



## **Issue Overview**

# **Health Care in the Criminal Justice System: An Updated Examination of the Issues**

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# **Issue Overview: Health Care in the Criminal Justice System**

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## **Introduction**

In 2003, the Missouri Foundation for Health (MFH) produced an issue brief providing a synopsis of the major health concerns in the criminal justice system. The report found that in comparison to members of ‘free society,’ prisoners have higher incidences of disease, substance abuse, and mental health issues.<sup>1</sup> Additionally, prejudice can create barriers that prevent inmates from receiving the same quality of health care afforded to non-inmates.<sup>2</sup> When exploring the issue of prisoner health, it is important to consider how the U.S. can fairly and adequately care for those convicted of crimes while also funding other vital services for the general population.<sup>3</sup> In 2001, medical care spending for state prisoners totaled \$3.3 billion, or approximately 12 percent of correctional facility operating expenditures.<sup>4</sup> In an attempt to overcome the financial challenges, private foundations have increasingly become involved in the effort to improve correctional health care through a variety of mechanisms.

By request, the MFH health policy staff has produced this updated issue overview on the current state of health care in the criminal justice system. This report attempts to objectively assess the major health needs, concerns, and challenges found within Missouri’s correctional system. This paper includes the following components:

- a brief overview of the criminal justice system,
- federal and Missouri statutory requirements for providing health care to prisoners,
- MFH contributions to correctional health,
- six main health concerns found in prisons and jails,
- philanthropic best practices, and
- recommendations for future MFH involvement.

## **Overview**

Currently, 2.2 million inmates reside in the custody of state and federal prisons and local jails in the U.S., an increase of 2.8 percent from 2005 to 2006.<sup>5</sup> At the end of 2005, an additional 4.9 million men and women were under federal, state, or local probation or parole jurisdiction.<sup>6</sup> In state prisons, between midyear 2005 and midyear 2006, the number of inmates increased 3 percent across the country. During this same time period, Missouri was the jurisdiction with the largest decrease in prison population growth (-2.9%). While Missouri’s decrease in prison population is significant, over 100,000 of Missouri’s residents remain either imprisoned or on probation or parole.<sup>7</sup> Approximately 97 percent<sup>8</sup> of these incarcerated offenders will reenter their communities and face obstacles such as unemployment, felony disenfranchisement,<sup>1</sup> limited housing, poor health, and a lack of access to health services. These obstacles present health implications

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<sup>1</sup> The practice of prohibiting people from voting based on the fact that they have been convicted of a felony.

for the families of inmates and for the health of the general population.<sup>9</sup> Because of this, the criminal justice and public health systems cannot be seen as separate entities.

### **Statutory Requirements for Prisoner Health Care**

The standards for correctional health care have been established through federal court rulings. In 1976, the U.S. Supreme Court decision of *Estelle v. Gamble* decided in favor of a Texas inmate who received insufficient treatment for a back injury suffered while performing prison work. The court concluded that the inmate had been subjected to cruel and unusual punishment in violation of the Eighth Amendment of the U.S. Constitution.<sup>10</sup> The court ruled that prisoners have a right to be free of “deliberate indifference to their serious health care needs.”<sup>11</sup> This landmark case incited drastic changes in the way health care is delivered in prisons and jails, resulting in a multibillion-dollar prison health industry.<sup>12</sup> Since *Estelle*, hundreds of cases have established three basic rights for prisoners: the right to access care, the right to care that is ordered, and the right to professional medical judgment.<sup>13</sup>

The U.S. correctional health care system does not fall under federal guidelines.<sup>14</sup> In 1972, the American Medical Association (AMA) and the American Bar Association (ABA) established a commission to study correctional health services. The commission set the first jail standards in 1976 and the first standards for juvenile facilities and prisons in 1979. This Commission became known as the National Commission on Correctional Health Care (NCCHC) in 1983. NCCHC accredits correctional health care facilities across the nation. The NCCHC standards are labeled either “important” or “essential.” In order for a facility to obtain accreditation they must uphold all essential standards. The Commission is aware of the fact that every facility will not be able to adhere to all of their standards, therefore, only those standards that must be executed at every correctional facility are identified as essential (e.g., providing health assessments, providing care for patients with special needs, and identifying suicidal inmates and intervening appropriately). Many observers believe that several other standards should be identified as essential as well, such as providing chronic disease services, preventing the use of tobacco products, and providing pregnancy counseling.<sup>15</sup>

Courts have mandated that some jails comply with NCCHC standards; however, participation is not mandatory for all correctional centers. NCCHC has accredited 444 correctional facilities, including 252 jails, 56 juvenile facilities, and 136 prisons.<sup>16</sup> Adopting NCCHC standards as a guide provides constitutionally required care to inmates and often protects facilities from litigation.

