary and benefit as a part of the Medicaid program and be formally recognized by parole and probation officials. The outreach worker must facilitate the rapid (within 7 work days) connection of the individual to health and social service providers.

Eliminate Co-payments – Co-payment for primary health care services including oral health services received in prison must be outlawed and entities guilty of violating this law must risk the loss of all local, state, and federal income support.

Extend Medicaid Coverage – Medicaid coverage must be extended to all those returning to community and states required to pay for such coverage.

Include Oral Health Care – Oral health coverage must become a part of services mandated by Centers for Medicare and Medicaid Services (CMS) as a part of state benefits programs. Where Dental Practice Acts restrict the practice of hygienists so that they cannot work offsite not under direct supervision, the individual state legislatures must amend these acts until a full culturally competent workforce of dentists is made available for full and part time work for the poor in their communities and in jails/prisons.

Increase Training of Health Care Providers – Primary care physicians and front-line workers (nurse practitioners and others in the nursing workforce) must be trained through postsecondary and continuing education courses to screen for signs of mental distress using culturally sensitive screening regimens and to provide medications and referrals for community-based counseling.

Increase the Number of Providers – All Graduate Medical and Nursing Education (GMNE) institutions must be required to provide health services, mediated by faculty and students in a sustained manner to these populations by

priority until disparities are reduced in the areas of primary health care, mental health and substance abuse treatment in recognition of their support from local, state and federal taxes and as demonstration of direct community-benefit for the aforementioned support.

Mandate Collaboration – All federally-funded and state-supported community-based clinics must have an approved and auditable plan for how they will work collaboratively with jails and prisons to include local district attorneys and departments of corrections in their area of service or risk loss of their status and funding. At the same time, the United States Congress must declare that the U.S. Department of Justice make it mandatory that all criminal justice entities have in place formal linkages with health, housing, social services, employment, and transportation agencies to give meaning to all of the mandates that must be put in place.

Address Barriers to Housing for Ex-offenders Verifiable housing must be available to the individual leaving jail or prison. The outreach worker and parole and probation officers must confirm that the available housing is located near transportation routes and neighborhood services and conveniences (viz. grocery, pharmacy and so forth). Housing policies that must be reversed are those that effectively bar men from coming home to their mothers, the mothers of their children, or to other individuals significant to the ability of the returnee to establish him or herself permanently in an identified community. Specifically: (1) the U.S. Department of Housing and Urban Development must remove from its books the option of local governments to bar community citizens, many of whom work or have worked at some time and paid taxes to build publicly subsidized housing (single units or multiple unit properties); (2) the U.S. Department of Housing and Urban Development must devise and grant incentives to locales that identify land where housing can be built, in collaboration with area for profit builders to increase housing stock, given the large number of individuals coming home as a result of the investment in building communal dormitories in rural communities that are designated as places to incarcerate individuals. This public policy supported displacement to rural community of individuals must be matched by a concomitant investment in relocation of the individuals back into their original homes, if the family or relation is willing and able to accommodate them; (3)

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Municipalities and states that fail to find a way to provide and/or build housing for returnees will be penalized by the payment of a tax penalty with the penalty funds being provided directly to individuals and agencies that exercise creative collaboration in development of housing options; and (4) Multi-state, multiple family, for-profit property owners must allocate ten percent of their housing stock for individuals and their families coming home in return for the tax benefit and local anonymity that the these owners enjoy as a result of differential tax systems in other states to which the funds are sent nationally owned housing conglomerates.

Address Barriers to Employment for Ex-offenders-

(1) Federal and state governments must continue and make more attractive its incentives program to employers that hire those coming home into positions that pay a living wage; (2) All State governments through a vote of the legislature and/or of the electorate must make it illegal for individuals to be barred from employment in any position based on their past felony conviction(s); (3) Federal and state governments must make available small loans programs to assist those coming home in setting up their own businesses (e.g. car detailing services, landscape services, food services, and any other businesses), provide training for the entrepreneurs in business plan development, fiscal management, and compliance with tax and other regulatory codes; (4) Federal and state funds should be available through relocation assistance programs to assist individuals with the purchase of transportation if public transportation is not available to them to support work, visits to health and social service providers, and to take care of other regular personal and household needs (e.g. groceries for the purchase of economically priced and fresh vegetables to promote good nutrition and health); and (5) Prison Industry Enterprise (PIE) must be given an incentive to relocate to areas to which the individuals are returning to provide employment. ***Where these industries have business enterprises in the rural and urban community, the PIE must show a direct relationship between working in the PIE and employment by that same firm in some capacity when the individual returns home.*** PIEs must themselves cover charges that prisons are passing on to prisoners for housing and food as a result of their access to labor. And, PIEs must pay at least minimum wage that is to be used by the prison employee to make childcare payments, build income to use for re-entry, and ultimately give meaning to the term "rehabilitation."

Address Food Security Issues – Food stamps must be automatically provided to every individual leaving prison and eligibility for continuing food stamps must be pre-authorized as a part of the separation from confinement process

Address Barriers to Family Connection – Individuals with children must be provided with free phone calls at least two times per month so that they can maintain a social and parenting relationship with their children and with the child's caregiver. By the same token, transportation for a prisoner's family to visit those held more than 50 miles from home must be provided to the family without charge. This quid pro quo is reasonable and rational given the decision to displace individuals far away from their homes.

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Increase Systematic and Ongoing Collection of Data- A system of data collection must be initiated that integrates the health data of prisoners with the data of communities to provide an accurate assessment of the health disparities in the African American communities that are inflicted as a result of the prison health system. Such a system will foster systems changes that can provide a more comprehensive system of health care to those communities and individuals in greatest need of care.

Create a Framework for the Development of Prison Health Standards – A national task force should be established through an organization such as the Institute of Medicine to provide standards for quality health care and to enforce laws and regulations. Another national entity should be charged with enforcing laws, regulations & general standards related to access to comprehensive care, protection from rape, provision of sterile equipment for tattooing, and oversight of other activities and services that will protect the health and human rights of those imprisoned, as guaranteed by the Constitution of the United States of America.

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

-Rev. Dr. Martin Luther King, Jr.

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