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How Health Care Reform Can Transform The Health Of Criminal Justice-Involved Individuals

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ABSTRACT Provisions of the Affordable Care Act offer new opportunities to apply a public health and medical perspective to the complex relationship between involvement in the criminal justice system and the existence of fundamental health disparities. Incarceration can cause harm to individual and community health, but prisons and jails also hold enormous potential to play an active and beneficial role in the health care system and, ultimately, to improving health. Traditionally, incarcerated populations have been incorrectly viewed as isolated and self-contained communities with only peripheral importance to the public health at large. This misconception has resulted in missed opportunities to positively affect the health of both the individuals and the imprisoned community as a whole and potentially to mitigate risk behaviors that may contribute to incarceration. Both community and correctional health care professionals can capitalize on these opportunities by working together to advocate for the health of the criminal justice-involved population and their communities. We present a set of recommendations for the improvement of both correctional health care, such as improving systems of external oversight and quality management, and access to community-based care, including establishing strategies for postrelease care and medical record transfers.

The United States continues to have the world's highest incarceration rates. Growing concern over this epidemic of incarceration^{1,2} led the National Research Council in 2012 to commission a special panel on the causes and consequences of incarceration. The council subsequently convened, with the Institute of Medicine, a workshop of health care, advocacy, policy, and social science experts to discuss the health care challenges and opportunities in the current criminal justice system.³ A number of the workshop participants continued this discussion and developed a set of recommendations that we describe here. These recommendations are intended to improve the health and care of

those involved in the criminal justice system, and they have implications for changes in policy and practice.

Health professions as a whole have not viewed the criminal justice system as part of community health, and criminal justice practitioners have only recently begun to consider the impact that addressing physical and behavioral health conditions can have on reducing criminal behavior. This state of affairs has contributed to a long-standing perception of correctional health as separate from mainstream health care in the United States, with detrimental effects on both public health and public safety. The Affordable Care Act (ACA), in particular, is generally not viewed as being applicable to correctional pop-

ulations, but, in fact, it opens the door to enormous reforms in the continuum of care between correctional and community-based providers.

More than 95 percent of prisoners eventually return to the general population, bringing their health conditions with them, and 80 percent are without health insurance upon reentry into the community. As a result, treatment initiated during incarceration frequently stops when an individual returns to the outside world, including even HIV care, which often receives priority treatment in the incarcerated setting.^{4,5} Risk of emergency care, hospitalization, and death is exceptionally high after release from jail or prison.⁶⁻¹⁰

Community providers inherit all of these problems. Drawing incarcerated populations into the community health care framework is critical for the nation, and it is especially relevant for poor communities, communities of color, and other socially marginalized groups that are both disproportionately imprisoned and often disenfranchised from medical care. Given the racial disparities of incarceration, if criminal justice involvement were to lead to increased access to health care upon release, this could cause a decrease in the racial disparities regarding health and health care in the community.

The State Of Correctional Health In The United States

Unprecedented incarceration rates in the United States began their dramatic increase in the 1980s. At that time, incarceration became the favored punishment for drug crimes, nonviolent offenses, and minor infractions, such as missing parole meetings and loitering.¹¹ Simultaneously, limited availability of community-based substance abuse treatment and mental health care led to the diversion of many people into the criminal justice system.¹²⁻¹⁵

More than half of all prisoners have an addiction, mental illness, or both, putting them at increased risk for HIV, hepatitis C, sexually transmitted diseases, and other infections, all of which are highly prevalent in the incarcerated population.¹⁶ In addition, an estimated 39–43 percent of all prisoners have at least one chronic condition, such as diabetes or hypertension,^{17,18} and that rate is expected to rise dramatically with the aging of the correctional population.^{19,20} Further complicating their health profiles and risks, prisoners often lack health insurance and access to preventive and primary care before and after their incarceration.

Within correctional institutions, there have been substantial improvements in health care

since the 1976 Supreme Court decision *Estelle v. Gamble*, which found that deliberate indifference to prisoners' serious medical needs violates the Eighth Amendment's prohibition of cruel and unusual punishment. While the 1996 Prison Litigation Reform Act restricted the litigation that can be brought by prisoners, *Estelle v. Gamble* opened legal avenues that led to expanded and improved health services for prisoners.^{21,22} Yet correctional health care continues to be inadequate in many facilities. A shortage of clinician staffing is a serious problem in many correctional facilities. Health outcomes resulting from such shortages were highlighted in testimony in the 2011 Supreme Court case *Brown v. Plata*, which noted that overcrowded conditions in California seriously impeded the delivery of health care and created a staff culture of "cynicism and fear."^{23,24}

All prisoners are supposed to be screened for suicide risk and medical history at admission, and most of them receive such screenings at most correctional facilities. However, far fewer prisoners receive postadmission medical exams and diagnostic blood tests. Moreover, few data are collected on whether the appropriate treatment is provided once a prisoner is diagnosed with a condition. This is especially true for substance abuse disorders. By one estimate, 70–85 percent of state prisoners were in need of drug treatment, while only 13 percent actually received care.^{15,25} In jails, where many people remain in custody for less than forty-eight hours, medical follow-through is especially challenging.

