PUBLIC HEALTH AND CORRECTIONS:
AN INTERGOVERNMENTAL PERSPECTIVE AND THE NEED FOR CONNECTIVITY

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PUBLIC HEALTH AND CORRECTIONS: AN INTERGOVERNMENTAL PERSPECTIVE AND THE NEED FOR CONNECTIVITY

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EXECUTIVE SUMMARY

On November 28, 2005, the National Academy of Public Administration's (the Academy) Prisons Positioning Committee and Center for Intergovernmental Relations convened a roundtable discussion with experts from the fields of criminal justice, public health, academia, and public administration to discuss the following:

- The need for interconnectivity of the public health care system and the corrections system in the U.S.
- The impact of these systems on each other and on citizens-at-large
- Obstacles to interconnectivity including cultural, intergovernmental, structural, information, and resource barriers
- Exemplar programs and success stories
- Potential avenues for future exploration and action

The purpose of the roundtable was twofold—1) increase awareness of these complex issues by various stakeholders, and 2) develop recommendations for specific action steps, future study, and possible avenues for the development of a national model of interconnectivity. The roundtable discussion and a summary of the discussion are presented in this report. A summary of key perceptions shared during the discussion and recommended next steps are presented below.

Key Perceptions Shared During the Discussion

Current Situation

There is a partially operative, public policy strategy in our country whereby prisoners who enter prison with an illness, or who become ill while incarcerated, will receive the necessary medical care in prison and while on parole or on probation back in their respective communities, if medical care is still needed. This public policy strategy is carried out effectively by federal correctional institutions. It is implemented effectively in many state prisons, but across some state prisons and in county and local jail systems there are great variations in the extent to which such a policy is implemented.

Long-Term Vision and Goal

Successful reentry of prisoners back into communities not only requires appropriate health care support, but also constructive preparation and rehabilitation of the prisoner for reentry during his/her incarceration. Other important factors include job availability, housing, emotional and social support, acceptance from one's family and the community, as well as a secure environment where the former inmate is not likely to be harmed and criminal behavior is not the norm. It is believed that if reentry processes and programs are implemented successfully, recidivism eventually will be lessened, families impacted by incarcerated members will be stronger in reducing crime among their children, and the amounts and types of crimes will continue to decline over future decades—*"Public health is public safety and public safety is public health."*

What is Most Needed to Achieve the Vision and Goal?

Critical to the success of implementing the above reentry procedures in most communities is careful planning and sustained interconnectivity among the major stakeholders including corrections officials, public health managers, governors, mayors, city managers, medical professionals, parole and probation officials, social welfare program managers, judges, prosecutors, victims organizations, and faith-based and other community organizations with proven track records of helping in these arenas.

Barriers to Achieving the Vision and Goal

The roundtable participants identified certain barriers that would need to be addressed to ensure successful accomplishment of the public policy objectives listed above. Some of the barriers discussed by this group of experts include the following:

- *Lack of Data Across Programs and Jurisdictions*—There is a lack of vital and comparable data across programs and jurisdictions about the screening of inmates when they are incarcerated and the kind, quality, or standards of health care that are provided or should be provided during incarceration and post-incarceration. In addition, it is very difficult to quantify the impact of the former prisoners' illnesses on the public health of the communities to which they return. There are no threads of continuity of data across families; or sharing of important medical data with key providers. Also, there is a lack of empirical evidence about corrective steps that are taken, the kinds of cooperative or interconnectivity models that are addressing these issues effectively, and their costs.

■ *Prisoners, Not a Public Health System Priority*—"Public Health" has no mandate to treat prisoners when they reenter their communities. The public health sector is currently more focused on security (bioterrorism) and pandemic issues of large populations, rather than on providing treatment to individuals in communities—whether former inmates or other citizens.

■ *Cultural Differences Among the Delivery Systems*—The cultures of the various stakeholder groups are quite distinct and different from each other and have to be known, understood, and mutually agreed upon if effective interconnectivity strategies are to succeed.

■ *Categorical Funding in the Public Health Arena*—Funding may be available only for the treatment or study of certain kinds of diseases, which makes it more difficult for revenue streams to be aggregated into broad and effective health service programs. Priority can be given to infectious or communicable diseases; but the impact of lack of treatment of mental health and drug addiction on increased crime rates also is very important.

■ *Lack of Complete Public Support for Investments*—A significant proportion of people in this country would prefer to incarcerate criminals, "throw away the key" and are not receptive to providing effective medical treatment during incarceration or post-incarceration.

What Can Be Learned From the Successful Experiences?