Missouri has 21 state correctional centers, with 18 male and two female institutions and one treatment center. The state also has a federal prison in Springfield. Nineteen correctional facilities have been accredited by the NCCHC. Accreditation for the Southeast Correctional Center in Charleston is pending. The accreditation application for the Jefferson City Correctional Center has yet to be submitted, but the state intends to have all facilities accredited in the near future.<sup>18</sup> Missouri Statute 217.230 establishes the right to health care for offenders. This right is further established by the VIII and XIV

amendments of the U.S. Constitution.<sup>19</sup> The goal of Missouri’s correctional health care system is to “return offenders to the community as medically stable as possible, so they may become productive citizens of the state.”<sup>21</sup> The Missouri Department of Corrections’ (MDOC) approach includes comprehensive medical care for state prisoners through a managed-care system that stresses health care education, disease prevention, immediate identification of health problems, and early intervention to prevent debilitating chronic health problems.<sup>20</sup>

### **MFH Contributions to Correctional Health**

MFH has become increasingly aware of the health implications incarceration places on the community. Through Basic Support funding the Foundation addresses financial burdens by supporting prisoner re-entry programs.

- The Center for Women in Transition (CWIT) has received Basic Support funding to offer services to non-violent women offenders while incarcerated and after release to aid in transitioning back to society.
- Project Cope, a congregational-based organization which provides ex-offenders with immediate basic needs (i.e., food, shelter, health and hygiene, transportation, and employment), currently receives Basic Support funding.

The majority of Project Cope’s clients suffer from both substance abuse and post-traumatic stress disorder (PTSD). Mary Ann McGivern, Executive Director of Project Cope, believes that the prison system does a decent job at providing treatment programs for substance abuse but offers nothing to properly assess, diagnose, and treat PTSD.<sup>51</sup> Project Cope offers basic needs services but also refers clients to medical professionals for appropriate mental health treatment. Without programs such as those offered by Project Cope many ex-offenders would not have the tools needed to transition back to society. MFH also provides Basic Support funding for the Cole County Family, Webster County Adult, and 35<sup>th</sup> Judicial Circuit drug courts. This funding supports evaluation and treatment of offenders, and salaries of substance abuse counselors. The support of prison re-entry programs is one of many options philanthropic agencies can take to address the issues of correctional health. In order to explore other avenues of philanthropic investment, it is important to have an understanding of the major issues that affect individuals in the criminal justice system.

### **Major Health Concerns in the Criminal Justice System**

#### **Background**

The NCCHC holds a national conference on correctional health care every year. The goal of the conference is to “present the most up-to-date and useful information in the correctional health care field.”<sup>52</sup> A representative of the MFH health policy staff attended the 2007 conference in Nashville, Tennessee. The NCCHC conference included sessions which reviewed the accreditation standards for jails, prisons, and juvenile facilities. Other sessions involved discussions on a variety of topics including, providing “quality” health

care, establishing dental programs, evaluating and treating gender identity disorders in prisons, and identifying and treating inmates with Type II Diabetes. Conference participants listed the following as the greatest challenges currently facing correctional health care:

- lack of state financial contributions to correctional health care,
- deficiency in research conducted to provide evidence-based evaluation of program effectiveness, and
- absence of major correctional health care data repository.

Without research and data, the attendees noted, legislators fail to see the need for increased funding.

In general, offenders have higher incidences of substance abuse, mental health problems, and infectious disease than non-offenders. Missouri offenders enter the prison system 10 to 12 years older physiologically than their non-offender counterparts.<sup>22</sup> This aging occurs due to complications from multiple health problems and the low utilization of health care services. Offenders are ineligible to receive Medicaid while incarcerated. Moreover, upon release the Medicaid reinstatement process is time consuming and often fails to address the offender population. The following categorization provides a brief background on the main health issues related to the prison population.

