MEETING SUMMARY

The Public Health Dimensions of Prisoner Reentry: Addressing the Health Needs and Risks of Returning Prisoners and their Families

National Reentry Roundtable Meeting
The Urban Institute
Los Angeles, California
December 11-12, 2002

With support from The California Endowment, The Robert Wood Johnson Foundation, and Centers for Disease Control

research for safer communities

URBAN INSTITUTE
Justice Policy Center

Reentry Roundtable

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Contents

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SECTION 1.
Welcome and Meeting Overview

Jeremy Travis, Urban Institute

One of the most profound challenges facing American society is the reintegration of more than 600,000 individuals who leave state and federal prisons and return home each year. The fourfold increase in incarceration rates over the past 25 years has had far-reaching consequences. One and a half million children have a parent in prison. Four million citizens have lost their right to vote. Prisoners leave correctional facilities with little preparation for life on the outside, insufficient assistance with reintegration, and a high likelihood of return to prison for new crimes or parole violations. The damaging cycle of removal and return of large numbers of young adults, mostly men, creates specific health needs and risks for returning prisoners, their families, and the community at large.

This is the fourth in a series of Reentry Roundtables initiated by the Urban Institute's Justice Policy Center as part of a policy research initiative to advance our understanding of the process, risks, and challenges of prisoner reentry. In October 2000, the Urban Institute invited academics, practitioners, service providers, and community leaders to the first Reentry Roundtable in Washington, D.C., which examined sentencing and public safety issues from health, substance abuse, labor market, racial, community, family, and gender perspectives. That dynamic discussion led to the organization of the second Reentry Roundtable in March 2001 in New York City, which explored the impact of state policies on returning prisoners, families, and communities and developed a research agenda on prisoner reentry. In March 2002, a third Reentry Roundtable focused on the role of society's civil institutions in facilitating the reintegration process for former prisoners. The Urban Institute hopes to convene Reentry Roundtable meetings twice a year, with the aim of promoting a national discussion on a variety of issues relating to sentencing and prisoner reintegration. Future topics will include employment, housing, and the impact of reentry on adolescent development.

The aim of this roundtable was to generate national discussion about the health needs and health risks of returning prisoners and their families, and offer policymakers a critical opportunity to improve outcomes. While the focus was on prison reentry, many participants noted that those returning from jails also pose health problems to their communities and the health care system. The two-day session provided an opportunity for meeting participants to explore the places where corrections, reentry, and health perspectives intersect. The national roundtable was followed by a one-day session focused on health and prisoner reentry in California.

The format of the roundtable discussion is as follows. The two-day meeting is divided into seven topics. For each topic, we commission background papers written by some of the nation's leading researchers. For each of these issues, the author of the commissioned paper starts the discussion on that particular topic with a brief review of the paper, followed by a highly interactive exchange of perspectives by roundtable participants. (A full list of participants can be found in Appendix A.)

SECTION 2.
Paper Presentations & Discussion

HEALTH PROFILE OF THE PRISON POPULATION

Lois Davis, RAND

Abstract:

Prisoners and the soon-to-be-released inmates are disproportionately inflicted with illness and tend to be sicker, on average, than the U.S. general population. The changing characteristics of the reentry population and their demographics have a direct impact on the prevalence of disease. Chronic medical conditions, infectious diseases, mental illness, and substance abuse are common within state prison and soon-to-be-released populations. Comorbidity of these conditions is also common among the prisoner population. In this context, ethical dilemmas to improved screening and treatment exist. The challenges to improve the health profile of the prison population and protect the health of the families and communities that are linked to this population are numerous.

- The characteristics of the reentry population are changing rapidly. The size of the release population is growing and concentrated in five states: California, Florida, Illinois, New York, and Texas. The length of time served by prisoners has also increased. Today, there are more "churners" (individuals who have multiple periods of incarceration) and more unconditional releases than in the past. Fewer prisoners are participating in educational, vocational, and prerelease programs. From a public health perspective, these factors have negative implications for successful reentry and addressing health care needs.

- Demographic trends also have implications for successful reentry and addressing health care needs. Releasees from state prisons tend to be older, introducing complex health issues associated with age. The growing number of female prisoners brings another set of reentry ramifications. There has been an increase of people who are infected with HIV in need of specific treatment.

- While the ethnic composition of state prison parolees has been stable over the past 10 years, important disparities remain in the amount of time served, black prisoners having longer stays. The reentry challenges for some communities (poor, communities of color) are greater than the challenges faced by others.

- The prevalence of infectious disease is on the average 4 to 10 times greater among prisoners than the rest of the U.S. population. Chronic disease, such as asthma, is higher. Mental illness is anywhere from 1.5 to 5 times greater. And the prevalence of substance abuse and dependence is higher.