General conditions of confinement in prisons and jails also have health consequences. For people living especially chaotic lives, incarceration can provide a stable environment with regular meals; reduced access to alcohol, drugs, and cigarettes; and increased access to health care. In fact, 40 percent of inmates are first diagnosed with a chronic medical condition while in prison.²⁶ However, this increased stability and access to care also comes at the price of higher levels of stress and other adaptations to severe conditions of confinement that may bring about adverse psychological changes and harm.²⁷ A number of the detrimental effects of prison life, particularly psychological and psychiatric complications, are not manifested until long after release.²⁷

Recommendations

Incarceration presents an important public health opportunity to screen and treat the medically disenfranchised. However, incarceration rates have long since surpassed the threshold (estimated at 325–430 per 100,000 residents)

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at which the negative effects of imprisonment on both public health and public safety outweigh any positive effects of increased screening and treatment.^{28,29} Our primary recommendation to policy makers and health professionals is to develop and support alternatives to imprisonment whenever they are appropriate, especially for first-time, nonviolent offenses such as possession of drugs for personal use. Diversion to drug and mental health courts, which generally try to solve problems for their clients, has been shown to both improve treatment retention and reduce recidivism.^{30,31} Below, we present a series of additional recommendations addressing two aspects of criminal justice-related health: improving care within correctional facilities and increasing access to community-based care before and after incarceration.

IMPROVING CARE WITHIN CORRECTIONAL FACILITIES Correctional health care is integral to community health care. With increasing attention to the standardization of clinical guidelines, it is crucial to ensure that correctional health care does not receive a “carve-out,” or separate set of rules or regulations, that permits setting lower standards of care. Correctional health care is unlikely to improve unless the barriers that currently separate correctional and community providers are reduced.

The enactment of the ACA provides an important opportunity for more general discussions about improving health services in the United States. Taking full advantage of this opportunity will require community and correctional providers to work together. Correctional providers can advocate for their patients by drawing attention to inadequate resources for appropriate testing and treatment and other conditions that compromise health or care delivery, including poor sanitation and excessive use of force. At the same time, the broader health professions should leverage their traditional moral authority into civic engagement on behalf of their collective patient body, which includes prisoners. For example, the health professions, through their professional societies, could push for legislative initiatives to improve transitional care programs for prisoners. The support of the health professions may help correctional and public officials emphasize the importance of improving the quality of health care not only during incarceration but after releasees return to the community.

Improving correctional care and postrelease outcomes will also require improving systems of external oversight and quality management, including appropriate definitions of quality of care. The current lack of standardized data collection and reporting makes it almost impossible to determine the extent and quality of correc-

Incarceration presents an important public health opportunity to screen and treat the medically disenfranchised.

tional health care across the country. Increased oversight and accountability are particularly important given the expansion of privately owned correctional facilities and the contracting of correctional health services to private companies. Incorporating correctional health into community health care quality measures may create an atmosphere of joint responsibility between the public health and safety systems.

Three specific structures may be especially conducive to increasing the oversight and quality of correctional care. The first is that the ACA may provide opportunities to incorporate correctional health into accountable care organizations (ACOs). These networks of doctors and hospitals are offered incentives to work together to simultaneously improve care and reduce costs for Medicare and Medicaid recipients. ACOs must meet specific quality benchmarks that emphasize prevention, and they additionally receive bonuses for cost containment. Incorporating correctional health services into this framework may be especially relevant given the growing size of the older correctional population, most of whom will eventually enter Medicare upon their release. Reminding community-based providers that these patients are likely to return to their care may provide incentives for them to extend the boundaries of existing ACO models.

Second, increasing the use of a risk-needs-responsivity (RNR) model appears likely to improve criminal justice outcomes, facilitate greater attention to data collection, and optimize triaging of the type of care individuals receive. The RNR framework is widely accepted in the justice community and rests on the premise that a person's prior history can determine his or her risk for future contact with the criminal justice system. It uses criminal justice history, unmet psychosocial needs such as mental illness, and targeted interventions to match releasees to programs most appropriate to their risk level.

