



**CORRECTIONAL HEALTH:
The Missing Key to Improving the
Public's Health and Safety**

October 2003

This report was prepared by Rachel A. Wilson, MPH, Co-Chair of the Correctional Health Campaign at the **Massachusetts Public Health Association** (MPHA). MPHA is a private non-profit statewide membership organization working to improve health status through education, advocacy, and coalition building. MPHA educates its members, the public health community, and the general public on health-related issues and promotes action to address public health concerns. For more information about MPHA, call (617) 524-6696 or visit www.mphaweb.org.

Acknowledgements

Many thanks to MPHA's partners and collaborators who contributed to the development of this document. Special thanks to:*

Alfred DeMaria, MD; Co-Chair, MPHA Correctional Health Campaign; Director of the Bureau of Communicable Disease Control/Assistant Commissioner, MA Department of Public Health

John Miles, Office of Health Disparities, Centers for Disease Control and Prevention

Laurie Robinson, Office of Women's Health-Region 1, U.S. Department of Health & Human Services

Thomas Conklin, MD, Hampden County Correctional Center

Susan Martin, Massachusetts Department of Correction

Virginia Cram, Sexually Transmitted Disease Clinic, MCI-Framingham

June Binney, UMass Correctional Health Program

Gary Larareo, Lisa Crowner & Tom Barker, Massachusetts Department of Public Health

Paul Benedict, Massachusetts Department of Mental Health

Gary Shostak, Massachusetts Department of Youth Services

Steve Kelly, Massachusetts Parole Board

Timothy Gagnon, Massachusetts Office of Community Corrections

John Auerbach, Barbara Ferrer, Monica Valdes-Lupi & Jabes Rojas, Boston Public Health Commission

Lyn Levy, SPAN

Edward Harrison, Action for Boston Community Development

James Ryan, MD, Boston Medical Center, Boston University School of Medicine, MA Medical Society

Hank Talbot, Massachusetts Housing and Shelter Alliance

Laurie Stillman, Asthma Regional Council

Tina Williams, Multicultural AIDS Coalition

Rev. Dr. Renee Jackson, United Baptist Church and Boston Re-entry Group

Christie Hager, Division of Public Health Practice, Harvard School of Public Health

Laurie Martinelli & Alex Sugerman-Brozan, Health Law Advocates

Jamie Bissonnette, American Friends Service Committee

Julie Rabinovitz, Office for Women, Family & Community Programs, Brigham & Women's Hospital

Diane McLaughlin & James Pingeon, Massachusetts Correctional Legal Services

Steven Saloom, Criminal Justice Policy Coalition

Geoffrey Wilkinson, Carrie Cortiglio & Gail Gramarossa, MA Public Health Association

** Affiliations listed for identification purposes only and do not imply organizational or agency endorsement.*

Special thanks to the Jessie B. Cox Charitable Trust, the Hampden County Correctional Center, and the members of MPHA for their support of MPHA's Correctional Health Campaign.

Table of Contents

I. Executive Summary	4
II. Health Burden of the Incarcerated Population.....	7
HIV/AIDS.....	8
Hepatitis C	8
Tuberculosis	8
Infectious Diseases Passing Through Corrections	8
Chronic Illness	8
Substance Abuse.....	8
Mental Health.....	8
Lack of Access to Health Care	8
Health Status of Detained Juveniles	8
III. Correctional Systems & Inmate Populations	9
Massachusetts Correctional Facilities	9
Correctional Health Service Providers	9
Inmate Demographics.....	10
IV. Reintegration and the Public’s Health	13
Health Care Coverage	13
Discharge Planning.....	14
Post-Release Supervision and Mandatory Minimums	14
V. Benefits of Addressing the Health and Mental Health Needs of Inmates	15
Improved Inmate Health.....	15
Improved Public Health.....	15
Improved Public Safety/Reduced Crime	16
Increased Success in Re-Entry	16
Protection of Correctional Staff Safety and Health	16
Cost Savings.....	16
VI. Recommendations	18
Health Care Coverage	18
Linkages with Community-Based Organizations	19
Health Promotion & Disease Prevention.....	20
Mental Health & Substance Abuse Treatment.....	21
Incarcerated Women	22
Public Health Oversight of Correctional Health Care.....	24
Data Collection & Tracking	24
Funding and Resources.....	25
Conclusion	25
VII. References	25

Executive Summary

Individuals moving through the criminal justice system experience disproportionately high rates of infectious diseases, chronic illnesses, mental health problems and substance abuse disorders. Since 97% of the incarcerated population eventually returns back to their communities, efforts to address their health and mental health needs is not only humane, but is also a public health necessity. For the last three years, the Massachusetts Public Health Association has led a correctional health campaign to build collaborations to improve the public's health and safety, by addressing the health of those who are moving through the criminal justice system. While policymakers often discuss the expenses and public safety issues related to crime in Massachusetts, the connection between these issues and correctional health are rarely discussed. It is crucial that these issues become a standard component of discussions about ways to improve public health and safety, control costs, reduce crime and recidivism, and increase successful re-entry of inmates back into their communities.

This report was developed after extensive consultation with a variety of stakeholders from state and federal agencies, including the Massachusetts Department of Correction (DOC), Massachusetts Department of Youth Services (DYS), Massachusetts Department of Mental Health (DMH), Massachusetts Department of Public Health (DPH), Massachusetts Office of Community Corrections (OCC), U.S. Department of Health and Human Services – Region I, and Massachusetts Parole Board; county jail health administrators; health, human service, and housing advocacy and legal organizations; former and current inmates; the faith community; mental health and substance abuse treatment providers; and community-based organizations. From these many discussions and strategy sessions, we have gathered the following information about correctional health in Massachusetts and identified several areas in need of attention.

The Health Burden of the Incarcerated Population: The incarcerated population is sicker and much less likely to have received medical care in the community than those who have not been incarcerated. Risky behaviors, lack of access to health care, poverty, substandard nutrition, poor housing conditions and homelessness put this population at increased risk for many illnesses.

- Disproportionately high rates of infectious diseases such as HIV/AIDS, hepatitis, and tuberculosis can create a public health risk to the communities to which most inmates will return.
- Chronic illnesses, such as asthma, high blood pressure, and bone/joint problems, create heavy medical and financial burdens to individuals, families and the state if left undetected and untreated.
- Substance abuse and mental health problems left untreated can create safety risks to fellow inmates and correctional staff while incarcerated, and to individuals and communities after release.
- Women exhibit higher rates of many health problems than men and detained juveniles experience many of the same illnesses as their adult counterparts.

Correctional Systems & Inmate Populations: The criminal justice system in Massachusetts is quite complex, making correctional health reform challenging at best. Generally, adult inmates are held in county jails and houses of correction while awaiting trial and when carrying out shorter sentences, while inmates at the state prisons are carrying out longer sentences. While the county jails and state prisons hold approximately the same amount of inmates at any one time, the turnover is much greater in jails, creating a different set of challenges. The Department of Youth Services detains juveniles awaiting trial and those who have been sentenced. The Office of Community Corrections and Parole Board monitor criminal justice populations who are on probation and parole. Although females make up only a small minority of the inmate population, their health and mental health needs are often more severe and complex than their male counterparts. Their histories of trauma and abuse are disturbingly high and the impact of their incarceration on their children is of great concern. People of color are disproportionately represented in the incarcerated population and detained juveniles often come from unstable family backgrounds.

Reintegration and the Public's Health: Ninety seven percent of Massachusetts inmates are ultimately released back to their communities.

- With severe cutbacks to Medicaid insurance coverage (MassHealth), community based health, mental health, and substance abuse treatment agencies, the barriers to successful reintegration and care are immense and growing.
- Even if an inmate is fortunate enough to be eligible for MassHealth coverage, the administrative barriers to enrollment upon release can create large gaps in access health care and prescriptions, severely hindering the ability for an ex-offender to make a healthy and safe transition to the community.
- While discharge planning has improved in the state prison system in recent years, the majority of inmates returning to their communities receive minimal re-entry planning for their medical and mental health needs in the community.

Without health care coverage, access to community programs, and assistance and support with reintegration, the criminal justice population's illnesses will worsen, posing an increased health and safety threat to the communities to which they return.

Benefits of Addressing the Health & Mental Health Needs of Inmates: By adequately addressing the health and mental health needs of inmates while incarcerated and as they move back to the community, there are many potential benefits including:

- Improved inmate health
- Improved public health
- Improved public safety/reduced crime
- Increased success in re-entry
- Protection of correctional staff safety and health
- Cost savings

Recommendations: Unfortunately, many of the state budget cuts in the past few years have resulted in a series of steps backward in Massachusetts' ability to successfully address the health needs of the inmate population. This report outlines several important actions that should be pursued and sustained in an effort to protect the health and safety of inmates and the communities to which they return.