### **Access and Quality Concerns**

The majority of the nation's penal systems provide privatized health care to prisoners. The nation's largest correctional health care firm, Correctional Medical Services, Inc. (CMS) located in St. Louis, provides health services to more than 250,000 inmates at over 300 sites in 24 states.<sup>23</sup> The MDOC Division of Offender Rehabilitative Services contracts with CMS to provide for the health needs of all state inmates. Mental health services are provided statewide through a contract with Mental Health Management Correctional Services, Inc. located in Virginia. Contract monitoring staff "ensure that offenders receive medical care that is equivalent to the community standard and that all mandates of the contract are fulfilled."<sup>24</sup> However, complaints have been filed by inmates citing inadequate treatment and negligence. Substandard care has led to untreated illness and injury and in some instances death. Cases and events that involve violations of prisoner's VIII and XIV amendments are often not widely publicized; however, many advocates and researchers seek to properly address violations of prisoners' rights.

Washington University School of Law professor, Margo Schlanger, conducts research on how litigation induces correctional facilities to change their behavior and policies. Schlanger believes litigation has been the primary method used to create effective change within correctional health care. She states "regardless of how the lawsuits come out, they hold institutions to account, and that tends to make them more attentive to the law."<sup>25</sup> Schlanger's research has required the use of court orders from civil rights cases, but these have been difficult to find. Therefore, with the assistance of fellow colleagues and students Schlanger created the Civil Rights Litigation Clearinghouse. The clearinghouse

contains a database of thousands of documents related to more than 1,000 civil rights injunctive cases from across the nation. Courts have created safeguards in the criminal justice system to make sure that offenders' constitutional rights are upheld. Even with this effort, room for improvement exists within the correctional system, especially as it relates to health care.

### **Chronic Disease**

The NCCHC standard for chronic disease services was established as "important" in 2003. The standard states that "patients with chronic diseases are identified and enrolled in a chronic disease program in order to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function."<sup>26</sup> Over the years state correctional departments have improved the systems that report data on the number of inmates with chronic diseases (e.g., diabetes, asthma, hypertension, major mental illness, and cancer). However, the lack of information available on specific chronic disease programs and the care offenders receive limits the ability of researchers to understand how the criminal justice system addresses these chronic diseases.

National statistics on prisoner deaths from most chronic diseases were not reported prior to the enactment of the Death in Custody Reporting Act of 2000. In January 2007, the Bureau of Justice Statistics released the results of a study on medical causes of death in prisons between 2001 and 2004. The study found that among state prisoner deaths over half resulted from heart disease and cancer. Liver disease, AIDS, heart disease, and cancer accounted for over two-thirds of the prison deaths between 2001 and 2004. The mortality rate for Hispanics and African Americans during this time was the same (206 deaths/100,000 inmates), while the rate for white inmates was 67 percent higher (343 deaths/100,000). Whites also had a mortality rate for heart disease and cancer that was nearly two times that of African Americans and Hispanics.<sup>27</sup> The disparity between white and African American mortality rates may be due to the younger age of the African American prison population. When incarceration rates are estimated separately by age group, African American males in their twenties and thirties are found to have higher rates than other groups.

The total number of reported deaths between 2001 and 2004 was 12,129, a relatively low number considering the total prison population. In general, however, the correctional system does not undertake preventive measures such as intake medical assessment, screening, nutrition and food services, and urgent care, all of which is essential in treating chronic disease.

## Communicable Disease

### Hepatitis C

The hepatitis C virus (HCV) has been established by the National Seroprevalence Survey as the leading cause of chronic blood borne viral infections in the United States. The most aggressive outcome of HCV, progressive liver fibrosis, eventually leads to cirrhosis in approximately 10 to 15 percent of the infected population. Numerous epidemiological studies have concluded that the prevalence of HCV infection in correctional facilities is substantially higher than in the general population (15-40% verses 1.6%). The prevalence rates suggest that between 300,000 and 400,000 HCV-infected people are incarcerated in U.S. prisons or jails at any given point of the year.<sup>28</sup>

At least one-third of all HCV-infected persons pass through a correctional facility in a year. The majority of those infected with HCV will be released to the community. Therefore, management of this infectious disease by correctional health care providers has significant public health implications. Due to this mass concentration, some view prison systems as ideal sites to implement comprehensive HCV prevention and medical management programs.<sup>29</sup>

Correctional institutions, however, face major challenges in their attempts to control the growing HCV epidemic. These challenges include:

- a lack of funding to evaluate and treat the large number of patients,
- a lack of knowledge about managing the disease in the prison environment, and
- the scarcity of follow-up care offered for offenders once released into the community.