There are some examples of how the corrections and public health systems are being implemented effectively, and the following characteristics have emerged:

■ *Visionary Leadership is Essential*—Visionary leadership seems to have been essential—especially in articulating a vision for legislators and enacting statutes and creating governmental structures that support the effort, getting the important stakeholders to come to the table and work together, and in educating the public and media about the worth and positive impact the efforts will have on the community and its investment in its people.

■ *Sustainability Requires New Leaders to Come Forward*—Renewable leadership (i.e., preparing for the follow-on leadership and continued implementation of the policy after the first charismatic innovator departs) also is very important.

■ *Community Ownership of Responsibility Very Important*—Educating the public that it is in their best interests, and encouraging the communities into which former inmates reenter to take ownership and responsibility for ensuring that returnees have sustained and successful reentry experiences, good health, and productive, crime-free lives.

Recommended Next Steps

The expert participants (listed in the report) recommended that the Academy (see Appendix A for more information on the Academy) follow through and move forward on the following issues and recommendations discussed in the roundtable:

■ Develop a corrections research agenda of nationwide scope covering such matters as protocols, prioritizations, and a website including a repository of documents such as the mental health piece of the *Consensus Report* and the President's *New Freedom Commission Report*. The existence of one accepted national research agenda would help funders make decisions on project proposals and provide guidance to academic researchers. The public health interconnectivity aspects would be an important part of this broader research agenda.

■ Collect and disseminate information on high-impact, cross-cutting initiatives and performance metrics for intra-agency, intra-committee, and intergovernmental use.

■ Communicate and coordinate with the National Academy of Sciences and contact the National Institute of Justice (NIJ) for funding support for prisoner and evaluation research, and necessary regulatory changes to enhance data-sharing of health information.

■ Explore how policies can be changed, including regulatory changes at all levels of government, to enhance the potential for the sharing of health information within a model of interconnectivity.

- Take over the coordinating role for the Surgeon General's task force performed by the Centers for Disease Control and Prevention (CDC) over the last few years. CDC convened, at least quarterly, federal partners and some outside organizations—American Correctional Association (ACA), National Commission on Correctional Healthcare (NCCH) and others in order to: share information on current and proposed research and demonstration programs, foster working relationships, plan and coordinate task efforts that would support the Surgeon General's Call to Action, and pool resources.

- Partner with the Public Health Service to generate interest among national and local print and broadcast news media about the Surgeon General's *Call to Action on Corrections and Community Health*.

- Become aggressively involved in revising the federal regulatory schema to enable more complete sharing of health-related data to support the interconnectivity model.

- Play a coordinating role in fostering interconnectivity at the local, county, state, and federal levels to enable inmates to have access to health care in their home communities upon release.

- Develop interconnectivity prototype guidelines.

- Conduct a study to clarify the intended results of the interconnectivity model and create a "business case" for the model, for use at each level of government.

- Develop standards or guidelines for health care for prisoners reentering society. Once established, the bar could slowly be raised to enhance the levels of care.

INTRODUCTION*

The more than 2 million inmates in American prisons and jails present a severe health care challenge. Drug use and other high-risk behaviors by inmates prior to incarceration, lack of prior access to health care, and the low economic and racial status of much of the inmate population has translated into a high prevalence of infectious, communicable, and chronic diseases. The high rate of return of these offenders to their communities means that prison health issues are public health issues. As a result, it is imperative that both correctional and public health care administrators not only ensure the quality of their individual systems, but work toward a model of system interconnectivity.

The incidence of communicable and infectious diseases in the prison population is profound. Although about 3 percent of the U.S. population goes through jail or prison in a given year, a 1997 study by the CDC found that in 1996 the prison population accounted for:

- 13 percent to 17 percent of HIV positive cases
- 12 percent to 15 percent of hepatitis B cases
- 29 percent to 32 percent of hepatitis C cases
- 35 percent of all tuberculosis (TB) cases

Inmates are also more likely than the general population to have chronic illnesses and more likely to have chronic illnesses earlier in life. Due to poor early-stage disease management, inmates show late-stage diseases at younger ages than the general population, and are, on average, physically older than their age would suggest. The fact that the vast majority of prisoners return to their communities means that the level and type of medical care needed for this population will place significant burdens on both prison health care and public health systems. The continuity and quality of care in either the community or prisons will impact the burden on and resources needed in both systems.

The high prevalence of illness among prisoners is not only medical. Estimates of mental illness among the prison population range from 15 percent to 20 percent, largely due to transinstitutionalization—the movement of the mentally ill from publicly funded mental health hospitals to nursing homes and correctional institutions.

The nature of prisons creates other, nondisease-specific public health issues. Prison populations include a mix of young, violent, gang-affiliated offenders with an increasing proportion of inmates over the age of 50 and inmates with mental and physical health problems. The potential for violence and the opportunity for younger offenders to prey on the older or sicker population is a public health issue itself.