1. Health Care Coverage
 - Restore the MassHealth Basic program (Enact S555/H3751)
 - Improve enrollment onto MassHealth upon release (Enact S598)
2. Linkages with community-based organizations
 - Promote replication and expansion of model programs that rely on partnerships between corrections and community-based agencies
 - Assess regional capacities for community and corrections collaborations (Enact H3393)
 - Restore and protect the community safety net
3. Health promotion and disease prevention
 - Fully apply nationally recognized correctional health guidelines for screening, immunization, and clinical management of inmates
 - Offer accurate and culturally appropriate health education materials, programming, and peer education programs
 - Allocate dedicated funding to treat hepatitis, as is currently offered for those with HIV
4. Mental health and substance abuse treatment
 - Adequately fund county jail mental health services
 - Invest in substance abuse treatment

5. Incarcerated women
 - Create parity for female offenders
 - Promote adoption of gender-responsive strategies for female offenders
 - Adopt programs and policies to support families
6. Public health oversight of correctional health care
 - Create a Correctional Health Task Force at the Department of Public Health (DPH)
 - Grant DPH the authority to inspect and regulate correctional health care facilities
7. Data collection and tracking
 - Invest in standardized computerized medical record systems and other technology
 - Require reporting of inmate health statistics to DPH
8. Funding and resources
 - Increase state revenues to meet the funding needs for public health approaches to correctional health care
 - Increase alternatives to incarceration

The recommendations included in this report focus primarily on policies and programs that directly address the health of inmates, their families, and their communities. It is important, however, to also consider the context of people's lives and environments as determinants of their health and well-being. Therefore, the broader scope of issues including sentencing policies, housing, education, jobs, and other factors should also be considered in efforts to improve the health and well-being of criminal offenders. A comprehensive effort that includes these components will go a long way to improving the health and safety of inmates, their families and their communities.

THE HEALTH BURDEN OF THE INCARCERATED POPULATION

- **HIV/AIDS**
- **Hepatitis C**
- **Tuberculosis**
- **Infectious Diseases Passing Through Corrections**
- **Chronic Illness**
- **Substance Abuse**
- **Mental Health**
- **Lack of Access to Health Care**
- **Health Status of Detained Juveniles**

In 2002, United States prisons and jails held more than 2 million inmates for the first time. In Massachusetts, more than 20,000 residents are incarcerated and over 40,000 more are on probation or parole.

The criminal justice population suffers a high prevalence of health problems. Most inmates have not had access to non-emergency medical care, creating an immense financial burden to the state in expensive medical interventions that could have been avoided through improved detection, prevention and treatment.

Incarcerated populations have significantly higher rates of substance abuse and risk behaviors, such as intravenous drug use and violence, than the general population. This contributes to the high rates of infectious diseases, such as HIV/AIDS, hepatitis C, tuberculosis, and sexually transmitted diseases found in the incarcerated population. Additionally, drug addiction, lack of access to health care, poverty, substandard nutrition, poor housing conditions, and homelessness often contribute to increased risk for chronic conditions such as hypertension, cardiovascular disease, skin conditions, poor oral health, gastrointestinal disease, diabetes and asthma.

The ramifications of these health problems are experienced not only by people moving through the criminal justice system, but also by the communities to which they return.

- **If infectious diseases are not prevented, detected and treated adequately, the public's health is being put in jeopardy.**
- **If the chronic illnesses and behavioral risk factors of the incarcerated population are not addressed comprehensively, vast financial resources will continue to be spent on preventable expensive medical interventions.**
- **If substance abuse and mental health treatment are not adequate and integrated, opportunities will be missed to use cost-effective means to protect the public's safety.¹**

HIV/AIDS

- At the end of 2000, Massachusetts adult state prisoners had **10 times the rate of confirmed AIDS cases** (1.3%) than the general U.S. population (0.13%);²
- Massachusetts had the **7th highest rate of reported HIV infection among inmates** (3.0%) of all reporting U.S. states;
- **Female inmates experienced over 1½ times the rate of HIV infection** (4.6%) than male inmates (2.9%);
- **17% of all U.S. AIDS cases and 13-19% of those with HIV infection** pass through correctional facilities in our country.³

Hepatitis

- Hepatitis C is **15 times more prevalent in male inmates** (27%) and over **24 times more prevalent among female inmates** (44%) entering custody of the Massachusetts DOC than the general public (1.8%);⁴
- **29-32% of all hepatitis C cases and 12-15% of people with hepatitis B** pass through U.S. correctional facilities.⁵

Tuberculosis

- National rates of TB are **4-17 times greater among inmates than the general population**;⁶
- Despite a successful tuberculosis program in Massachusetts correctional facilities established following an outbreak in 1990, **TB rates in Massachusetts prisons (approx. 15 per 100,000) are almost 4 times the rate in the general population (approx. 4 per 100,000)**.⁷

Chronic Illness

Data on the prevalence of chronic illnesses among inmates in Massachusetts are scant. However, a self-report study conducted at the Hampden County Jail showed that:⁸

- 17% of males and 29% of females reported having **asthma**
- 11% of males and 15% of females reported **high blood pressure**
- 29% of males and 41% of females reported **bone/joint problems**.

The Mass. Dept. of Correction reports that:⁹

- 6.6% of DOC prisoners have **pulmonary disease**
- 8.3% have **cardiovascular disease**

Substance Abuse

- **59% of men and 68% of women** entering the Massachusetts state prison system reported past injection or inhalation of drugs;¹⁰
- The Office of National Drug Control Policy reports that **50-70% of the offender population has a diagnosed substance abuse disorder**;¹¹
- Youth who are incarcerated in DYS facilities also have high rates of substance use with **35% reporting weekly alcohol use** and **50% reporting weekly marijuana use**.¹²

Mental Health

- In Massachusetts state prisons, **more than 17% of male inmates and over 50% of female inmates have open mental health cases**;¹³
- In Massachusetts jails, approximately **12% of inmates have mental health disorders**. One third of these jail inmates meet criteria established by the Massachusetts Department of Mental Health as “seriously mentally ill (i.e. major depression, bipolar disorder, schizophrenia) and the other two thirds have other mental health problems that put them at high risk (i.e. acutely distressed, personality disordered, potentially suicidal, substance abusers);¹⁴
- In general, national studies indicate that **over three-quarters of people with mental illness who are incarcerated also have a co-occurring substance abuse disorder**.¹⁵

Health Status of Detained Juveniles

Children detained in Massachusetts Department of Youth Services facilities also experience higher rates of illness, mental health problems and substance abuse than the general public. Some common health problems found among this population include asthma, dental problems, traumatic injuries, orthopedic injuries, sexually transmitted diseases, psychiatric problems, substance abuse, and dermatologic problems.¹⁶

CORRECTIONAL SYSTEMS & INMATE POPULATIONS

- **Massachusetts Correctional Facilities**
- **Correctional Health Service Providers**
- **Inmate Demographics**

Massachusetts Correctional Facilities

There are two systems that incarcerate adults in Massachusetts:

- State prisons, operated by the Massachusetts Department of Correction; and
- County jails and houses of correction, controlled by the locally elected county sheriff.

In general, county jails and houses of correction (HOC) are located in the same facility and hold inmates who are awaiting trial or have been sentenced to terms up to 2 ½ years. The state prison generally holds inmates convicted and sentenced to terms of longer than 2 ½ years. One exception is the 88% of females in DOC facilities who are serving county sentences. County inmates usually come from the surrounding community, while those housed in state DOC facilities can come from anywhere in the state.

There are 18 correctional facilities operated by the Massachusetts Department of Correction (DOC) and 13 county Houses of Correction. Seven of the county houses of correction (Hampden, Essex, Worcester, Middlesex, Hampshire, Berkshire, and Franklin) are funded directly by the state, but are operated by the locally elected sheriff.

The Department of Youth Services operates 102 programs, including 64 facilities for detained youth and 38 programs for youth who live in the community (residing with a parent, guardian, foster parent or residing in an independent living program).

A third system is the Office of Community Corrections, which operates 22 facilities statewide that provide intermediate sanctions and substance abuse programming for up to 5,000 prison-bound male and female offenders annually. The Centers provide services and sanctions to offenders who have a strong potential for high-risk behavior and eventual incarceration. Additionally, the Centers' mission includes providing these services to inmates being released from prison on parole.

Correctional Health Service Providers

The health care delivery systems for the state prisons and county correctional facilities are very different. The Correctional Health Program of UMass Medical School provides health care for prisoners at all state Department of Correction facilities. In 2002, they replaced Correctional Medical Services, a national for-profit correctional health provider that had previously provided health care for state prisoners.

Each county procures its own health services, with some utilizing private for-profit correctional health providers, while others provide their own health care or contract with community agencies to provide health services. Counties often have different priorities, missions and investment in health care, which can lead to large disparities in staffing ratios, screening, and treatment practices. The burden on the counties is enormous, since they are often the first stop for a tremendously high volume and turnover of inmates. While county correctional facilities have few specific policies and procedures in common, progress has begun in this arena by county health administrators who have initiated a working group seeking to address consistent standards and guidelines.

Inmate Demographics

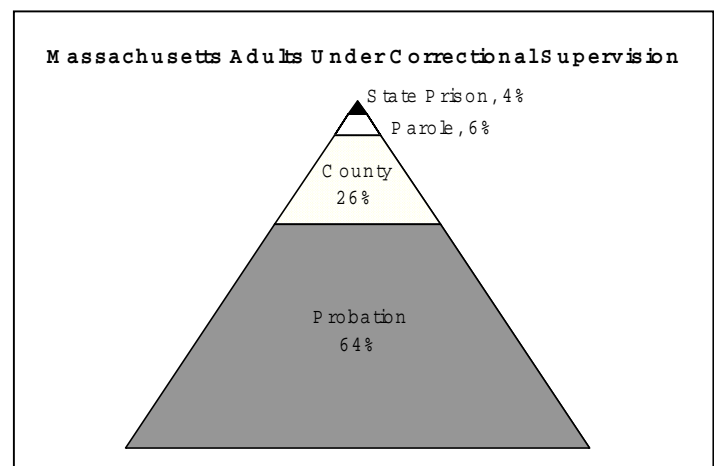
On any given day, about half of Massachusetts inmates are incarcerated in the state prison system and the other half is being held in county correctional facilities. Approximately 5% are women and the average inmate age is in the 30's. The average age of juvenile detainees is 17 years old and females make up 15% of this population (Table 1).