Table 1. National Estimates of Selected Chronic and Communicable Diseases and Mental Illness Among Inmates and U.S. Population[A]

Condition	Estimated Prevalence among Prisoners	Estimated Number of Inmates	Prevalence among U.S. Population
Chronic Diseases[B]			
Hypertension	18.3%	283,105	24.5%
Asthma	8.5%	140,738	7.8%
Diabetes	4.8%	73,947	7.0%
Communicable Diseases[C]			
AIDS	0.5%	9,200	0.09%
HIV Infection	2.3 – 2.98%	35,000 – 47,000	0.3%
Hepatitis C	17.0 – 18.6%	303,000 – 332,000	1.8%
TB infection	7.4%	131,000	N/A
TB disease	0.04%	1,400	0.01%
Mental Illness[D]			
Post Traumatic Stress Disorder	6.2 – 11.7%	62,388 – 118,071	7.2%
Major Depression	13.1 – 18.6%	132,619 – 188,259	18.1%
Schizophrenia / Psychosis	2.3 – 3.9%	22,994 – 39,262	0.8%

[A] National Commission on Correctional Health Care. 2002. "Prevalence of Communicable Disease, Chronic Disease and Mental Illness Among the Inmate Population" in *The Health Status of Soon-to-be-Released Prisoners, A Report to Congress*, Volume 1.
[B] Estimates of chronic diseases among the inmate population are for 1995 and include prisons and jails.
[C] Estimates of communicable infections and diseases are for the prison population in 1997.
[D] Estimates of mental illnesses among the inmate population are for state prisoners in 1995.

- Co-morbid conditions are also an issue for the prison population. Although data are sparse, it is believed that co-morbidity is on the rise. Treatment plans upon release for prisoners who are dually and triply diagnosed are limited.

- There is a clear need for better data management and tracking systems. State prisons do not collect data on a regular basis to allow for estimates of disease prevalence. As a result, it is impossible to assess the true profile of prisoner health. The tracking systems in place are also inadequate.

- Improved screening raises a host of ethical and treatment issues. If a condition is identified, there is an ethical duty on behalf of the prison to provide treatment and to transition the care to community providers upon the inmate's release. This is especially true for prisoners with infectious diseases, mental illness, and chronic medical conditions. With limited resources, it is unclear who would pay for increased and improved services.

- The bottom line is, resources are limited. The challenge is to address the economics of an improved system. Repackaging the issue to appeal to the public health community is crucial.

Comments:

- The term "ex-offender" is pejorative and should be abandoned. A preferable term would be "former prisoners" or "individuals with a previous conviction." Similarly, "prisoners" should be used instead of "inmates" or "criminals." Most do not have criminal minds; they are men and women in and leaving prison.

- Understanding the type of health care that is available in the communities from which prisoners come is extremely important. It may be that the health profile of the prisoner population is a reflection of the inadequate health care that is administered in poor communities of color. Prevalence of disease is generally higher in prison than it is in poor communities. However, in many cases, a prisoner's health status improves when he/she is incarcerated. For many, the correctional system is their only guarantee of care. Further research in this area is needed.

- It is also important to keep the jail population in mind. From a criminal justice point of view, the policy for one system normally affects the policy of the other. And, from a sociological point of view, jails have a larger impact on low-income communities of color because more people move through jails than through prisons.

- One of the most provocative discussion points is whether there is an ethical duty to diagnose and treat prisoners. In most cases, the correctional system recognizes the prevalence of mental illness, drug and alcohol abuse, and Hepatitis C, but does very little about it unless there is a legal threat or humanitarian influence. Recognizing that each prisoner is tied to a family and community, it is important to think carefully about the impact of these decisions both in and outside prison walls.

- The way in which screening is presented and offered can make a significant difference in the willingness of a prisoner to undergo testing. When screening is properly packaged, voluntary testing rates have been as high as 80 percent. Understanding why prisoners choose not to undergo testing is central to thinking in this area. Many opt not to undergo testing for fear of being tagged "mentally ill" or "sick," placing the individual in a vulnerable place within the prison culture.

PRISON HEALTH CARE SERVICES

B. Jaye Anno, Consultants in Correctional Health Care

Abstract:

Prior to 1970, little attention was paid to the conditions of confinement for our nation's prisoners, including access to adequate health care. Many correctional officials considered health care a privilege that could be given or withheld, depending on a prisoner's behavior. Today, almost all but the smallest prisons and jails have an adequate health care delivery system in place. While substantial improvements have been made in correctional care over the past 30 years, much remains to be done. Improved quality and effective discharge planning are central to moving forward.

- *What is the range of services offered in correctional facilities?*

  Ambulatory health services are offered on site. Regional systems and community providers are often used for diagnostic services, hospitalizations, and specialized care. Most prisons use resources in the community.

- *Who provides health services?*

  Licensed practitioners provide the services. In the past, unlicensed doctors and inmate nurses were the norm. Today, doctors are board certified or board eligible.