As the prison system grapples with treating its large HCV population, new advances in antiviral therapy have been developed with sustained virologic response<sup>ii</sup> rates of 40 to 50 percent. However, only a minority of HCV-infected inmates receive antiviral therapy due to administrative and financial barriers. In addition, the expense of antiviral therapy limits its use in correctional facilities, with a course of treatment estimated as ranging from \$7,000 to \$20,000.<sup>30</sup>

### Tuberculosis

The incidence rate of Tuberculosis (TB) in the general population has remained at fewer than 10 cases per 100,000 since 1993. In correctional facilities, case rates range as high as 10 times that of the general population. In 2005, researchers from the Division on TB Elimination at the Centers for Disease Control and Prevention published a study on the health disparity of TB in the general population compared to correctional inmates from 1993 to 2003. The study concluded that a disproportionately high percentage of TB cases in the U.S. occurs among those in correctional facilities.<sup>31</sup>

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<sup>ii</sup> Sustained virologic response is defined as undetectable HCV for 6 months after completion of therapy.

Common risk factors for those carrying the disease include excess alcohol use, injection and non-injection drug use, and homelessness within one year prior to TB diagnosis. In addition, inmates with TB were more likely than non-inmates with TB to be HIV infected. One study found that HIV infection was documented in 35.8 percent of inmates with TB in state prisons, 20.7 percent in jail, and in 13.2 percent of those in federal prisons. The percentage of TB cases among local jail inmates and federal prison inmates increased between 1993 and 2003. Over the ten year period, the case rate in state prisons decreased from 52.3 per 100,000 to 6.6 per 100,000, a decline of 87.4 percent.<sup>32</sup> This disparity between state and federal prisons may have been due to increased screening for TB in federal prison which resulted in better case detection.

### HIV/AIDS

The most recent national data on reported cases of HIV/AIDS in state and federal prisons are from 2005. The numbers of both HIV-positive state and federal prisoners and AIDS-related prisoner deaths has decreased consecutively for six years. By December 31, 2007 there were 22,480 state and federal inmates who were HIV infected or confirmed as having AIDS, which is a decrease from 22,936 at the end of 2004. Fortunately, the introduction of protease inhibitors and combination antiretroviral therapies in state and federal prisons has successfully reduced the number of deaths and the rate of death due to AIDS-related causes.<sup>33</sup>

Nonetheless, due to the high turn-over of inmates, jails report an alarmingly high rate of HIV/AIDS infection. When individuals who practice unsafe behaviors (i.e., injection drug use and unprotected sex) cycle through the criminal justice system, HIV spreads at a faster rate. A Kaiser Family Foundation 2007 report on HIV/AIDS cases in the Washington, D.C. jail found a large number of HIV cases among female inmates. Over the course of six months, 3,216 inmates were tested for HIV. The report concluded that of the 607 women tested 7.3 percent were HIV positive, compared to 2.7 percent of the men.<sup>34</sup> The suspected major contributors to disease transmission among these women is commercial sex work and injection drug-use. The report also concluded that inmates 45 and older had the highest rate of HIV, with nearly 5 percent of all inmates in this age range testing positive for HIV.

The District of Columbia automatically tests for HIV upon entry and release from jail (unless an inmate refuses to receive a test). The district's jail is one of a few facilities nationwide to offer such testing, and less than 10 percent of inmates refuse testing.<sup>35</sup> Because nine out of 10 D.C. jail inmates are released to the community within 30 days, this automatic testing policy could positively impact the health of the broader community and prevent further infections if tied with appropriate treatment and counseling on preventing the spread of the disease.