Table 1

	State Prisons Dept of Correction ¹⁷ <i>Jan. 1, 2002</i>	County Correctional Facilities ¹⁸ <i>2002 Average</i>	Department of Youth Services ¹⁹ <i>March 3, 2002</i>
Daily Census	9,610	11,071	3,285
Gender: Male	94%	95%	85%
Female	6%	5%	15%
Average Age: Male	37	32	16.8
Female	36	33	17.1
Total # of new entries per year	2,255 (2001) ²⁰	16,291 (2002)	23,000 (2001)

Figure 1

While the State Department of Correction and County Houses of Correction hold a similar number of inmates in their facilities at any one time, there is a much higher rate of inmate turnover at the county jails than the state prisons. For example, there were over 16,200 people sentenced to county facilities in 2002, with an average sentence of six months.²¹ This compares to only 2,255 sentenced to the DOC in 2001. If we also consider those under correctional supervision who are not incarcerated, there are almost 40,000 people on probation and over 3,000 on parole (Figure 1).²²



Gender

Female inmates suffer higher rates of many illnesses than their male counterparts. For example, women incarcerated by the Massachusetts Department of Correction:

- Have **1.6 times** the rate of **HIV** infection than male inmates²³
- Have **1.6 times** the rate of **hepatitis C** than male inmates²⁴
- Reported **1.2 times** the rate of a history of **past injection or inhalation of drugs**²⁵
- Are **2.9 times** as likely as male inmates to have an **open mental health case**²⁶

The prevalence of physical and sexual abuse, rape and trauma found among female inmates is staggering. For example, at MCI-Framingham (the state DOC facility housing women):²⁷

- **65%** of female inmates reported a history of **sexual partner violence**
- **55%** reported having been **raped, forced or intimidated to have sex**
- **32%** reported **parental/caretaker violence**

Jail data on health indicators are scarce. However, a survey of women incarcerated at the Hampden County Correctional Center in Western Massachusetts found that:²⁸

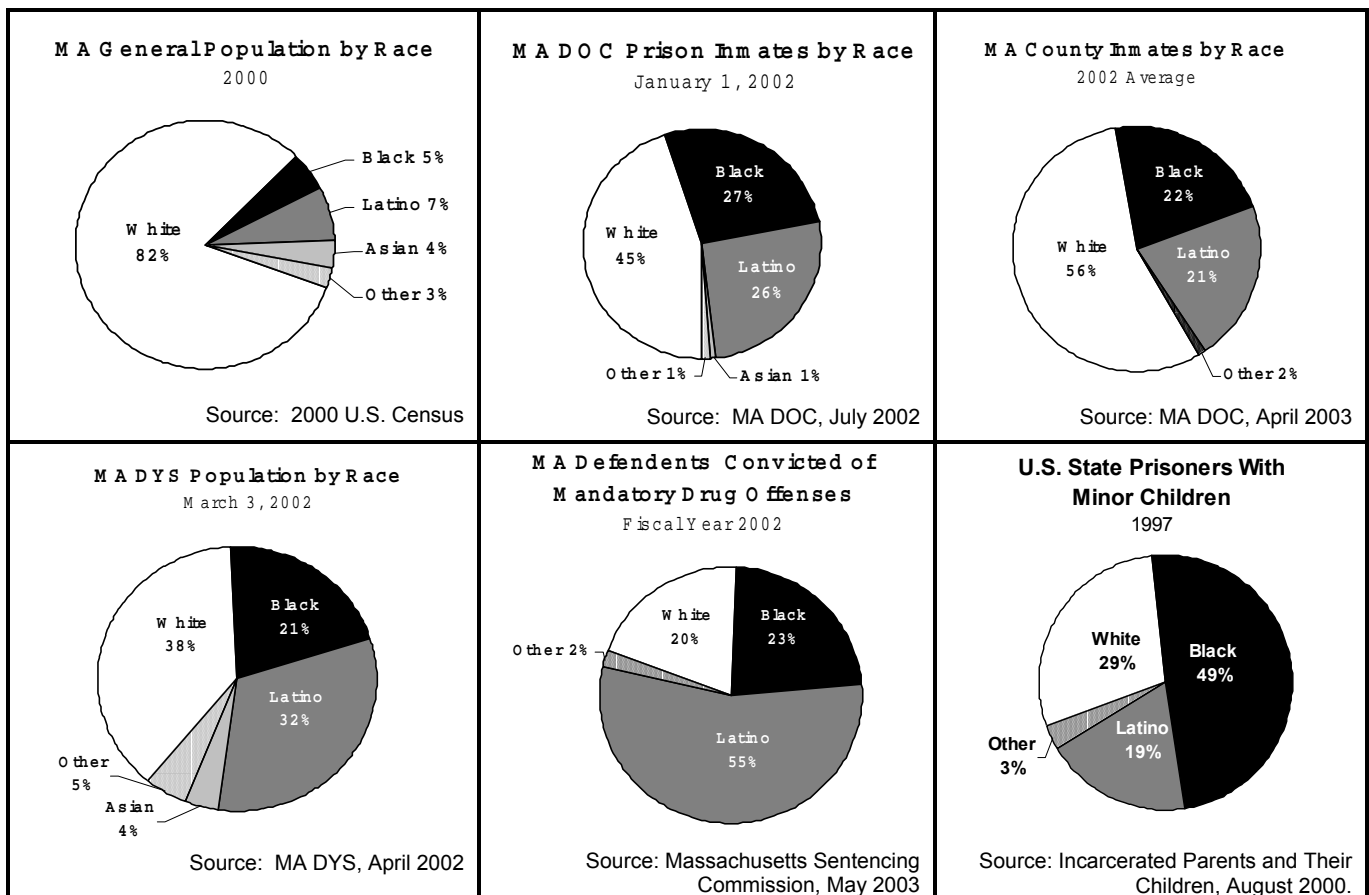
- **75-90%** are **addicted to substances**
- **80%** of their **crimes are related to their addictions**
- **33%** have **no stable home to return to** upon release
- **66%** have **not worked** for more than three years in their lives
- **60%** demonstrate moderate but serious **mental health issues**
- **61%** were **sexually abused as children**
- **78%** had experienced **sexual and physical violence**
- **37%** had made one or more efforts to **commit suicide**

Given the high rates of trauma and violence in these women’s lives, the policies, practices and programming addressing their needs must be appropriate to and mindful of their histories. However, since women represent only 5% of the incarcerated population in Massachusetts, many facilities do not provide sufficient or gender-specific programs for their female inmates. The paths that lead women to incarceration are very different from men and must be addressed with gender appropriate environments, systems, policies and practices.

Race and Ethnicity

African Americans and Hispanics are disproportionately represented in the incarcerated population (Figure 2). For example, in 2000, blacks were 9 times more likely and Hispanics were 7 times as likely to be incarcerated in Massachusetts as whites. **Blacks and Latinos accounted for over 52% of Massachusetts inmates - over 4 times the proportion of black and Latino residents in Massachusetts.**²⁹ Nationally, approximately 28% of black males will enter State or Federal prison during their lifetime, compared to 16% of Hispanic males and 4.4% of white males. In Massachusetts, over four times as many people of color were convicted of mandatory drug offenses than whites. Nationally, black children are nine times more likely and Hispanics are three times as likely as white children to have a parent in prison.³⁰

Figure 2



The populations of color that are so disproportionately represented in the incarcerated population are also the populations that suffer a disproportionate share of illness in the general public. For example:

- African-Americans continue to experience death rates that exceed the death rates of white non-Latinos for heart disease, stroke, lung cancer, breast cancer, motor vehicle crashes, and homicide.³¹
- People of color have tuberculosis case rates that exceed that of whites; these rates range from 8 times the white rate for Latinos to more than 30 times the white rate for Asian/Pacific Islanders.³²
- African-Americans and Latinos have the highest rates of primary and secondary syphilis.³³
- African-Americans and Latinos represent approximately 12% and 14% of the US population, respectively, but 47% and 19% of new AIDS cases.³⁴
- African-American and Latina women lack access to pre-natal care at twice the rate of white women.³⁵

Given the over-representation of African Americans and Latinos in the criminal justice system, a focus on improving the health of those moving through corrections must be a crucial component of national efforts to eliminate racial and ethnic health disparities.

Juvenile Populations

Demographics of children held in the Massachusetts Department of Youth Services facilities³⁶:

- 62% are non-white
- 87% are from non-traditional homes
- 40% are on public assistance
- 55% have a history of DSS involvement
- 75% are on probation
- Most come from 17 communities in Massachusetts

During the past 10 years, the DYS population has more than doubled, yet funding has not increased similarly. This has resulted in overcrowding, program closures, and understaffing. Some of the reasons for the growth in the juvenile detention population include an increase in the adolescent population, harsher sentencing for juveniles, increases in sexual offenses, and extensions past discharge dates due to increased levels of “dangerousness”. Another significant factor is the increase in number of mentally ill juveniles being placed in DYS awaiting a placement for treatment for mental illness. This is particularly true for the female population.