- *What is the quality of those services?*

  Unfortunately, it is unknown. It is safe to say that correctional health care services are 20 years behind the state of practice. The National Commission on Correctional Health Care, however, is beginning to offer training for quality control and improved services.

- *How do inmates access services? Are there routine screenings?*

  Upon arrival, a general medical history of the prisoner is taken. In some cases, a TB test will be administered. A comprehensive exam is normally performed as a follow-up. Each system has the authority to decide what tests are needed. Some try to follow the guidelines set forth by national health organizations. Periodic exams also occur. In terms of access, most systems use the written request method, where the prisoner submits his/her name, number, and complaint. Walk-in and sign-up appointments are also available at some facilities.

- *Are there underserved populations?*

  Prisoners who are mentally retarded, mentally ill, are substance abusers, or have hepatitis generally do not receive adequate services. The terminally ill is another population that does not receive much attention. With the aging inmate population, many are dying behind bars. In some cases, hospice programs have been initiated, but it has been difficult to make accommodations that abide by the hospice philosophy in a confined environment.

- *Where does the funding for health services come from?*

  Funding is by and large provided by the state government. Medicaid and Medicare are not available to inmates and are not a way for institutions to finance their programs. Most prisoners do not have insurance, and for those who do, it is often revoked once they are imprisoned.

- *Is there sufficient funding?*

  On the average, a system will spend 10 percent of its budget on health care. The average dollars spent for prisoner health care is $2,700 per person per year, compared to $4,000 per person per year outside of prison.

- *Is there a way to improve the system and better utilize the dollars allocated to health care?*

  Many prisoners enter the system several times in a lifetime. Currently, there is not a system to access previous records of care provided. As a result, tests and exams are often repeated. A system that links the medical attention provided in prison and with the care given in the community may facilitate better utilization of current dollars. Improved discharge planning would link the released individual to the appropriate services in his/her community.

Comments:

- The variation of care that exists across jurisdictions makes it difficult to compare one state system with another.

- The state of Oregon has developed a rationing system to ensure that correctional services are comparable to what is available to the general public. Oregon provides services to its prisoners that are equal to those accessed by the insured poor, making correctional health care reflective of Oregon's statewide trends. This process has also enabled Oregon to make important budgetary decisions related to correctional care.

- The state of Texas has developed a unique system. The medical branches of the University of Texas and Texas Tech run the correctional health care system. A committee made up of two physicians appointed by the governor, university representatives, and correctional facilities administrators provides oversight. To date, approximately 3.1 million medical exams and/or appointments have been solicited and nearly every case has been attended to within 48 hours. Upon arrival, an intake for communicable diseases and baseline data is performed. The Texas correctional facilities provide approximately 100,000 hospitalizations, 338,000 dental visits, 13,000 specialized medical consultations, and 6,000 radiology reports per year. All facilities are accredited by different agencies, and outside monitoring is employed to ensure proper care is given.

- The fragile nature of health services in correctional settings brings an added dimension to the discussion. Good physicians do not stay long, and service provision can change radically depending on the health service administrator in place. High turnover coupled with frequent prisoner reform acts has an impact on what can be done. When designing a

correctional health care system, these factors must be taken into account. Furthermore, funding correctional health care is a low priority for many decision makers. The political environment in which budgetary discussions take place is a reality.

- When speaking with state legislatures, it is important to reframe the issue so that the discussion is not about coddling prisoners, but rather about intervening in a population where there is high prevalence of disease. By treating this population, benefits are accrued for the individual and community.

- While prisoners are the only group of Americans with a constitutional right to health care, there are actually very few medical services that are legally mandated. The menu of services is left to the discretion of state decision makers. In many cases, a service is provided to avoid potential lawsuits.

COMMUNITY HEALTH CARE SERVICES

Nicholas Freudenberg, Hunter College

Abstract:

Inmates enter the nation's jails and prisons with a disproportionate burden of illness, receive limited or inadequate treatment while behind bars, then return to communities that face significant challenges in providing the health care and the public health services that can promote health and prevent disease. This presentation examined the health care environment in low-income, mostly urban communities in order to better understand the specific issues that returning inmates face and inform the development of strategies to reduce these problems. While these problems are familiar to observers of the American health care scene, a review of the causes and consequences of limited access to quality health care provides a context for the development of comprehensive strategies for the reintegration of returning inmates.

- Criminal justice and correctional policies in the United States have created disproportionate incarceration rates in communities that face other serious social problems, including inadequate education, high unemployment, and limited health care. In low-income communities, the obstacles in finding affordable, high-quality health care are considerable.

- The health service issues that prisoners experience upon release into low-income neighborhoods are:
    - Lack of health insurance—the groups at highest risk of incarceration are also the highest at risk of not being insured;
    - Managed care barriers to service—co-payments and deductibles may deter low-income individuals from receiving care;

- Maldistribution of health care services—health care providers go to communities that can pay for their services;
- Poor coordination of health care with mental health and substance abuse services;
- Racial and socioeconomic status (SES) disparities in access to and quality of care;
- Limited coordination between health care and public health systems; and
- Diminishing role of the public sector in health care and erosion of safety net programs.