## Mental Illness

More than half of all prison and jail inmates have reported a mental health problem according to the Justice Department's Bureau of Justice Statistics. Of all the health challenges that prisons face, mental illness is the most prevalent. The most commonly reported symptoms include characteristics of mania, major depression, and psychotic disorder. Female inmates reported higher rates of mental health problems than male inmates. Table 1 presents the national estimates of inmates who reported symptoms of a mental disorder in 2006.<sup>36</sup>

	Mania	Depression	Psychotic Disorder
Jail	54%	30%	24%
State Prison	43%	23%	15%
Federal Prison	35%	16%	10%

There is a large association between mental health problems and violence and past criminal activity. Approximately 61 percent of state prisoners and 44 percent of jail inmates exhibiting signs of mental health problems have current or past violent offenses.<sup>37</sup> In addition, inmates with mental health problems have high rates of substance dependence or abuse. In 2006, 19.7 percent of admitted offenders to Missouri state prisons were mentally ill, with 46.2 percent of the female population and 14.9 percent of the male population showing symptoms of mental illness.<sup>38</sup>

As a matter of policy, most state prisons and jail jurisdictions as well as all federal prisons provide mental health services to inmates. These services include screening at intake, providing therapy or counseling by trained mental health professionals, and distributing psychotropic medication.<sup>39</sup>

## Substance Abuse

The U.S. domestic war on drugs during the 1980s had an overwhelming effect on the prison system. The number of state prisoners incarcerated for drug offenses rose from 9 percent to 21 percent between 1986 and 1991. In addition, there has been an increase in the population of those who abuse and are dependent on alcohol and drugs. The most recent survey conducted on prison substance abuse took place in 2004 by the Bureau of Justice Statistics. At that time, 53 percent of state and 45 percent of federal prisoners met the DSM-IV<sup>iii</sup> criteria for drug dependence or abuse.<sup>41</sup>

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<sup>iii</sup> The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), is the standardized collection of mental health diagnoses in the United States. Published by the American Psychiatric Association, the manual contains information about each disorder as well as diagnostic criteria.

Ideally offenders would receive drug and alcohol treatment while incarcerated as a method of rehabilitation. However, inmates are more likely to receive treatment or participate in a program following incarceration while on probation or parole. In 2002, one in four dependent inmates received substance abuse treatment after release from prison whereas one in five had this care while incarcerated.<sup>42</sup>

## **Women's Health**

Women represent the fastest growing population within jails and prisons. They comprise approximately 10 percent of the national prison population. Within this group, African American and Latino women are disproportionately represented. The prison system was primarily designed for men and therefore the care, treatment, and services provided generally fail to address the specific needs of women.<sup>43</sup> Studies conducted on preventive care for women in prison have often found that women view their interaction with providers as negative and face obstacles in scheduling tests, obtaining results, and seeking follow-up care.<sup>45</sup>

Women prisoners note that their reproductive health and psychosocial issues are not properly addressed due to the lack of regular gynecological exams, breast exams, and counseling. These beneficial exams can detect disease and potentially provide an early diagnosis. Many female prisoners are survivors of physical and sexual abuse, yet have not received adequate health care. Approximately 44 percent of women inmates reported that they were physically or sexually assaulted at some time during their lives, with 69 percent of these women having the assault occur before they turned 18.<sup>44</sup> Pregnant women who are incarcerated face even greater challenges. Their pregnancies are often complicated by drug and alcohol abuse, smoking, and sexually transmitted infections (e.g., HIV or Hepatitis B). Nationally, a few model programs exist where incarcerated pregnant women can learn about prenatal care and parenting skills; however, these programs are not provided in all jails and prisons.<sup>46</sup>

## **Philanthropic Best Practices**

Due to the lack of financial support of the criminal justice system and the impact of prisoner's health on the broader community, foundations have increasingly become interested in addressing the health issues of the prison population. In 2006, the Jacob and Valeria Langeloth Foundation commissioned a report, *Philanthropic Opportunities in Correctional Health*, which provides a preliminary guide for foundations in addressing the issues of correctional health care.<sup>50</sup> Foundations have typically supported correctional health care programmatically, through prisoner re-entry initiatives or juvenile justice programs that focus on mental health issues, substance abuse, and HIV/AIDS. However, other interesting avenues exist which foundations may use to support and provide services to correctional health care.