Children of Inmates

The incarceration of parents greatly impacts the lives of their children. A report by the Department of Justice published the following data from 1999.³⁷

- **Nearly 1.5 million children under the age of 18 had a parent who was incarcerated.** Twenty-two percent of these children were under the age of five.
- Over 60% of state prison inmates who are parents lived over 100 miles away from the correctional facility in which they were being held.
- Black children were almost nine times more likely to have a parent in prison and Hispanic children were three times as likely to have a parent in prison than white children

“A variety of studies have found that increased contact between inmates and their families can contribute to an inmate’s re-integration, in turn, is an indicator of reduced risk of re-offense. Institutional programming and visitation can encourage healthier family relationships, further developing a critical element in the offender’s post-release support system...For inmates who have children under the age of 18, family programs and services can also address the forces underlying an intergenerational cycle of crime.”

Services for Families of Prison Inmates,
National Institute of Corrections, February 2002.

Incarceration can cause physical and emotional damage to the children of inmates³⁸. The loss of caregiver support and benefits, disruption of family ties, changes in housing and school, and feelings of guilt and shame can leave lasting behavioral and emotional problems.³⁹

REINTEGRATION & THE PUBLIC'S HEALTH

- **Health Care Insurance Coverage**
- **Discharge Planning**
- **Post-Release Supervision & Mandatory Minimums**

Given that 97% of prisoners are ultimately released back to their communities,⁴⁰ a significant amount of state and national attention has begun to focus on the issue of re-entry, with a growing emphasis on the public health impact and cost-savings of addressing inmate health. However, given the number of inmate needs that must be addressed upon release (housing, jobs, education, family, legal, etc.), increases in the number of inmates released without any type of supervision, cuts to Medicaid eligibility, and administrative barriers to Medicaid enrollment for those who are eligible, the challenges to addressing health and mental health needs upon release are enormous.

Health Care Coverage

Health care coverage upon release from incarceration is crucial for an inmate to receive the substance abuse treatment and health/mental health services required for a healthy transition back into the community.

Before April 1, 2003, most Massachusetts inmates were eligible for Medicaid health coverage for the long-term unemployed, referred to as MassHealth Basic, upon release from correctional facilities. This program provided ex-offenders with the insurance coverage they needed to gain access to the health, mental health, and substance abuse care and medications they needed for a healthy transition back into their communities. The greatest challenges, at that time, were the **administrative barriers to enrolling inmates onto MassHealth coverage immediately upon release from jail or prison.** Gaps in coverage could last from days to weeks after release, greatly hindering an ex-offender's access to the health, mental health and substance abuse services needed for a successful transition.

The elimination of MassHealth Basic coverage on April 1, 2003, created significant barriers to preparing inmates for follow-up care and medications after release. Probationers, parolees, and ex-offenders no longer had access to many of the substance abuse treatment, mental health services, and medications that were crucial to maintaining a crime-free lifestyle. The loss of access to the healthcare necessary to prevent exacerbation of illness and spread of infections was expected to ultimately affect the public's health and emergency rooms were beginning to see sicker people presenting for more expensive medical care. All of these outcomes were anticipated to add to an already heavy financial burden of incarceration and health care costs to the Commonwealth of Massachusetts.

In the FY04 state budget, the legislature created MassHealth Essential, a new one-year program for those who had been eligible for MassHealth Basic, that began on October 1, 2003. However, this program will cover fewer people and will be more restrictive than MassHealth Basic - with lower income eligibility, enrollment capped at 36,000 people, and coverage of fewer services. Additionally, the program could disappear in October 2004 if the legislature does not refund it.

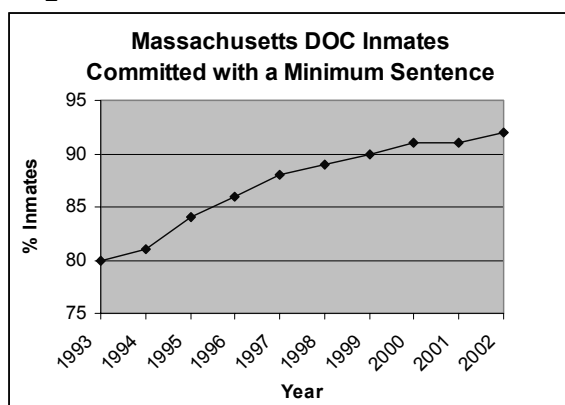
Discharge Planning Although health insurance is a major component of meeting the health care needs of inmates upon release from correctional facilities, there is also a great need for discharge planning that includes case management and support for utilizing available services. Assistance in completing paperwork, setting up appointments with health and mental health providers, as well as support in keeping these appointments after release are vital to assuring that the health care that an inmate may have received while incarcerated will continue.

While most correctional facilities have personnel designated to oversee discharge planning, **the health care needs of inmates may be left unaddressed by the discharge planner unless the inmate has a serious medical condition.** Often, the crucial issues of housing, family, and jobs are the primary focus of the discharge planner's responsibility. Additionally, with recent cuts to community-based organizations that provide health care, substance abuse treatment, and mental health services in the community, the number of places to which an inmate can be referred to for assistance in his/her transition are quickly disappearing.

Establishing safe and reliable housing upon release is a crucial component of discharge planning. According to the DOC, fifteen percent of inmates released from Massachusetts state prisons have no plans for housing. The MA Housing and Shelter Alliance estimates that as many as 3,200 to 4,000 inmates leave correctional facilities with no housing. Inmates released directly to the streets or homeless shelters are at risk for relapse, recidivism, and a range of health care problems.

Post-Release Supervision & Mandatory Minimums Post-release supervision is a crucial component of increasing the likelihood of successful reintegration into the community upon release and reduced risk of reincarceration. One way for inmates to receive assistance with re-entry is from their parole officer upon release. However, the broad adoption of mandatory minimum sentencing in response to the "Truth in Sentencing" Law enacted in 1994 and the increase in inmates choosing to carry out their full sentence instead of being released onto parole have significantly increased the number of inmates being released directly to the street without any post-release supervision (Figure 3). In fact, **Massachusetts has the 9th lowest rate of post-release supervision of all U.S. states**⁴¹. For those who are eligible and do elect parole, reincarceration due to violation of parole requirements can create a vicious and costly cycle of recidivism. In 1999, over 20% of admissions to state prisons were among parole violators⁴². The adoption of more flexible sanctions and increased use of community-based agencies such halfway houses and residential treatment facilities upon release will help to address the challenges of reintegration.

Figure 3



Increased attention has been paid recently to the issue of re-entry and reduced post-release supervision. The possibility of including a period of time at the end of an inmate's sentence for step-down or post-release support is gaining support and becoming recognized as an important component of reducing recidivism. However, **the need to address health issues upon release is severely lacking from this discussion.** Given the strong linkages between health status and ability to function successfully in the community, it is crucial that all post-release supervision proposals and forums under consideration include discussion of health and mental health needs.

It is also important to note that **over two-thirds of the population under correctional supervision are not incarcerated, but are on probation or parole.** Parolees and probationers are a forgotten population who experience many of the same problems as incarcerated individuals. Probation and parole supervisors must work to improve linkages with community-based agencies to provide the necessary health, mental health, and substance abuse programming, support and services they need to function productively and pose less of a threat in society.

BENEFITS OF ADDRESSING THE HEALTH AND MENTAL HEALTH NEEDS OF INMATES

- **Improved Inmate Health**
- **Improved Public Health**
- **Improved Public Safety/ Reduced Crime**
- **Increased Success in Re-Entry**
- **Protection of Correctional Staff Safety and Health**
- **Cost Savings**

The health services staffs at correctional facilities are charged with the task of providing services to some of the sickest people in our state, with very limited resources. Adequate allocation of resources, collaboration with community and state partners, and prioritization of health in the arena of corrections are necessary for correctional health practitioners to address the health issues of those moving through our criminal justice system. By supporting and collaborating with health services staff in correctional institutions in carrying out their responsibilities, we can hope to see many benefits.

Improved Inmate Health

The majority of inmates have not received regular medical or mental health care prior to incarceration. An inmate’s health can be improved significantly if his/her health and mental health needs are recognized and treated while incarcerated and after release (Table 2). Additionally, prevention and education while incarcerated can help to prevent the inmate from getting new illnesses.

