

Journal of Correctional Health Care

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JOURNAL OF CORRECTIONAL HEALTH CARE 2007; 13; 80

DOI: 10.1177/1078345807301143

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Prison Health and the Health of the Public: Ties That Bind

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Journal of Correctional
Health Care
Volume 13 Number 2
April 2007 80-92
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10.1177/1078345807301143
<http://jchc.sagepub.com>
hosted at
<http://online.sagepub.com>

The social, economic, and health consequences of incarceration can no longer be ignored. The disparities experienced by individuals in U.S. jails and prisons reflect the human and social consequences of political policies and cultural biases. More punitive sentencing policies have had a direct impact on ethnic and minority communities. Increasing rates of incarceration and the disproportionate impact on African Americans have resulted in the destruction of entire families and urban communities and increasing health disparities. Rather than mirroring the general population, the proportion of people of color in U.S. prisons and jails reflects the prevailing economic, health, and educational disparities. Rates of communicable and chronic disease during incarceration and upon release demonstrate the severity of these disparities and the extent of unmet health needs, including HIV, sexually transmitted diseases, tuberculosis, chronic disease, mental illness, and substance abuse. The complications of these conditions and the lack of resources and the barriers inmates face when they return to the community are national problems that must be addressed through policy decisions and collaboration and coordination at the local, state, and federal levels.

Keywords: public health; prison health; correctional health care; reentry; health disparities

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, 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 Online Dictionary*, www.m-w.com).

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

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The author declares no conflict of interest. For information about *JCHC*'s disclosure policy, please see the Self-Study Exam.

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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 & Beck, 2006). 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. A growing body of evidence points to levels of ill health and inadequate treatment that suggest a willful disregard of prisoners' basic human rights. Whatever the length of individual sentences, taken as a group, prisoners are more likely to suffer serious illness and premature death. And those risks are compounded by the many systemic barriers to receiving needed health services once they are released.

At present, health care provided in the prisons across the United States varies greatly. Although standards of care for inmates are promulgated by the National Commission on Correctional Health Care (NCCCHC) and other organizations, as well as various government agencies, compliance with these standards is voluntary and no one set of standards is universally accepted. Dr. Robert Greifinger, a 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 & Formicola, 2005). With longer prison sentences, more men and women are growing old in prisons and developing the diseases of the elderly (respiratory illness, 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, Graham, Lawrence, & Shansky, 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. 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 multidrug 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; NCCCHC, 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, Schoenbach,

& 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. S44).

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.

The People in Our Prisons and Jails

At the end of 2005, nearly 2.2 million men and women were incarcerated in jails and prisons in the United States—the rough equivalent of one out of every 136 U.S. residents. Of those inmates sentenced to at least 1 year in prison, 547,200 were African American males; this represents 40% of this population, compared with 35% for Whites and 20% for Hispanics. Moreover, African American males aged 25 to 29 years had the highest incarceration rate when compared with other racial and ethnic groups. In 2005, 8.1% of African American males in this age group were incarcerated compared with 2.6% Hispanic and 1.1% White (Harrison & Beck, 2006).

The same data show that women represented 7% of all prisoners, an increase from 6.1% 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 imprisoned and three times as likely as White women (Harrison & 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, more than 700,000 people incarcerated in state and federal prisons were parents. Data from 1997 indicate that before incarceration, more than 70% in both state (70.9%) and federal (73.5%) prisons were employed, taxpaying citizens. These wage-earning men and women were parents to at least 1.5 million minor children, most of them (58%) younger than the age of 10 with an average age of 8 (Mumola, 2000).

Looked at another way, these data indicate that only 2% 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 nine times more likely to have a parent in prison than white children and Hispanic children were three 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—and in particular their potential for incarceration themselves (Travis & 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 older in prison. Between 1992 and 2001, the number of inmates aged 50 years or older increased 172.6%, representing almost 8% of the prison population in 2001 (Anno et al., 2004). This graying of the prison population impacts both health care needs and possibilities for resocialization. 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 after release compounds health consequences for the prison population. Because 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- 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 workers and their families. Moreover, some jobs may not allow employees to take time off for medical care, forcing the low-wage ex-offender to choose between 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 reestablish 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 hardscrabble existence or repeated sentences. Resources must be provided to those reentering society through prerelease 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 on the prison system from the 1980s onward. Between 1986 and 1991, the number of state prison inmates incarcerated for drug offenses rose from 9% to 21%. In the federal system, the drug offender population rose from 25% in 1980 to 61% in 1993. Overall, the state and federal prison population increased from 329,821 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. Whereas the number of White inmates increased 163% from 1980 to 1993, the roll of Black prisoners increased by 217% (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 at 89 months compared with that of a White offender at 70 months (Cole & Littman, 1997).

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 dealt a heavy blow to prison health care systems across the nation. 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. The U.S. Department of Justice reported that state prisons spent \$3.3 billion on inmate medical care in 2001, a 34% increase over 1996 (Stephan, 1999, 2004).