Many releasees struggle with housing, employment, and personal relationships, and health issues become a low priority.

As a guide to service delivery, the RNR model has been associated with positive outcomes including reduced recidivism, and its focus on behavioral change indicates potential improvement in health outcomes as well.³²

Finally, instituting accreditation of correctional health care services and facilities could provide a more direct means of enforcing quality measurement and oversight. Correctional facilities currently have the option of voluntary accreditation (from the American Public Health Association, the National Commission on Correctional Health Care, and the American Correctional Association, among others), but there are generally no consequences for violations or lapses of accreditation. An expectation for all correctional facilities to become and remain accredited, with clear-cut consequences for lapses, would provide a possible mechanism to measure standards and improve performance.

INCREASING ACCESS TO COMMUNITY-BASED CARE Improving the quality of correctional health care is only part of the solution to improving the quality of care to this vulnerable population. A second set of activities must focus on improving access to high-quality, community-based care. Appropriate medical and behavioral health treatment services have the potential to improve individual and community health while simultaneously reducing recidivism.

The ACA provides an invaluable foundation but not a complete solution. Most evidently, the ACA will increase access to health care for people released from incarceration by reducing the financial barriers through the expansion of Medicaid (currently in about half of the states) and subsidized health insurance through the Marketplaces, or exchanges. Lack of insurance has been a major obstacle to health care for criminal justice-involved populations. Correctional staff can identify people eligible for coverage and help releasees complete the process of enrolling in an exchange or in Medicaid. This may

help alleviate the detrimental effects of the current practice in many states where state insurance is terminated rather than suspended upon incarceration. In addition, ways to share health care costs at the federal, state, and local levels should be explored to optimize services.

However, there are multiple barriers to care beyond the lack of insurance. Many releasees struggle with housing, employment, and personal relationships, and health issues become a low priority. The lack of coordination between criminal justice and public health organizations also creates obstacles to care, especially at transition points—including return to the community—where medical information may not follow. Policies that require that electronic health records be used by correctional facilities and that the records be accessible to health care providers upon an individual's release could facilitate improved transition of care.

The mental health and addiction treatment needs of some complicate their reentry into the community by posing a barrier to access to health care and treatment for other health needs. For many with active, untreated mental illnesses or addiction, they are unable to engage in health care, make appointments, or participate in a treatment plan or other activities that can optimize health care. Thus, the ACA's expanded coverage for behavioral health treatment is especially important for this population. Policy makers should work with insurance plans to incentivize providers to meet releasees' needs for mental health and addiction care. This provision has the potential to increase the use of health care and reduce incarceration and recidivism by treating these common underlying conditions.

Finally, community providers must improve their own cultural competence. Such competence is usually described in terms of race, ethnicity, and class issues. Providers must also be open to understanding and addressing the unique needs and risk factors associated with an incarceration history. The Transitions Clinic program is a relatively recent innovative approach that provides a "medical home" for people with chronic diseases transitioning out of prison. More than ten locations across the country now offer medical services to these individuals and their families. The program has shown that employing community health workers who have a history of incarceration themselves can improve primary care engagement and reduce the use of high-cost acute care.²⁶

Conclusion

Prisons and jails are necessary for the protection of society. For decades, though, the US health

and criminal justice systems have operated in a vicious cycle that in essence punishes illness and poverty in ways that, in turn, generate further illness and poverty. Individuals in the community with under- or untreated disease, particularly addiction and mental illness, often find themselves in a cycle that is driven by criminal justice approaches instead of medical or therapeutic approaches—a cycle that exacerbates rather than alleviates the original health problems and increases risks of recidivism and unresolved health disparities. Participants at the Institute of Medicine and National Research Council workshop³ argued that this vicious cycle could feasibly become a “virtuous circle” instead. Jails and prisons currently struggle to meet constitutional protections for health care services; however, new financing and delivery models create the opportunity for these institutions to play an active and beneficial role in the health care system. To fulfill this potential requires the active en-

agement of the health professions.

Medical professions share in the responsibility for the current state of correctional health care. Health care reform is an unprecedented opportunity for health care professionals to advocate for the health of the criminal justice-involved population and their communities. Health professionals, correctional officials, and policy makers who are reluctant to invest the time in this work should bear in mind that they are only delaying and thereby increasing the public health burden and costs. Eventually, nearly all of the rapidly aging correctional population will be released. Addressing the health needs of this population earlier will reduce the burden of their care on the health system later.³³

The ACA provides a tremendous opportunity to begin to address the many complex challenges of one of the most important problems of our time. This opportunity should not be squandered. ■

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