Table 2: Self-Reported Data from Hampden County Jail

Self-Reported Health Status (n=131)	At Intake	6 months post-release
General Health		
Fair/Poor	55%	34%
Good	24%	33%
Very Good/Excellent	21%	33%
Pain (Moderate/Severe)	40%	20%
Emotional problems (Moderate/Severe)	66%	43%

Source: Lincoln T, Conklin TJ, et al. APHA Annual Meeting 2002

Improved Public Health

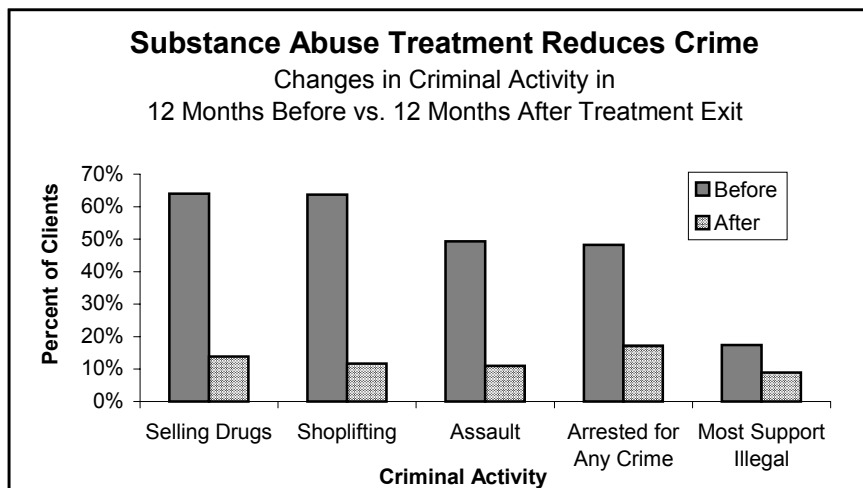
As indicated earlier, inmates in Massachusetts experience much higher rates of communicable diseases than the general public. Since most inmates will ultimately return back to their communities, effective screening, immunization, education, and treatment can help to reduce the risks of the inmate’s families, sexual partners, and communities. Correctional facilities may also be the first to detect emerging trends in communicable disease patterns, as was the case in the surge of TB cases in the late 1980’s and early 1990’s.

Improved Public Safety/Reduced Crime

Table 3

Research indicates that those who suffer from both mental health problems and substance abuse disorders are at higher risk for violent and criminal behavior⁴³. By addressing these issues while a person is incarcerated and continuing that care upon release, we can expect to reduce crime and recidivism, while increasing public safety (Table 3).

Substance abuse treatment alone has been found to contribute to a 20% reduction in recidivism.⁴⁴



Source: 1997 National Treatment Improvement Evaluation Study (NTIES)

Increased Success in Re-entry

When an inmate returns to his/her community, he/she is confronted with the responsibilities of finding housing, reunifying with family, seeking a job, and the many temptations of being pulled back into the risky behaviors that he/she practiced prior to incarceration. Without sufficient support, coverage, and assistance in seeking health and mental health care, as well as substance abuse treatment, the likelihood of a successful transition is severely hampered.

Protection of Correctional Staff Safety and Health

Correctional facility staff also benefit from healthier inmates. Screening for and treating infectious diseases among inmates reduces risk of transmission to staff. Identifying and providing appropriate and integrated mental health and substance abuse treatment for inmates benefit staff by reducing inmate behavioral problems and increasing safety.

Cost Savings

Investing in Substance Abuse Treatment:

- In 2000, the average cost of housing an inmate for one year in a DOC facility was \$36,131, while the cost of substance abuse treatment cost \$1,800 to \$6,800 per year⁴⁵.
- Substance abuse treatment has been found to contribute to a 20% reduction in recidivism⁴⁶.
- A 1994 study by the Rand Corporation found that every dollar invested in substance abuse treatment saves taxpayers \$7.46 in societal costs.

Preventing and Treating Infectious Disease: The costs associated with early detection, prevention, and treatment of illnesses such as HIV, AIDS, and hepatitis C are significantly less than addressing these illnesses once they have progressed.

- 27% of males and 44% of female inmates in Massachusetts inmates are infected with hepatitis C, which is the leading indication for liver transplants. Since hepatitis C is the leading indication for liver transplants – *which cost an average of \$300,000 each* – interventions to detect and prevent progression of hepatitis C are cost effective.
- An in-depth and ongoing study at the Hampden County Correctional Center in Ludlow, Massachusetts found that the comprehensive HIV/AIDS testing and treatment programs are likely pay for themselves when all costs to society are considered; potential indirect savings could be as high as \$270,000 per inmate.

Promoting More Appropriate Use of the Health Care System: It is difficult to find data on health care access of inmates outside of correctional facilities. However, a survey of inmates at the Hampden County Correctional Center in Ludlow, Massachusetts found that 80% of chronically ill inmates had not received regular medical care prior to incarceration and many had been using the local hospital emergency room as their primary care provider. If inmates are supported and receive coverage to seek regular medical care after release, the community will realize the cost savings of fewer emergency room visits that require expensive medical intervention.

Contracting with non-profit providers: Savings can be realized by correctional facilities by contracting with community-based, non-profit providers instead of relying on for-profit health care providers. For example, the Hampden County Correctional Center (HCCC) offers comprehensive care and prevention services for inmates at just below the median cost for all jails, by contracting with local non-profit health care, pharmacy, dental care, optometry, health education and mental health providers (Table 4).

Table 4

1998 Jail Health Care Costs	1998 HCCC	U.S. Jails – 1998 *		
		Low	Median	High
Annual Health Care Cost per Inmate	\$2,639	\$1,097	\$2,660	\$6,821
% Total Jail Budget Spent on Health Care	9.6%	7.8%	15.0%	34.6%

* Source: 2001 USDOJ, Large Jail Survey

RECOMMENDATIONS

- **Health Care Coverage**
- **Linkages with Community-Based Organizations**
- **Health Promotion & Disease Prevention**
- **Mental Health & Substance Abuse Treatment**
- **Incarcerated Women**
- **Public Health Oversight of Correctional Health Care**
- **Data Collection & Tracking**
- **Funding & Resources**
- **Conclusion**

The recommendations that follow address the need to provide comprehensive health and mental health care to people moving through the criminal justice system while under correctional supervision and as they reintegrate back into their communities.

HEALTH CARE COVERAGE Without coverage for health and mental health care, substance abuse treatment, and medications upon release, inmates returning to the community will not be able to access the services they need for successful reintegration.

Enact S555/H3751, An Act Restoring the MassHealth Basic Program, sponsored by Sen. Mark Montigny and Rep. Deborah Blumer

MassHealth Basic health insurance coverage for the long-term unemployed, for which most inmates were eligible upon release from jail or prison, was eliminated on April 1, 2003, leaving many people with limited access to services as they attempted to achieve a healthy transition back to the community. This coverage - which helped inmates receive health, mental health, and substance abuse services and medications after leaving correctional facilities - was necessary to continue the care that they had received while they were incarcerated, thus protecting the investment made by correctional facilities in their health care. With the loss of MassHealth Basic coverage for released inmates, the improvement in health and mental health that may have been achieved while incarcerated was often quickly erased as they walked out the door.

The creation of the MassHealth Essential Program is an important step forward in beginning to repair the disappearing public health and safety net. However, due to the limitations of the program (lower income eligibility, a cap on the number of recipients, fewer covered services, and expiration after one year), MassHealth Essential is not a substitute for full restoration of MassHealth Basic. We encourage the legislature to pass S555, An Act Restoring the MassHealth Basic Program, sponsored by Senator Mark Montigny. This investment will ultimately save money by preventing the unnecessary costs of: increased re-incarceration of those who return to drug use after release; increased threats to public safety for the many who are dually diagnosed but unable to obtain mental health medications and treatment in the community; the expensive medical interventions that will be increasingly necessary to address medical problems left untreated in the community; and increased transmission of diseases that could have been prevented.

MODEL PROGRAMS

Hampden County's Public Health Model of Correctional Health Care

The Hampden County Correctional Center (HCCC) has implemented a "public health model of correctional health care" based on the premise that inmates can receive high quality care at minimal cost if a jail contracts with non-profit providers from the communities to which the inmates return. Community based providers in Hampden County contract with the HCCC to begin working on discharge planning and health care issues shortly after an inmate *enters* the facility and continue to provide treatment and support to the inmates as they transition back into the community. HCCC contracts with the DOC to provide re-entry and transition services to inmates from Hampden County with six months of their sentence remaining. HCCC also runs a model program for female inmates, which is gender appropriate and based on well-established relational models specific to women. For more information about this innovative model, visit www.mphaweb.org/hccc.html.

Transitional Intervention Program (TIP)

The TIP program, administered by the Dept. of Public Health (DPH), provides reintegration services for HIV positive inmates, to help ensure continuity of care and treatment as they leave jail and re-enter the community. The DPH contracts with community based organizations who help bridge the gap between services provided while inmates are still incarcerated and those available upon release. TIP services start before inmates are released and continue for six to nine months post-release, until transition can be made to appropriate community-based services. TIP services are available in all Massachusetts Department of Corrections facilities, county jails and county houses of correction. For more information, call 617-624-5309.

Forensic Transition Team (FTT)

The FTT is administered by Dept. of Mental Health and works with the Dept. of Correction, Dept. of Youth Services, county jails, and parole and probation agencies to help severely mentally ill offenders link with community programs and adjust to life after prison. The FTT provides service planning and continuity of care for both sentenced and pre-trial clients. The program relies on interagency collaboration, including cross-training between agencies. DMH reports that recidivism rates for mentally ill offenders who work with FTT is significantly lower than the general inmate population.

(Continued on following page)

Enact S598, An Act Relative to MassHealth Enrollment for Persons Leaving Correctional Facilities in MA, sponsored by Senator

Richard T. Moore In addition to providing MassHealth coverage for inmates as they return to their communities, it is crucial that such coverage begin immediately upon release from correctional facilities. Before MassHealth was temporarily eliminated in April 2003, there was often a lag of several days to several weeks after release before an ex-offender's enrollment began. During this time, they often faced many obstacles to obtaining the medications and treatment necessary for a safe and healthy return to society. In order to assure continuity of care, the enrollment process must begin immediately upon release. S598 requires that the Division of Medical Assistance work in collaboration with the Department of Correction, county jails, and county houses of correction to "establish a system of medical care such that persons who will become eligible for MassHealth benefits upon release from Massachusetts correctional facilities shall begin receiving benefits immediately upon such release".