- The health profile of returning prisoners places specific demands on community health services, which can be summarized as infectious disease treatment and prevention, mental health services, substance abuse treatment, chronic disease management, coordination of care for multiple problems, and access to providers with the motivation and skills to treat the returning population.

- The public health benefits of improved care for returning inmates are reduced transmission of infectious disease, reduced substance use, improved management of mental illness and other chronic conditions, reduced use of emergency rooms and hospitalization, less family disruption, improved social cohesion in the community; improved public safety, and lower costs.

- Promising strategies to reduce barriers to care have been identified. Pre- and post-release case management programs have been increasingly used within the criminal justice system, especially for drug-using and HIV-infected prisoners. Partnerships between correctional and community health providers have also proved to be a model well suited for smaller cities with a limited number of service providers. Communities have assets; the key is to bring the assets together to work for the community. Categorical programs on HIV, substance abuse, or mental health have also proved to be effective despite the problems associated with coordination. Finally, health education on issues such as asthma, HIV prevention, and health care utilization can reduce barriers to improved health and access to care.

- To encourage dialogue and focus efforts to improve health care for returning inmates, several policy and funding recommendations can be made. The first recommendation is to make Medicaid available to eligible prisoners at the time of release. Current federal regulations enable but do not require states to provide care. Many prisoners leave the prison system and need to be reinstated in the Medicaid program. It takes approximately six weeks to process a reinstatement, which is a long time for someone in need of medication.

- Funding community health and mental health centers that serve returning prisoners in geographic areas provides another opportunity to enable successful reentry.

- Another recommendation is to establish managed care "special needs" programs for returning inmates that provide comprehensive and coordinated medical, mental health, and substance abuse services.

- A final policy recommendation is to create a state or local agency that would manage and monitor the multiple issues individuals face when reentering.

Comments:

- The coercion issue involved with reentry is important to keep in mind. For those who resist the multiple requirements placed upon them and decide not to comply with established treatment plans, how is their health outcome compromised?

- There is a tremendous waste of resources on prisoners who come into the system on multiple accounts. If Medicaid were to follow the prisoner through their stay, would this result in better records, better care, and reduced costs? Researchers have estimated that state governments would save up to 50 percent on their correctional health care budgets if Medicaid could follow individuals into prison.

- The California Endowment is trying to improve the capacity of community health clinics to serve community needs. How can the Endowment, as a funder, prepare community clinics to be attuned to the specific needs of the reentry population?

- Community clinics will be moved to address the reentry population when an identifiable caseload is experienced. It is difficult for community clinics to tackle the needs of a specific community without the funding to do so.

- California has digitized its transitional case management system for HIV and mental health patients. There is a tremendous amount of prerelease and discharge planning involved. The CDC partners with the public health department and community based groups to streamline information. Social workers gather prisoner information and save it into the database. When an inmate leaves the system, his/her medical information is transferred to the community providers. The early returns have been very good. California is working to develop a system where if a person returns to prison, their previous records are readily available and duplicate services are avoided.

ROLE OF FAMILIES AND SOCIAL NETWORKS IN IMPROVING HEALTH OUTCOMES

Nancy Wolff, Rutgers University

Abstract:

After years of incarceration, prisoners often draw upon their social networks to assist them with reintegration. Research conclusively shows that the health, well–being, and service utilization behavior of individuals with impaired health improve through the emotional and material

support provided by their social networks. People with poorer social networks, however, are expected to have worse health and justice outcomes.

This paper focused on the social capital of prisoners and the impact of criminal behavior and incarceration on its formation and mobilization. It argues that the incarceration experience has the potential to alter the characteristics, potential, and mobilization of social capital in ways that reduce its ability to produce improved health and justice outcomes for former prisoners. To offset this depreciation effect, the authors recommend a set of investment strategies that could potentially have a positive impact on the prisoner's social capital and prospects for successful reentry. Success is likely if investment occurs continuously over the prison sentence. Sturdy "social" bridges between prisoners and the community take more than a day to build, but if built, may lead to a road worth traveling.

- Support from family and friends improves health outcomes, treatment compliance, quality of life, and community tenure.

- Social networks vary from prisoner to prisoner. Size, composition, quality, and efficacy (ability to work efficiently and effectively) are factors that make each social network unique. Research has found that social networks for disadvantaged populations are smaller and less effective.

- The formation and mobilization of social capital is influenced by four factors: the *willingness* of the prisoner's social relations to provide assistance, the *ability* of the prisoner to motivate help from his/her social relations, the resources and *endowments* of the social relations, and the *social context* of these relationships.

- At the point of incarceration, each individual enters with a stock of social capital. With time and isolation, that social base and connection are weakened. In prison, a prisoner's identity often changes. Slowly, the prisoner's social capital becomes more prison-based, rather than community-based. Time behind bars can also alter individual mobilization capabilities.