Communicable and Chronic Diseases

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

Failure to provide prisoners with comprehensive medical care fuels public health crises both inside and outside of the correctional facility. Because inmates with chronic diseases are in poor health, 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 before 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 their 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. The number of missing teeth increased with age (Mixon, Eplee, Feil, Jones, & Rico, 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, Ro, Erwin, & Treadwell, 2005).

HIV/AIDS

In 2004, an estimated 23,046 people incarcerated in state and federal prisons 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. In state prisons, 2.6% of all females were HIV positive compared with 1.8% 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 (2006) 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" (p. 9).

These estimates may be low: In a 1996 report, only a handful of U.S. state and federal prison systems conducted mandatory screening of inmates (Braithwaite, Hammett, & Mayberry, 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 on 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. Because many releasees do not have insurance or Medicaid coverage (reinstitution of their benefits can take weeks to months if they are eligible at all), they do not have medical care or medication. Prerelease planning to manage HIV/AIDS could ensure that networks for payment and facilitated access to services be in place before an individual's return to the community. Outreach workers collaborating with parole and/or probation officers could mediate this process.

Mental Health

Incarcerated people suffer from many mental health conditions. Data from 1997 indicate that inmates in state prisons had comparatively high rates of schizophrenia and another psychotic disorder (2% to 4%), anxiety disorder (22% to 30%), posttraumatic stress disorder (6% to 12%), major depression (13% to 19%), bipolar disorder (2% to 5%), and dysthymic disorder or chronic low-grade depression (8% to 14%). In federal facilities, the prevalence of these mental health conditions is lower, with approximately 2.5% suffering from schizophrenia or another psychotic disorder, 13% to 16% with major depression, 1% to 3% with bipolar disorder, 6% to 12% with dysthymia, 18% to 23% with an anxiety disorder, and 4% to 7% with posttraumatic stress disorder. Of inmates in jails, approximately 1% had schizophrenia or another psychotic disorder, 8% to 15% had major depression, 1% to 3% bipolar disorder, 2% to 4% dysthymia, 14% to 20% an anxiety disorder, and 4% to 9% posttraumatic stress disorder (NCCCHC, 2002).

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

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% of females compared to 55% of males), federal prisons (61% of females compared to 44% of males), and local jails (75% of females compared to 63% of males). Of women with mental health problems in state prisons, 68% reported past physical and sexual abuse (James & Glaze, 2006).

Many inmates with mental problems also have a co-occurring disorder of substance abuse. James and Glaze (2006) found that 63% 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%, state prisoners at 74%, and federal prisoners at 64%. Because 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% among state prisoners, 41% among federal prisoners, and 43% among jail inmates. In addition, about 43% of state prisoners, 38% of federal prisoners, and 48% of jail inmates indicated they had participated in binge drinking in the past. Inmates with mental health problems also were twice as likely to be homeless in the year before their arrest (James & Glaze, 2006).

In a 2000 Bureau of Prisons (n.d.) analysis examining the co-occurrence of substance abuse disorders with depression and antisocial personality disorder (APD) among federal inmates, researchers noted that "38% of the male inmates dependent on one or more drugs had a diagnosis of APD as compared with 43% 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 who 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 one in three state prisoners and one in six jail inmates received treatment following admission (James & Glaze, 2006). Beck and Maruschak (2001) 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% of facilities housing state prison inmates screened inmates at intake; 65% conducted psychiatric assessments; 51% provided 24-hour mental health care; 71% provided therapy/counseling by trained mental health professionals; 73% distributed psychotropic medications to their inmates; and 66% help released inmates obtain community mental health services (p. 1). Furthermore, 10% of inmates were receiving psychotropic medications and fewer than 2% 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% more likely than female inmates to commit suicide, and violent offenders had a suicide rate three times that of nonviolent 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 (Baker & Bell, 1999; Borowsky et al., 2000). 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 & 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. Mumola and Karberg (2006) note that in 2004, 56% of state inmates and 50% 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%), cocaine or crack (21%), stimulants (12%), heroin and other opiates (8%), and hallucinogens (6%). Of those inmates in federal prisons, 26% used drugs at the time of their current offense and 50% within a month of their current offense. Among federal prisoners, the most commonly used drugs a month before their current offense were marijuana (36%), cocaine or crack (18%), stimulants (11%), heroin and other opiates (6%), and hallucinogens (6%).

For state inmates, 53% to 58% of all racial/ethnic groups reported using drugs in the month before the offense. For federal inmates, 58% of Whites, 53% of Blacks, and 38% of Hispanics reported using drugs in the month before the offense. In federal prisons, Mumola and Karberg (2006) note, "men (50%) were slightly more likely than women (48%) to report drug use in the month before the offense in 2004 (p. 3). On the other hand, in state prisons, women (60%) were more likely to use drugs in the month before their current offense (56% for men). Of drug abusing inmates in state prisons, 14% were homeless the year before admission and 68% were employed in the month before incarceration. Of recent drug users in state prisons, 39% reported participation in a variety of drug abuse programs, including self-help groups, peer counseling, and drug abuse education programs. However, only 14% participated in drug treatment programs with a trained professional. Of federal inmates who were recently incarcerated drug abusers, 45% participated in drug abuse programs but only 15% received treatment provided by a trained professional (Mumola & Karberg, 2006).