The diverse structure of correctional health care systems results in varied services being offered to offenders. Therefore, it is difficult to define a 'best practice' relating to how

health care services should be offered. Nonetheless, many public health or community-based models of correctional health care include the following elements:

- a clear program mission statement,
- strong partnerships with community leaders (i.e., law enforcement and health professionals),
- effective discharge planning from prison,
- community involvement in offering services to ex-offenders (i.e., employment and housing),
- strong case management and outreach while on probation and parole,
- co-location of health practitioners (i.e., where health practitioners work both within the prisons and in the community providing offenders a sense of stability with their health care services), and
- operational support within facilities to encourage correctional workers, health care providers, and community service providers to work across disciplines.<sup>48</sup>

The mission statement associated with any model must place correctional health care in a community re-entry context and must recognize offenders and ex-offenders as displaced members of a community. The model should contain collaborations between community health centers, departments of corrections, departments of public health and mental health, hospitals and clinics, and private providers. Effective discharge planning, community involvement, and strong case management and outreach involve a pre-and post-release phase of treatment and services, as well as adequate interaction between correctional facilities and community partners.

The Langeloth report provides nine specific recommendations for foundation involvement in supporting correctional health care. The recommendations include:

- supporting access to Medicaid funds,
- data collection, research, and evaluation,
- capacity building,
- policy advocacy and system reform,
- training and technical assistance,
- curricula development,
- support services to families of offenders,
- convening stakeholders, and
- gender-specific health care.

The recommendations suggest that offering post-incarceration services and providing services to local jails rather than state or federal prisons may be the most effective way for foundations to become involved in the correctional health care field. The infrastructures of the correctional system remain secretive and highly secure, which often makes it difficult for policy advocacy and philanthropic investment. However, many foundations have found ways to employ Langeloth's recommendations and provide significant investments in correctional health care.

## Uniting Correctional and Community Health

Hampden County (Massachusetts) Correctional Center's Public Health Model of Community Corrections (HCCC) continues to be regarded as the leading model addressing correctional health care. Rather than contracting with one primary health center, HCCC contracts with four community-based health centers. These include one not-for-profit clinic, two centers affiliated with large hospitals, and a federally qualified health clinic. The success of HCCC can be attributed to the leadership of the Hampden County Sheriff and to his understanding of the need for community-based correctional health care. In 2006, the Robert Wood Johnson Foundation (RWJF) granted \$7.5 million to Community Oriented Correctional Health Services, a nonprofit policy research organization, to expand the HCCC model nationwide over the subsequent three years.<sup>49</sup>

## Funding and Advocacy

In Pittsburgh, a group of foundations interested in criminal justice has come together and formed a funders collaborative (i.e., Funders in Criminal Justice (FCJ)). The group has been credited for adding the topic of correctional health care to the Grant Makers in Health annual meeting in February 2006. FCJ has been influential in creating specialty courts, including a drug court and a mental health court that are fully funded by public sources. FCJ relies heavily on private funding which goes toward direct services in jails, primarily in mental health services.

## Prisoner Re-entry in Society and Support Services for Families

On a local level, non-profit organizations in St. Louis, Missouri are providing immediate services for recently released offenders. The mission of St. Vincent DePaul's Criminal Justice Ministry is to "bring Christ's message of compassion, reconciliation, and hope through person-to-person response to the needs of prisoners and their families." This mission is upheld by providing direct religious, health, and education services to offenders. The St. Patrick's Center, addresses the needs of the homeless population some of whom have been recently incarcerated. It offers numerous programs (i.e., substance abuse treatment, GED training, and independent living skills). The St. Patrick's Center also has a 'Healthcare Wing' which provides access to primary health care, medical specialties, and dental care to a population that would be otherwise unserved. The Incarnate Word Foundation empowers women through education in maternal health, domestic violence, and incarceration. This foundation provides specific educational opportunities for women including academics, job and life skills training, and health promotion and prevention.

In general, private foundations across the nation have focused correctional health care initiatives on the jail population due to the greater social and political barriers affecting health care delivery in prisons. However, with over 97 percent of Missouri state and federal prison offenders re-entering the community, foundations that focus on public health have an incentive to overcome the social and political barriers and ensure that prison inmates receive the same quality of care as the general population.