- Before investing in prisoner social capital, it is important to understand the normative assumptions that underpin research on social capital. The first assumption is that all individuals come from a middle-class upbringing. The second issue is the emphasis that is placed on the ability to maintain connections. The last is the assumption that everyone has the ability to maintain healthy family connections. These assumptions are not generally characteristic of prisoners or their families. Challenging these assumptions and replacing them with more flexible notions of family and family involvement is necessary.

- At the prerelease stage, interventions are recommended that assess the social capital of the prisoner, diversify the prisoner's social capital by expanding the number and type of social connections, and strengthen the connections through interpersonal skill building and social opportunities.

- The most difficult work begins at release. This is the moment when social capital, if it exists, pays initial dividends. In many cases, the first steps off a bus back into the city can also be the first steps toward homelessness. Outreach and engagement services have most likely not been arranged. For this reason, a post-release investment strategy is recommended that involves community-based professional services and peer support.

- While social capital has the potential to promote prosocial outcomes, the typical prison experience that focuses on punishment and social isolation can be expected to change the stock of social capital in ways that weaken its potential and mobilization over time. But the prison experience could, with appropriate and continuous investments, have a positive impact on the prisoner's social capital and prospects for successful reentry.

Comments:

- Social networks and social capital are not resources the prison system typically relies upon when assisting with reentry. However, real-world interactions are heavily dependent on social networks. The correctional system should look to assisting prisoners in developing networks rather than simply directing them to an agency. A holistic approach is needed where networks are used to support connections with services. Social capital is an invaluable asset in keeping and maintaining contacts with medical and mental health services.

- Giving prisoners the opportunity to define their assets is an extremely important exercise. It gives the power back to the individual. If the individual is able to identify his/her strengths and define specific ways he/she can contribute while incarcerated, the prisoner can receive the proper training and preparation. When the prisoner is released, he/she can be connected with successful ex-prisoners on the outside and community resources for continued assistance.

- The most stigmatizing label one can have is the label of an "ex-con." The potential of successful ex-prisoners assisting those who are coming out is tremendous; however, many former prisoners hide their "ex con" status.

- In New York, an inclusive model is used to capitalize on social and institutional assets available at release. A social network of high-powered former prisoners with advanced degrees has been formed to provide mutual support and guidance. The network also reaches out to other released prisoners. However, this is just one case. More networks of this type are needed. It is important to keep in mind that many incarcerated individuals are highly ingenious. Skills that were once used for ill purpose are transferable to positive endeavors.

- According to research conducted in New York, approximately 30 percent of all families in these communities have someone they care about coming out of jail. They are not homogenous families; they range in class, ethnicity, and location. Most of these families provide emotional support, which makes it extremely difficult to determine to what extent a family can play a role in a prisoner's life. As a prisoner, there are a lot of assumptions about your family, namely that it is dysfunctional.

- Understanding the environment to which prisoners are returning is another important piece. La Bodega de la Familia, a community-based program in New York, assists families and offenders in the reentry process. Prior to the prisoner's return, a family assessment is performed. Once the prisoner is released, the organization works with the family to develop an action plan in the presence of a parole officer. Ultimately, it is about building relationships and networks of support. This is especially important when health issues are involved. The program is voluntary. The intent is to be perceived as a public health model, and *not* as a punishment program.

- Reentry affects men and women in different ways. The National Network for Women in Prison is a small, grassroots organization with a leadership-training program for incarcerated and formerly incarcerated women. The organization has successfully pulled together a cadre of people who can assist other women and others who have great capacity to lead.

- When planning reentry, there are collateral consequences to consider—limitations on welfare, Section 8 housing, educational grants, etc. These are the invisible punishments that occur long after release.

LINKAGES BETWEEN PRISON AND COMMUNITY HEALTH SERVICES

Ted Hammett, Abt Associates

Abstract:

Correctional inmates are disproportionately burdened with many types of health problems. The vast majority of inmates return to the community, making periods of incarceration the ideal venue for a variety of preventive, diagnostic, and treatment interventions. These services will benefit not only the inmates themselves, but also the larger community. It is also possible, although largely unproven to date, that timely and efficient health interventions for correctional inmates and releasees may result in downstream savings in other publicly funded programs and services. Inmates and releasees often have extensive needs and face major obstacles; however, no single agency or entity has the clear responsibility to help releasees achieve stability in their lives following release and connect to community health care systems and other support services.

This paper discusses salient characteristics of current discharge planning and community linkage programs, with attention to the barriers to and facilitators of successful linkage and continuity of care. Programs with documented success and/or promising strategies for linking

releasees to community health services are presented. Continuing gaps in the research on discharge planning and community linkages are also discussed.