Inmates with substance abuse problems before incarceration have a greater risk of contracting a variety of diseases, including HIV, multiresistant tuberculosis, hepatitis B and C, endocarditis, bloodstream bacterial infections, and sexually transmitted diseases (Cole & 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 were 2.7% of those who had used drugs in the month before their current arrest, 4.6% of those who had used a needle to inject drugs, and 7.7% of those who 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, Butzin, Martin, & Inciardi, 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. 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 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, whereas Medicare is a federal program. Current law prevents the federal government from paying its share. (Commission on Safety and Abuse in America's Prisons, 2006, p. 50)

To overcome these barriers the Commission on Safety 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 between 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 on 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 to receive medical treatment
- Changing Medicaid and Medicare rules that prohibit correctional facilities from receiving federal funds for the health care of inmates who may be eligible
- Making Medicare and Medicaid benefits available to eligible inmates immediately upon release

In addition to these recommendations, it is imperative to provide health care 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 recommendations of the Commission on Safety would represent a bold step toward improving the treatment and care of men and women in prisons and jails and for those going home. But 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?"

The answer is twofold. First, the cost to incarcerate one individual for 1 year was almost \$23,000 in 2001 compared to \$5,700 for 1 year at community college (Stephan, 1999, 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.

Second, 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 an important step, sufficient human caring must be part of policy as well. To do otherwise risks wanton indifference and neglect of a vulnerable population 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 also 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 and our communities and mortgage future generations.

Where to Improve the Health of Those Coming Home

Policymakers and practitioners must do the following to stop the unnecessary human suffering and death among the incarcerated for health 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 coverage for comprehensive primary health care that includes mental health care, substance abuse treatment on demand, and oral health care for those returning to their communities from prison or jail. Coverage alone does not equate to accessible quality health care, so the discharge process should entail providing all releases with health insurance cards, referring them to a specific community-based provider, and networking with a community outreach worker. This will remedy the coverage gaps experienced by many poor men, in particular those who are African American or Hispanic.

Eliminate co-payments. Co-payment for primary health care and oral health services received in prison must be discontinued because it is a disincentive for inmates to seek care when they cannot afford the co-payment.

Include oral health care. Oral health coverage must become an integral part of services required by the Centers for Medicare and Medicaid Services as a part of state benefits programs. Moreover, to ensure sufficient staffing in prison, jails, and underserved communities, as well as a culturally diverse workforce of dental professionals, recruitment efforts must be stepped up to meet the need for dentists and hygienists, and any restrictions that prevent hygienists from serving these populations should be removed.

Increase mental health 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 institutions should be required to provide health services to correctional institutions and to the underserved communities where many inmates return until disparities are reduced in the areas of primary health care, mental health, and substance abuse treatment. Provision of such health services would act as a counterbalance to the support these institutions receive from local, state, and federal taxes.

Encourage collaboration. All federally funded and state-supported community-based clinics should develop plans to work collaboratively with jails and prisons, local district attorneys, and departments of corrections to address the needs of the incarcerated and especially those who are returning to their communities. Also, the U.S. Department of Justice should require that all criminal justice entities establish formal linkages with health, housing, social services, employment, and transportation agencies to facilitate the transition to community for former inmates.

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 and, in particular, inmates and former inmates. Analysis of such data will foster systems changes that will lead to a more comprehensive system of health care to those communities and individuals in greatest need of care.

Promote the usage of national standards. An organization such as the Institute of Medicine should review and recommend standards for quality health care, promote their use, and enforce laws and regulations to ensure quality care. Another national entity should be charged with enforcing laws, regulations, and general standards related to access to comprehensive care, protection from rape, and 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.

Address other barriers to reentry for releasees. Because inmate health does not exist in a vacuum, policymakers must address the other barriers and hidden sanctions that impact the health of inmates and of the communities to which they return. Recommendations include the following:

- To help incarcerated parents maintain family connections, free telephone calls should be permitted to enable them to foster social and parenting relationships with their children and their children's caregivers. In addition, for prisoners held more than 50 miles from home, their families must be given free transportation for periodic visits.
- Address barriers to housing by ensuring that verifiable housing is available to the individual leaving jail or prison and removing restrictions that prevent released inmates from returning to public housing.
- Federal and state governments must make more attractive their incentive programs to employers to hire releasees for positions that pay a living wage. They also should prohibit employers from barring individuals from employment based on their past felony conviction(s).
- Food security must be ensured by providing food stamps to individuals leaving prison and jail, and eligibility for continuing food stamps must be preauthorized as a part of the discharge process.

Prison health and the public's health are intertwined. We need 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.

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