## **Recommendations for Future MFH Involvement**

The Langeloth report along with the efforts of various philanthropic organizations illustrates the capacity to become involved in improving the quality of correctional health care and its effects on the community. Grantmakers are supporting programs which focus on linking correctional and community health, juvenile justice, prisoner re-entry, research and evaluation, policy and system reform, and support services to families of offenders and ex-offenders. As previously mentioned, MFH provides Basic Support funding to programs whose primary interest is prisoner re-entry. However, MFH may wish to become involved in other capacities as well.

### **Policy and System Reform**

The health policy area could get involved on a federal level by educating legislators on the need to reform policies which expand provisions for state and local offender reentry demonstration projects. The projects provide services to offenders and their families upon reentry into society. On the state level, the health policy area could be involved with capacity building, policy reform, and stakeholder convening with grantees and local non-profits which cater to the offender population.

The Langeloth report fails to address litigation; however, the research of Margo Schlanger of Washington University Law, has found that litigation has been extremely effective at changing the policies of correctional health care. The use of litigation against the criminal justice system is not a new concept. In the early 1990s a group of students at law school clinics decided to dedicate their work to exonerating wrongfully convicted people through DNA testing, which reformed the criminal justice system and has helped prevent future injustice. MFH may choose to support innovative solutions to correctional health care issues using similar litigation practices.

Through grants awarded to community justice policy centers or joint law and medical school clinics, students and professors could identify particular problems in Missouri jails and prisons and when warranted file class action lawsuits. New York University has a Medical-Legal Advocacy Clinic where law students work with Social Pediatric medical residents in the Residency Program in Social Pediatrics (RPSP) at Montefiore Medical Center to provide residents of a predominantly African American and Latino community in the South Bronx with comprehensive legal representation and health care services. Additionally, there are numerous colleges and universities including St. Louis University that have joint health and law programs. These programs do not currently address correctional health care in this capacity; but, if offered funding they may rally around the cause.

## Linkage of Correctional and Community Health and Support Services for Families

Programmatically, MFH could expand its efforts and address substance abuse, mental illness, and women's health by:

- using the Mental Health and Substance Abuse (MHNSA) funding stream to support programs whose clients suffer dually from substance abuse and PTSD.
- incorporating the prison population as a target population in the women's health funding area, and supporting re-entry programs specifically designed for women.
- using the Health Interventions in Non-Traditional Settings (HINTS) to continue funding organizations such as churches whose doors are often open to the homeless and recently incarcerated populations.

In addition to funding, MFH can continue to use research as an educational tool to bring awareness to the health care issues offenders and ex-offenders face within prison and in transitioning to society.

### **Conclusion**

This overview of health care in the criminal justice system provides a synopsis of the main issues that affect the health status of inmates in Missouri and the nation. While statutory requirements are in place to address prisoner health care, major issues surrounding access and quality of care, chronic disease, communicable disease, mental illness, substance abuse, and women's health still prevail. Many of the challenges in correctional health care stem from a lack of funding to evaluate and treat large numbers of patients as well as from a lack of follow-up treatment in the community.

A need exists for additional resources from outside state and federal government sources to improve the state of correctional health care. Foundations are becoming increasingly involved in the effort to provide services to offenders transitioning to society. Programs which recognize offenders and ex-offenders as displaced members of the community, involve strong community partnerships, effective case management, and employ committed service providers serve as model programs in addressing correctional health care.

The Missouri Foundation for Health has several existing funding streams which could be used to offer support to correctional health care, namely MHNSA, HINTS, and Women's Health. However, the prison population is one of the most underserved and unserved populations in the nation and could be addressed in some capacity in all funding areas. MFH serves as a conduit for information for policymakers to make important decisions about Missouri residents' health care. Through advocacy, research, and programmatic outreach MFH could increase awareness and improve the health of thousands of displaced individuals every year.

The health of inmates within the nation's correctional system directly affects the health of the general population. The health problems facing these inmates are vast and need to be addressed during and after incarceration. MFH grant making and health policy work may provide a means to address these public health issues that have the potential to ultimately improve the health of all Missourians.

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### **Personal Communication**

Interview with Angela Bliss, National Commission on Correctional Health Care (NCCHC) Accreditation Operations Coordinator, 13 September 2007.

Interview with Brian Hauswirth, Missouri Department of Corrections Spokesman, 13 September 2007.

Interview with Mary Ann McGivern, Project Cope Executive Director, 14 September 2007.

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