- Based on a study of discharge planning for HIV-infected inmates in 10 states and extensive literature on transitional services for prisoners with medical and mental health problems, several recommendations for organizing and staffing effective continuity of care programs are made:
    - Dedicate funding for discharge planning and post-release follow-up.
    - Assign dedicated staff to provide prerelease discharge planning services and designate a discharge planning coordinator at each facility and statewide.
    - Arrange for state public health department collaboration and oversight of continuity of care.
    - Establish collaborations with CBOs and outside agencies to meet with inmates prior to release. Assign case managers to work with released inmates. When possible, the same provider should work with the client before and after release.
    - Involve parole officers in supporting reintegration and continuity of care, yet recognize there are different roles that may make the involvement of parole agencies problematic. The distinction between the criminal justice function and correctional function needs to be clear.
    - Institutionalize discharge planning through formal agreements among agencies and with CBOs, designated agency liaisons, and broad community networks to allow for comprehensive referrals.
- Established discharge planning programs also identify the following operational issues as important:
    - A dual system with literal continuity of care from facility to community-based providers is the ideal model, but is probably feasible only in systems covering relatively small geographic areas.
    - Outside discharge planning, providers need to work with correctional medical and security staff to identify and access eligible clients.
    - Correctional discharge planning providers need to develop relationships with community providers in order to place inmates in post-release care.
    - Discharge planning is most effective when the provider has multiple personal contacts with the client (face-to-face or by correspondence or telemedicine) before release.

- Effective discharge planning programs set up specific appointments for the client after release, instead of making general referrals to services, and give the client clear instructions about how and when to keep the appointment.

- Continuity of medical care is more likely to occur if clients receive medication at release, a copy of their prison or jail medical summary, a post-release medical appointment, and assistance completing applications for medical benefits.

- The transition may be made smoother by connecting clients to community case management, mental health care, substance abuse treatment, housing, cash benefits, and assistance with other basic needs.

- Client success can hinge on meeting immediate needs after release, such as transportation, emergency shelter, cash, food, and clothing.

- There are several research gaps that make it difficult to "sell" the importance of discharge planning and continuity of care. The first is the almost complete absence of rigorous evaluations of such programs. The second related gap is the almost complete absence of cost and cost-benefit studies of discharge planning and continuity of care programs.

Comments:

- From the correctional facilities perspective, its commitment to service ends at the gate. Prison systems often state that they do not have the time, resources, or capacity to make connections with community resources and facilitate transitions. As a result, there is a large gulf between the services in prison and in the community.

- From a prisoner's perspective, there are very specific cultural interpretations of transitional services. Historically, support programs have been disease specific. The perception of many releasees is that transition support and continued case management is essentially another arm of the correctional facility. For that reason, many do not want to be controlled or "cased" any more. A program's success will depend on the ability to relate to the releasee population.

- In Northern California, Centerforce attempted to change prisoner perceptions about transitional services by holding a community resource fair where providers were invited to present their work to the prisoners. The prisoners, in turn, were able to establish face-to-face contact with the providers. The relationship that is formed between a provider and the releasee within the first five minutes often dictates whether a releasee will continue with the plan of treatment.

- An innovative pilot program for discharge planning and case management for HIV/AIDS and mental health patients has proved to be successful in California. The program makes appointments for prisoners 90 days prior to their release date. Appointments are then reconfirmed 30 days before release. Arrangements are also made to ensure that prisoners have a 30-day supply of medications upon release.

- The categorical funding issue is important to keep in mind. Often, great services are being provided, but a fragmented model of care is perpetuated. There is a need to begin to think about a primary care model where a wide array of illness can be treated simultaneously and in a coordinated fashion. It is also important to think about creative ways that categorical funding can be used to address other issues as well.

- Over the past 40 years, a booming prison system has been created. This system has become a conduit of an enormous amount of resources. With the continuous increase in the incarcerated population, there is a need to begin to envision a societal structure that is less dependent on correctional systems. Funding streams need to be disentangled from prisons. Citizens should not have to be criminalized to access services provided to a broader audience.

BARRIERS TO HEALTH SERVICES FROM A RACE AND GENDER PERSPECTIVE

Ray Patterson, Howard University, and Bob Greifinger, The Bromeen Group

Abstract:

Prisoner 722515 is a 26-year-old Hispanic male with a 10-year sentence related to gang activity. He has refused to provide a urine sample for medical testing out of fear that correctional staff will touch his penis. His limited English proficiency prohibits him from understanding that the sample will not require staff involvement. He will be released in two weeks.

Prisoner 896273 is a 42-year-old woman with a family history of metastatic breast cancer. She detected a lump in her breast, but the correctional facility did not administer the mammography for several months. She was released two years later with breast cancer.

These vignettes clearly illustrate the cultural dimensions of medical care in a prison setting. Race, ethnicity, language, and gender directly influence a prisoner's ability to access medical services. And these same factors will follow the prisoner back into the community upon release.