LINKAGES WITH COMMUNITY-BASED ORGANIZATIONS

The organizations that currently provide services and support to the people in the communities to which inmates return are the ideal partners to address the health and mental health needs of the incarcerated population as they re-enter society. Community-based organizations are established and trusted resources in the community who are familiar with the cultures and needs of the people in the area. They know intimately the resources and others agencies that exist in the community and have the expertise to assist an inmate's transition in many ways. Partnerships between corrections and community-based organizations to plan for reintegration also promote sharing of information and resources, as well as increased knowledge of each other's systems and needs.

Promote replication and expansion of model programs that rely on partnerships between corrections and community-based agencies

Several collaborations between correctional facilities and community-based organizations have proven to be quite successful in Massachusetts. Such programs that rely on corrections and community partnerships, should be should be expanded and replicated in other settings throughout Massachusetts. (See model programs, p. 18 & 19)

Enact H3393, The Re-Entry Health Study Act introduced by Boston Mayor Menino and sponsored by Rep. Liz Malia.

This bill would authorize a county correctional health care assessment of community-based capacity to provide health or social services to inmates released from correctional facilities. Passage of this bill would help to designate counties where programs building on strong collaborations between corrections and community-based organizations would be most feasible.

Restore & protect the community safety net

Community based programs and agencies provide the safety net that catch, support and provide services to inmates as the re-enter society. However, state funding for these very agencies continues to be cut at an alarming rate. If the homeless shelters, community health centers, mental health providers, substance abuse treatment centers, and other community agencies do not have the capacity to provide services and programs for inmates leaving corrections, the possibilities of a successful transition are in serious jeopardy.

HEALTH PROMOTION & DISEASE PREVENTION

The majority of illnesses experienced by those who are incarcerated are preventable. For those that have already contracted a communicable disease, there are ways that they can prevent the spread of their disease to others. By utilizing health promotion and disease prevention methods in correctional facilities, inmates will benefit from improved health and corrections will benefit from a reduced need for costly medical interventions and increased safety of staff from transmission.

Correctional facilities should follow national guidelines for screening, immunizing, and treating illness and disease among inmates

Examples include, but are not limited to:

- Centers for Communicable Disease Control (CDC), Morbidity and Mortality Weekly Report (MMWR): Guidelines for Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings (<http://www.cdc.gov/mmwr/PDF/rr/rr5201.pdf>)
- CDC/MMWR: Guidelines for Prevention and Control of Tuberculosis in Correctional Facilities (<http://www.cdc.gov/nchstp/tb/pubs/mmwr/rr4508.pdf>)

At a minimum, all correctional facilities in Massachusetts should be accredited by the National Commission for Correctional Health Care (www.ncchc.org).

MODEL PROGRAMS

(Continued from previous page)

Father Friendly Initiative

The Men's Health Access Initiative at the Boston Public Health Commission (BPHC) uses intense case management to link recently incarcerated men at the Suffolk County House of Correction with the BPHC's Father Friendly Initiative and with community-based health care. Case managers work with male inmates prior to their exit from jail to help them navigate access to service providers and health care institutions. The case managers themselves are drawn from the communities where most of these young men live and therefore are able to identify with the barriers and challenges of poverty, racism and lack of health insurance and serve as a role model.

Aid to Incarcerated Mothers (AIM)

AIM provides pre-release and post-release services for incarcerated mothers and their children. Services include: clinical services, health education, case management, legal advocacy, counseling, parenting education, support groups, information, referrals, technical assistance, and family reunification support for mothers & children.

Half-Way Back Program

The North Cottage Half-Way Back Residential Treatment Program is a ten bed, 60 day Intensive Residential Treatment Program located in Norton, Massachusetts. This program serves as an alternative to incarceration for parolees who have violated parole from four county houses of correction.

Community Corrections Centers

Located in urban centers statewide, the Office of Community Corrections' 22 *Community Corrections Centers* provide an array of services to offenders as an alternative to incarceration or upon release from correctional facilities. The Centers have been able to establish valuable linkages to the community health infrastructure in order to facilitate the initiation or continuity of comprehensive health care.

Keep Teens Healthy Program

Planned Parenthood's *Keep Teens Healthy* program which promotes healthy behaviors among adolescent MassHealth members operates in several DYS facilities. The program consists of group and individual meetings on a variety of topics including: sexuality education, self-esteem, sexually transmitted diseases (including HIV/AIDS), relationships, and more.

Corrections should partner with the Department of Public Health and community-based organizations to offer accurate and culturally appropriate health education materials, educational programming, and peer education programs

- **Peer education:** Health education programming taught by current or former inmates to their incarcerated peers has been found to be particularly effective.^{47,48} Not only do inmates tend to trust and take in the information from their peers more readily, but the educator benefits from increased knowledge, self-esteem, and leadership skills. Successful and sustainable peer education models address a wide array of issues including HIV/AIDS, hepatitis C, and harm reduction. Peer education programs should be implemented in all correctional facilities in Massachusetts.

Peer Education in Texas

The AIDS Foundation Houston has partnered with the Texas Department of Criminal Justice and the University of Texas Medical Branch to develop a model peer-based HIV/STD/TB/Hepatitis C education program. In 2002, more than 150 inmates were trained on HIV/AIDS peer education in the largest conference of its kind. Separate gender-appropriate curricula's have been designed for men and female offenders. Phone cards that require listening to a prevention message are given to offenders upon release.

26th National Conference on Correctional Health Care, 2002

- **Health Education Materials:** The Massachusetts Department of Public Health (DPH) has developed a wide array of health education materials that are often offered in several languages. However, the availability of these materials or how to obtain them is not always apparent to correctional health administrators. DPH health materials should be made available to correctional institutions and agencies in a way that is easy to order and receive.

Allocate dedicated funding to treat hepatitis C

The rate of hepatitis C in prisons and jails has reached epidemic proportions with 27% of males and 44% of females who are incarcerated in Massachusetts prisons infected⁴⁹. However, the cost of treatment (approximately \$25,000 for a one year treatment regimen) is so prohibitive to jails and prisons that efforts to screen for and educate inmates about this illness are often not pursued. The fact is that there are a great many things can be done short of treatment to protect an infected individual from exacerbation or spread of his/her illness. Massachusetts correctional facilities need to strive to offer testing, counseling, education and (when appropriate) treatment to those who have risk factors for hepatitis C. Hepatitis C is now the leading indication for liver transplants in the U.S., at an average cost of \$300,000 each. As sentences grow with the adoption of mandatory minimums and the jail and prison population continues to age, prisons will increasingly be faced with the burden of much more daunting costs than treatment. It is important to begin to explore the ultimate goal of hepatitis C treatment coverage similar to that provided to those with HIV and AIDS in Massachusetts.

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

The mental health services provided by the Department of Correction have undergone upgrading in the past several years. However, mental health funding and services at the county jails are often significantly less than those within the state prison system. The lack of services and resources for mental health care at the county jails puts inmates, correctional staff, and the general public at risk.

The Health Status of Soon-To-Be-Released Inmates: A Report to Congress

“Providing mental health services to offenders who require them is necessary for the safety and well-being of offenders and staff, the smooth operation of corrections, and community safety and quality of life...Jails are increasingly important in identifying and treating acute and chronic medical and psychiatric conditions at a time when indigent care is dwindling...Clearly, providing mental health services to persons with mental illnesses who come into contact with the criminal justice system is not an option, but a constitutional necessity.”

National Commission on Correctional Health Care, March 2002

Adequately fund county jail mental health

Due to state budget cuts, the Department of Mental Health (DMH) was forced to discontinue their funding contribution for county jail mental health services in FY02. The DMH funding reduction, coupled with additional cuts in county budgets, forced severe reductions in mental health staffing at many Massachusetts jails during the past two years. However, even before the funding cuts of recent years, the DOC invested a much greater amount of funding for far fewer inmates⁵⁰.

A recent DMH analysis shows that the county jails would require more than \$5.6 million in funding for mental health staffing and services to reach the levels of mental health care provided by the Department of Correction. (Note: This does not include the funds required for mental health medications and other services.) We recommend that the state allocate adequate funding to the counties, targeted specifically for mental health services.

Invest in substance abuse treatment

Substance abuse remains one of the most significant factors leading to crime and re-incarceration. It is estimated that for every \$1 spent on substance abuse treatment, more than \$7 is saved⁵¹. In the criminal justice system, the cost savings and public safety implications of appropriate and comprehensive substance abuse treatment are particularly apparent. For example, education and treatment is shown to be seven times more cost effective than arrest and incarceration for substance addiction⁵². Funding for substance abuse programs run by the Massachusetts Department of Public Health have been cut by over \$11.3 million in the past three years, resulting in significant reductions to DPH funded substance abuse services in correctional facilities and community based substance abuse programs that help prevent incarceration and provide services to inmates upon release.

In addition, the closure of over half of Massachusetts' detoxification facilities resulting from the elimination of MassHealth Basic in April 2003 was extremely detrimental to efforts toward successful reintegration of inmates and prevention of incarceration. As a result of the closure of these publicly funded detoxification beds, more people are being sent to the penal system for assistance with their substance abuse problems. The Department of Correction has experienced significant increases in the number of involuntary civil commitments of residents to their facilities for alcohol and substance abuse treatment. With nowhere else to go, men are being sent to the Massachusetts Alcohol and Substance Abuse Center and women to MCI-Framingham for 30 days of substance abuse treatment, under Massachusetts General Laws, chapter 123, section 35. **Over the past year, the civilly committed population of men in the custody of the Department of Correction has increased by 50%**, from an average of 120 to 180 admissions per month, with over 200 men in the custody of the Department of Correction for their alcohol and substance abuse treatment on any given day. The increase in civil commitments for women at MCI-Framingham is even more significant, increasing from 149 in calendar year 2002 to 127 in just the *first half* of 2003. If these numbers remain constant through the end of 2003, this will reflect a **70% increase in the civil commitment of women Massachusetts since 2002**.

As a group, civilly committed men and women tend to struggle not only with alcohol and substance abuse, but with significant medical and mental health conditions. They also utilize a disproportionate share of "assistance with daily living" services, inpatient hospital resources, and correctional infirmary beds at a great cost to the state. With a lack of resources available for programs in the community, judges and families are relying on the criminal justice system to provide public health, mental health, and other human services to a population with very complex needs.

INCARCERATED WOMEN

Since women are such a small proportion of inmates at most county correctional facilities, they are often offered "one size fits all" policies and programming designed primarily for male inmates or may lack programming altogether. Women inmates need to be able to access programs that provide them with the education, health services, job training, work experience, parenting classes, and other skills

and services that lead towards a more successful transition back to the community. Given the specific needs of women, the histories of trauma that most have experienced, and their many health and mental health needs, policies, programming and services must take these factors into consideration and be gender responsive. For program and services to be effective they must also exist within an environment and structure appropriate for females. Additionally, programming must take into account the major role that the children of female inmates play in their lives. The opportunity to provide female inmates with the skills and support that can help them to be better mothers when they are reunited with their children upon release must not be ignored.

Create parity for female offenders

Massachusetts correctional facilities should adopt the American Correctional Association's 1995 policy statement which reads, "Correctional systems should be guided by the principle of parity. Female Offenders must receive the equivalent range of services available to male offenders, including opportunities for individual programming and services that recognize the unique needs of this population"⁵³. Parity in programs and services does not suggest that female offenders should receive identical programs and services as men, but speaks to the need for access to a similar number of offerings and resources. This parity should include, but not be limited to: access to health services (including regular gynecological exams and screenings), recreation, substance abuse treatment, mental health services, education, and job training.

Promote adoption of gender-responsive strategies for female offenders

Given their histories and the different ways that women learn and communicate than men, programming, services and methods for should be designed specifically for females. Correctional facilities housing female offenders should utilize *the Guiding Principles and Gender Responsive Strategies* highlighted in the recently released National Institute of Corrections document "Gender Responsive Strategies: Research, Practice and Guiding Principles for Women Offenders". Correctional facilities that house women should offer integrated services and programs that include, but are not limited to: domestic violence, parenting, prenatal care, reproductive health and screening, and gender-specific substance abuse and mental health treatment.

Adopt programs & policies to support families

Programs that facilitate visitation by children, co-housing for non-violent female offenders and their children, and comprehensive prenatal care to pregnant inmates can help to help to establish, maintain and enhance family bonds, improve the health of newborns, and increase the likelihood of emotional health of children⁵⁴. They also contribute to reduced recidivism and help to break the cycle of family crime⁵⁵. Massachusetts policymakers and correctional administrators should:

- Work to assure that pregnant and postpartum inmates receive the care that they need for a healthy delivery, as outlined in H2854 sponsored by Rep. Kay Khan.
- Support and expand special community housing for pregnant and parenting female inmates to promote parenting skills and mother-child bonding.
- Support and expand programs that facilitate family visitation while incarcerated and assist in reuniting families upon release (see description of AIM on page 19).

Women Inmates & Their Children California Models

Program for Inmate Mothers: Reunites eligible women with their children aged 6 years or younger. The mothers care for their children in a highly structured residential treatment facility outside prison walls.

Community Prisoner Mother Program: Allows eligible inmates to move from a prison setting to a community-based facility for the remainder of their sentence, an average of 9 months.

The Family Foundation Program: Provides alternative sentencing for mothers and pregnant women.

Source: *Services for Families of Prison Inmates*, National Institute of Corrections, February 2002

PUBLIC HEALTH OVERSIGHT OF CORRECTIONAL HEALTH CARE

Inmates in the United States are the only population that has a constitutional right to health care. However, this care often lacks external oversight. The concerns that arise from such a system are similar to those that led to the establishment of the Office of Patient Protection at the Department of Public Health (DPH), which works with a Managed Care Oversight Board to address patient complaints against insurers. We propose that the legislature do the following.

Create a Correctional Health Task Force

Expand the DPH Office of Patient Protection to include a *Correctional Health Task Force* with the authority to investigate reports of systemic or procedural problems in provision of health care. The task force would include public health, mental health, and correctional health representation and would also provide guidance and technical assistance in developing correctional health procedures, protocols, and guidelines at correctional facilities.

Grant DPH the authority to inspect and regulate correctional facilities

Expand DPH's authority to inspect and regulate all state correctional health facilities, clinics, infirmaries, and hospitals, in the same way it has authority over licensed health care facilities in the community.

DATA COLLECTION AND TRACKING

Accurate data that record and track inmate health history, current health status, and movement through the criminal justice system are needed for appropriate care, continuity of care and to determine health status indicators of the incarcerated population in aggregate. These data are also necessary to conduct the evaluation research necessary to determine which inmate programs are most effective in improving health outcomes. By evaluating health care needs and outcomes, correctional facilities, public health practitioners, and community providers can make the most effective use of their limited resources.

Invest in standardized computerized medical record systems & other technology

Most Massachusetts correctional facilities use antiquated paper record systems to collect and track inmate health data. This often creates significant problems in the timely transfer of medical information between facilities, continuity of care upon release, and intake and care when a person re-enters a correctional facility. The adoption of one standard computerized inmate health tracking system by all Massachusetts correctional facilities would help to alleviate many of these problems and creates many new possibilities for: gathering data to track health trends and needs among jail inmates in Massachusetts, increasing the ability for correctional facilities to serve a sentinel function of detecting potential disease outbreaks in the community, promoting more universality in health care from jail to jail, and promoting meaningful outcome research. Standard data elements and compatible systems will also allow health information to travel with inmates through the many transfers that occur within and across correctional health systems, reducing costly duplication of medical care and screenings.

Hampden County Correctional Center is in the final phases of the developing a computerized medical intake and inmate tracking system specifically designed to meet the special information system needs of health care delivery in the correctional setting. **Hampden County Sheriff Michael J. Ashe has offered to share this software with other correctional facilities**, most who are not currently working with computerized systems. At a minimum, the adoption of compatible information systems with consistent data standards and structures by all correctional facilities can be an important component of improving the continuity of care inmates receive.

Require reporting of inmate health statistics to the Department of Public Health

The Massachusetts Department of Public Health tracks many illnesses among the general public, but has large gaps in health indicators from the incarcerated population. If all correctional facilities adopt

a similar computer system and gather similar medical information, the data that is tracked could be very useful in allocating resources and tracking trends. This would also increase the effectiveness of disease control measures, should they become necessary, as in the case of an outbreak.

FUNDING AND RESOURCES

While some of the recommendations above need little or no money to be implemented, others require an investment of state resources. The investment recommended in this report will ultimately save taxpayer dollars through reduced recidivism, reduced need for expensive medical interventions, and more appropriate use of the health care system.

Increase State Revenues

Massachusetts is currently in a fiscal crisis that will create significant challenges to implementing many of the recommendations listed above. The current lack of state funds is due to a structural budget deficit, well documented by the Massachusetts Budget and Policy Center (www.massbudget.org). It is critical that Massachusetts lawmakers increase new revenues in the fairest ways possible in order to protect the programs that serve inmates while incarcerated and provide the safety net in the community that is needed for a successful transition after release.

Increase Alternatives to Incarceration for Non-Violent Offenders

Policymakers should consider the cost-savings of providing alternatives to incarceration for non-violent offenders. Much of the increase in inmates during the past ten years was due to the implementation of mandatory minimums in response to the war on drugs of the 1980's. A recent study shows that \$40 billion is spent on imprisoning 2 million offenders in the U.S. A full \$24 billion of this amount is spent on incarcerating non-violent offenders⁵⁶. Thirty four percent of Massachusetts' DOC prisoners were incarcerated for nonviolent offenses on January 1, 2002. For women, the percentage was much higher – with 65% of incarcerated females serving time for a nonviolent offense⁵⁷. In county facilities, 75% of new commitments to Massachusetts' county facilities in 2002 were for non-violent offenses. For female inmates in county facilities, the figure was 86%⁵⁸.

In many cases, it would be much more cost-effective for the offender to receive comprehensive substance abuse and/or mental health treatment instead of incarceration. Alternative sentencing for pregnant offenders should also be explored. As we are faced with dwindling state resources, such alternatives must be explored as a method to achieve reduced recidivism, cost-savings and increased public safety.

CONCLUSION

This report provides a wide range of options from which policymakers and administrators can take action to improve the health of inmates and the communities to which they return. At the core of these recommendations is the premise that corrections, public health, and community health need to collaborate to address the health problems of a very sick and often invisible population. These entities must work with policymakers and others to reach the common goals of protecting the health of disenfranchised populations, improving the public's health, and increasing public safety by using cost-effective methods.