This paper describes several formidable barriers to the design and implementation of successful primary, secondary, and tertiary prevention programs behind bars. Some deal with the experience and culture of the individual inmate, while others illustrate the culture and biases of correctional health care. Sensitivity to race, culture and gender is believed to improve health outcomes for the inmates themselves and for the communities to which most return.

- Through litigation and nationally accepted standards, correctional health care has advanced in the domain of personal health care services. Inmates have the right to access care ordered by their physicians.

- Inmates come primarily from poor communities and are disproportionately minority, from diverse cultures and beliefs. In the world outside of prison, there is some evidence that sensitivity to race, culture, and gender improves outcomes of health care. It is intuitively obvious that the successful community reintegration of former inmates will stem, in part, from prerelease programs tailored to individuals' culture and beliefs.

- It is important to understand the difference in mission, purpose, and philosophy of a correctional system compared to a health care or public health entity.

Comments:

Barriers to health from a racial, cultural, and gender perspective

- Disparities to health care are clearly exemplified in the African-American reality. African Americans make up approximately 13 percent of the total population, yet represent 45 percent of the prison population. Many of the imprisoned African Americans are substance abusers, but care for substance abuse is the least provided service.

- External efforts to address the race and gender dimensions of health care provision create an opportunity for correctional systems to explore the issue. The Department of Health and Human Services identified the need to eliminate racial disparities as a goal. This commitment has had a tremendous influence on funding patterns. At a minimum, this creates an opportunity for the correctional system to address racial disparities when accessing health care.

- The public health field is sympathetic to the race and gender barriers to health care. It is important to package the issue in such a way that the field will be more inclined to join the discussion.

- The growing interest in men's health services provides another opportunity for correctional health care and transitional health care funding.

- When looking at issues of cultural competence, it is essential to identify programs that have successfully tackled this issue.

Strategies to overcome disparities

- While many of the community-based approaches to health care are directly applicable to the prison environment, there are also many that are not. Group therapy, for example, tends not be an effective technique for prisoners. It involves leaving one's cell and exposing oneself to the scrutiny of follow inmates. If, however, issues of confidentiality are addressed and the prisoner is assured that the information discussed during the session will not be relayed to a parole office, group therapy can work.

- Front door screening and evaluation has been identified as an effective strategy to increase access and improve care.

- Peer education has proved to be effective when dealing with the racial, cultural, and gender dimensions of access.

- Training and conversations that go beyond the "isms" are also effective ways to raise consciousness and address disparities.

- Emory **University** is involved in a multisite initiative to provide cultural competency training to community-based programs that serve the Latino and African-American populations.

REVIEW OF EVALUATION LITERATURE ON HEALTH OUTCOMES

Embry Howell, Urban Institute, and Robert Greifinger, The Bromeen Group

Abstract:

Earlier this year, the National Commission on Correctional Health Care released a Report to Congress on the Health Status of Soon-to-be Released Inmates. The document provides a comprehensive overview of the health care issues surrounding the return of a large number of former prisoners to local communities. To serve these returning inmates' needs in a comprehensive, cost-effective way, it is important to catalogue what is already known about providing the services they may need. It is also important to understand how the overall societal costs of care can be lowered through effective service provision.

This paper provides a review of the literature on the cost-effectiveness of health services for returning prisoners. The limited literature on the cost-effectiveness of health services, coupled with the scarce amount of information on services for returning prisoners, has forced the researcher to concentrate on the review of studies of other marginalized groups that are similar demographically (primarily poor men, substance abusers, the homeless, and low-income veterans). These groups experience many similar health conditions, as well as low levels of health care and poor access to care.

- Research focused on five health conditions that are disproportionately prevalent in returning prisoners: HIV/AIDS, sexually transmitted diseases, tuberculosis, serious mental illness, and substance abuse. The similar communities were identified to be the homeless population, substance abusers, seriously mentally ill, and poor veterans.

- HIV/AIDS education and prevention programs were shown to be cost saving. Treatment, on the other hand, for HIV/AIDS is not cost saving, but it is cost-effective compared to treatment of other serious illnesses.

- Screening for sexually transmitted diseases (STDs) and TB is effective, and proper drug therapy can cure the illnesses. Screening and treating the incarcerated population is cost

saving. The cost-effectiveness of screening and treatment in the community, however, depends on the compliance issues involved.

- Community-based mental health services that include intensive case management (sometimes called assertive community treatment or ACT) are costly but do improve the overall wellness of those who receive such services.

- Substance abuse disorders are highly prevalent in prison populations, with estimates ranging from 29 to 80 percent. Methadone maintenance is a cost-effective but not a cost-saving treatment for substance abuse. Residential care is an effective but more costly option. Outpatient care is judged to be more cost-effective. When the justice system monitors abusers, clients are more likely to return to jail.

- In summary, health care for the five conditions studied can be cost-effective when judged against other prevention and treatment, and some treatments are cost saving. Many of the benefits accrue to society as a whole, not just the population served. Currently, the service system for returning prisoners is underdeveloped and under funded. Developing a consensus for action is difficult because benefits and costs accrue to different sectors.