REFERENCES

- ¹ Pepper, B. Interfaces between criminal behavior, alcohol and other drug abuse, and psychiatric disorders. Center for Substance Abuse Treatment; Treatment Improvement Exchange Communiqué 1993. Spring: 5-7.
- ² U.S. Department of Justice, Bureau of Justice Statistics. HIV in Prisons, 2000. October 2002.
- ³ National Commission for Correctional Health Care: A Report to Congress. The Health Status of Soon-To-Be-Released Inmates. March 2002.

-
- ⁴ Eastman E, Rappaport E, DeMaria A, Werner B. 129th Annual Meeting of the APHA [abstract], Validation of self-reported risk as a method for identifying anti-hepatitis C positive individuals at time of intake physician examination at Massachusetts Department of Correction Facilities. October 2001.
- ⁵ Hammett TM, Harmon P, Rhodes W (Abt Associates, Inc). The Health Status of Soon-To-Be-Released Inmates. National Commission for Correctional Health Care: A Report to Congress. March 2002.
- ⁶ Ibid
- ⁷ Massachusetts Department of Public Health. Division of TB Prevention and Control. Unpublished data, 2003.
- ⁸ Conklin T, Lincoln T, Wilson R, Gramarossa G. A Public Health Model for Correctional Health Care. Hampden County Correctional Center. October 2002.
- ⁹ UMass Correctional Health Program, 2003 (unpublished data).
- ¹⁰ Eastman E, Rappaport E, DeMaria A, Werner B. 129th Annual Meeting of the APHA [abstract], Validation of self-reported risk as a method for identifying anti-hepatitis C positive individuals at time of intake physician examination at Massachusetts Department of Correction Facilities. October 2001
- ¹¹ Office of National Drug Control Policy, 1999. Drug Control Strategy. Washington, DC.
- ¹² Shostak G. Unpublished data as presented at The Massachusetts Public Health Association's Correctional Health 101 Seminar. April 2, 2002.
- ¹³ Appelbaum KL. Prison Mental Health Services in Massachusetts. UMass Medical School. As presented at the Massachusetts Public Health Associations Correctional Health 101 Seminar Series. May 2002.
- ¹⁴ Smith DB, Packer I, Fisher W, Simon L. The Prevalence of Mental Illness in Massachusetts Jails. Massachusetts Department of Mental Health, Dept. of Psychiatry at UMass Medical School, Sheriff's Departments of Hampden and Worcester Counties.
- ¹⁵ National GAINS Center. The Courage to Change: Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System. December 1999.
- ¹⁶ Shostak G. Unpublished data as presented at The Massachusetts Public Health Association's Correctional Health 101 Seminar. April 2, 2002.
- ¹⁷ Massachusetts Department of Correction. January 1, 2002 Inmate Statistics. July 2002.
- ¹⁸ Massachusetts Department of Correction New Court Commitments to Massachusetts County Correctional Facilities During 2002. April 2003.
- ¹⁹ Shostak G. Unpublished data as presented at The Massachusetts Public Health Association's Correctional Health 101 Seminar. April 2, 2002.
- ²⁰ Massachusetts Department of Correction. 2001 Court Commitments to the Massachusetts Department of Correction. March 2003.
- ²¹ Massachusetts Department of Correction. New Court Commitments to Massachusetts County Correctional Facilities During 2002. April 2003.
- ²² U.S. Department of Justice, Bureau of Justice Statistics. Probation and Parole in the United States, 2001. August 2002.
- ²³ U.S. Department of Justice, Bureau of Justice Statistics. HIV in Prisons, 2000. October 2002.
- ²⁴ Eastman E, Rappaport E, DeMaria A, Werner B. 129th Annual Meeting of the APHA [abstract], Validation of self-reported risk as a method for identifying anti-hepatitis C positive individuals at time of intake physician examination at Massachusetts Department of Correction Facilities. October 2001
- ²⁵ Ibid
- ²⁶ Appelbaum KL. Prison Mental Health Services in Massachusetts. UMass Medical School. As presented at the Massachusetts Public Health Associations Correctional Health 101 Seminar Series. May 2002.
- ²⁷ Burke MC, Etkind P, Cram V, Baral G. The Psychosocial and Service Needs of Women Seen in a Prison-based STD Clinic. MA Dept. of Public Health, Division of STD Prevention; Correctional Medical Services; Boston University School of Social Work. (Unpublished data).
- ²⁸ DeCou K. Testimony Before Special Oversight Hearing of the Joint Committee on Health Care, November 9, 2001. Hampden County Jail and House of Correction. Ludlow, MA. Committee Briefing Packet: Boston: Statehouse Press; 2001.
- ²⁹ Human Rights Watch, Press Backgrounder. Race and Incarceration in the United States. February 2002.
- ³⁰ U.S. Department of Justice, Bureau of Justice Statistics. Incarcerated Parents and Their Children. August 2000.

-
- ³¹ Keppel KG, Percy JN, Wagener DK. Trends in Racial and Ethnic-Specific Rates for Health Indicators: United States, 1990-1998. Centers for Disease Control, National Center for Health Statistics. Atlanta, GA: US Department of Health and Human Services; January 2002.
- ³² Ibid
- ³³ Ibid
- ³⁴ Kaiser Family Foundation. Policy Brief: Critical Policy Challenges in the Third Decade of the HIV/AIDS Epidemic. Menlo Park, CA: Henry J. Kaiser Foundation: January 2002.
- ³⁵ Keppel KG, Percy JN, Wagener DK. Trends in Racial and Ethnic-Specific Rates for Health Indicators: United States, 1990-1998. Centers for Disease Control, National Center for Health Statistics. Atlanta, GA: US Department of Health and Human Services; January 2002.
- ³⁶ Shostak G. Unpublished data as presented at The Massachusetts Public Health Association's Correctional Health 101 Seminar. April 2, 2002.
- ³⁷ U.S. Department of Justice, Bureau of Justice Statistics. Incarcerated Parents and Their Children. August 2000.
- ³⁸ Parke R, Clarke-Steward KA. Effects of Parental Incarceration on Young Children. Paper presented for the USDHHS Conference "From Prisons to Home" Conference, January 2002.
- ³⁹ Shilton MK, Resources for Mother-Child Community Corrections. The Mother-Child Community Corrections Project, International Community Corrections Association, LaCross, WI.
- ⁴⁰ Ansel, D. From Cell to Street. MassInc, January 2002.
- ⁴¹ Glaze LE. Probation and Parole in the United States, 2001. US DOJ, Bureau of Justice Statistics Bulletin. August 2002.
- ⁴² U.S. Department of Justice, Bureau of Justice Statistics. Trends in State Parole, 1990-2000. October 2001.
- ⁴³ Pepper, B. Interfaces between criminal behavior, alcohol and other drug abuse, and psychiatric disorders. Center for Substance Abuse Treatment; Treatment Improvement Exchange Communiqué 1993. Spring: 5-7.
- ⁴⁴ Taxman FS. Effective Practices for Protecting Public Safety through Substance Abuse Treatment. NIDA. March 24, 2000. University of Maryland.
- ⁴⁵ Center for Substance Abuse and Treatment, National Treatment Improvement Evaluation Study (NTIES), 1997 highlights. (<http://ncadi.samhsa.gov/govstudy/f027/default.aspx>)
- ⁴⁶ Taxman FS. Effective Practices for Protecting Public Safety Through Substance Abuse Treatment. University of Maryland, College Park, May 2000.
- ⁴⁷ Grinstead O, Faigeles B, Zack B. The effectiveness of peer HIV education for male inmates entering state prison. Journal of Health Education, Nov/Dec, 28 (6):S31-43.
- ⁴⁸ Grinstead O, Zack B, Faigeles B, Grossman N, Blea L. Reducing post-release HIV risk among male prison inmates: a peer-led intervention. Criminal Justice and Behavior, 1999, Vol. 26, p. 453-465.
- ⁴⁹ Eastman E, Rappaport E, DeMaria A, Werner B. 129th Annual Meeting of the APHA [abstract], Validation of self-reported risk as a method for identifying anti-hepatitis C positive individuals at time of intake physician examination at Massachusetts Department of Correction Facilities. October 2001
- ⁵⁰ Testimony of Marylou Sudders, Commissioner of the Massachusetts Department of Mental Health to the State Health Care Committee's Correctional Health Oversight Hearing on November 9, 2001.
- ⁵¹ Rydell, CP and Everingham SS. Controlling Cocaine. Prepared for the Office of National Drug Control Policy and the U.S. Army. Santa Monica, CA: Drug Policy Research Center, RAND, 1994.
- ⁵² Ibid
- ⁵³ Lanham MD. American Correctional Association, Public Correctional Policy on Female Offender Services, 1995.
- ⁵⁴ Parke R, Clarke-Steward KA. Effects of Parental Incarceration on Young Children. Paper presented for the USDHHS Conference "From Prisons to Home" Conference, January 2002.
- ⁵⁵ Services for Families of Prison Inmates, National Institute of Corrections, February 2002.
- ⁵⁶ Zeidenberg and Schiraldi. Justice Policy Institute, Washington DC.
- ⁵⁷ Massachusetts Department of Correction. January 1, 2002 Inmate Statistics. July 2002. <http://www.state.ma.us/doc/pdfs/1102.pdf>.
- ⁵⁸ Massachusetts Department of Correction. New Court Commitments to Massachusetts County Correctional Facilities During 2002. 2002.