Comments:

- When conducting a cost-benefit analysis of health treatment and services, the societal benefits are often left out of the discussion. The impact is difficult to quantify, and for that reason, the analysis relies on those factors that can be easily measured (number of hospitalizations, etc.). The societal benefits and associated savings do not show up on the governmental budget.

- Demonstration projects are effective at showing the savings that can occur in specific locations. The challenge is to bring these projects to scale.

- Community-based organizations can also contribute to the quality, availability, and cost-effectiveness of reentry health services.

- Before looking at other alternatives, there is quite a lot that can be done to better manage the dollars that are currently being spent on services.

Section 3.

Next Steps for Research and Policy

RESEARCH AND POLICY QUESTIONS

Nicholas Freudenberg, Hunter College

At the end of the meeting, Nicholas Freudenberg provided the group with a list of research and policy questions that had emerged during the two-day discussion. Dr. Freudenberg started by highlighting aspects that will yield quality research in this area. According to Dr. Freudenberg, a good research agenda will:

- Focus the limited research dollars and resources strategically;
- Target the problems and issues that are most likely to be solved and most likely to have an impact on health;
- Gain the support of key stakeholders, such as practitioners, communities, and inmates; and
- Attract resources from current funding streams.

Having set the stage, Dr. Freudenberg presented a list of questions that emerged from the discussion and were identified as priority areas for future inquiry:

- What has been the impact on former prisoners of contact with the public health care system, both before and after incarceration?
- How do health services for prisoners and released individuals lead to improved public health?
- What have been successful health interventions at the individual, institutional, and system levels?
- How can we bring these successful efforts to scale?
- What are the cost benefits and cost-effectiveness of various approaches?
- How do we incorporate formerly incarcerated prisoners into the program development side of transition planning?
- How do we reduce the stigma of former prisoners?
- How do we engage the community and community-based service providers in reentry issues?

- How do we create a message and agenda that is appealing to multiple audiences?
- What are public opinions that will best support this policy agenda?
- What policy changes will support healthy reentry?
- What are the connections between criminal justice and health outcomes? What are the crosscutting issues?

Policy Recommendations:

The growing interest in prisoner reentry has created a strategic moment to influence policy. Local and federal initiatives have engaged new constituencies in the discussion and heightened overall interest in this area. To effectively communicate information about the health dimensions of prisoner reentry to a broader audience, meeting participants discussed the importance of repackaging the issue as a public health concern. Including personal vignettes and case studies in the discussion will bring a human face to the issue and move individuals and institutions to act. Empowering formerly incarcerated individuals to speak out about incarceration and reentry was another strategy advocated by meeting participants.

While numerous policy recommendations surfaced during the two-day discussion, several ideas surfaced time and time again:

- Revisit correctional systems' mission statements and include effective reentry as a core component.
- Allow eligibility for comprehensive benefits (e.g., Medicaid) to follow a prisoner in and out of prison.
- Eliminate the duplication of services by developing database management systems that are easily accessible to the necessary parties.
- Prioritize intersystem cooperation to blend funding sources and engage individuals and communities in the reentry process.
- Invest in reentry health as a strategy to promote community health and well-being.
- Encourage the use of social networks in the reentry process.
- Involve former prisoners in the reentry process.
- Create an agency that deals with the reentry population and their specific needs.

Concluding Remarks

With 1,600 individuals walking out of prison gates every day, the health needs and risks of returning prisoners are central to the reintegration process. The meeting of the Reentry Roundtable explored this exciting new terrain—the public health dimensions of prisoner reentry. Discussion began with careful review of the correctional health care system and the prisoner health profile. Research revealed that the incarcerated population is disproportionately afflicted by mental, chronic, and infectious diseases. While progress has been made to improve correctional health care, resulting in improved health status for many prisoners, inadequacies prevail. Discussion then moved outside the gates to assess the community health services available to prisoners once released. Research found a very limited capacity on behalf of the service providers to deal with the specific needs of the returning population. The challenge today is to increase the organizational capacity of community health care providers to service this unique and growing population. Once a clear portrait had been painted of health care in and outside prison walls, meeting participants focused their attention on identifying the linkages between prison and community health care and the prospects for successful reentry. Several exciting projects are currently under way to ensure smoother transitions and safeguard public wellness. The roundtable concluded with a series of research questions and policy recommendations.

Grappling with the public health dimensions of prisoner reentry is a complicated task. Rather than providing answers, the Reentry Roundtable has assisted in fleshing out the complexities of the issue. New ideas have been generated, alliances formed, and agendas defined. Most important, the Reentry Roundtable has launched a nationwide discussion on health and reentry. The challenge that lies ahead is the application of these learnings to improve the lives of the incarcerated and formerly incarcerated populations of America and their families.