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* See Appendix B for selected sources used in the Introduction.

The scale of the correctional health care challenges, and the resultant public cost, has increased dramatically with the explosive growth of the American prison population. From 1970 to the present, this population went from 325,000 to over 2 million—a growth rate of roughly 500 percent.

While it may be easy for some in the public to dismiss this issue as a "prison problem," ill inmates present immediate and significant threats to the public health. Well over 90 percent of prison inmates will eventually be released and returned to the community at the rate of over 600,000 per year. Additionally, with nearly one-half million correctional employees, and thousands of visitors daily to prisons and jails, the prevalence of diseases in prison will directly impact public health. This relationship is not unidirectional, however. With recidivism rates in excess of 50 percent for most correctional systems, the quality of ex-inmates' health care in the community will impact future correctional costs and care when they recidivate. Since ex-inmates rely heavily on the public sector for health care services and the majority return to prison, the correctional health care system and public health systems can no longer be viewed as distinct, but ideally need to be transformed into one continuous network.

Yet, correctional systems and public health systems are neither adequately connected, nor adequately funded. Recent events in California—federal receivership of the California Department of Corrections and Rehabilitation's health care system and a recent RAND Corporation report that identified significant gaps in the state's public health infrastructure— indicate that each system individually may have significant operational, management, and resource issues. Collectively, the two systems are poorly interconnected. Correctional agencies, tied to the criminal justice and law enforcement arena, have cultures, models of care delivery, constraints, and practices that are very different from those of public health systems. The two systems typically reside in different and unrelated cabinet-level agencies at all governmental levels, and while public health care systems are typically managed at the county or city level, the majority of prisoners are released through federal and state prisons.

This lack of connectivity raises a number of significant issues, including lack of continuity of care for inmates released into the community, poor exchange of medical information on inmates about to be released (especially troublesome in the area of communicable diseases), inadequate community care for inmates who have completed their sentences, and inefficient utilization of medical resources. With the health care crisis and prevalence of uninsured citizens in the broader community, the discussion of resources for inmates' and ex-inmates' medical care is particularly difficult. Yet, without a more comprehensive view of health care across divergent systems and levels of government, both the public's and inmates' health will continue to be at risk.

ROUNDTABLE PARTICIPANTS

Participants in the roundtable discussion included the following:

Katherine Brown, Policy Analyst
Criminal Justice Programs
Council of State Governments

Lois Eldred, Director
Pilot Demonstration Branch
HIV/AIDS Bureau
Health Resources and
    Services Administration
U.S. Department of Health and
    Human Services

Robert Greifinger, Correctional Health
Care Consultant

Roderick Q. Hickman, Secretary,
State of California
Department of Corrections
    and Rehabilitation

George Keiser, Chief
Community Corrections/Prison Division
National Institute of Corrections

Newton Kendig, Medical Director
Bureau of Prisons
U.S. Department of Justice

Thomas MacLellan
Social, Economic, and Workforce
    Development Division
National Governors Association

Pat Nolan, Vice President
Prison Fellowship;
Member, Board of Directors
National Institute of Corrections

Allan Noonan, Dean
Public Health
Morgan State University

Gregg Pane, Director
Health Department
District of Columbia

Hugh Potter, Program Consultant
Division of HIV/AIDS Prevention/OD
Science and Program Integration
Corrections and Substance Abuse Activities
National Center for HIV, STD, and
    TB Prevention
Centers for Disease Control and Prevention

Michael Quinlan, Senior Vice President
Corrections Corporation of America;
    Academy Fellow and Chair,
    Academy Prisons Positioning Committee

David Thomas, Chair
Department of Surgery
Nova Southeastern University College of
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Melinda Tinsley, Public Health Analyst
Special Projects of National
    Significance Program
Health Resources and Services
    Administration/HIV/AIDS Bureau

John Vanyur, Assistant Director
Federal Bureau of Prisons; Member, Academy
Prisons Positioning Committee

Reginald Wilkinson, Director
State of Ohio Department of
    Rehabilitation and Correction

OPENING REMARKS AND CHARGE TO THE PARTICIPANTS

In his opening remarks, Dr. Vanyur, moderator of the roundtable discussion, stated:

> Our goal is, at the end of the day, to try to move the ball a little bit . . . to try to start formulating what action steps we need to take at this table, and possibly even trying to develop some type of model of interconnectivity as we move forward . . . I don't want to spend a lot of time today talking about what we know—the prevalence in corrections of mental illness, communicable diseases, etc. (see Appendix C for statistics). I want to talk about things that we don't know, and then given what we don't know, what we need to do to move beyond that.

Vanyur asked participants to concentrate their remarks on adults in prisons rather than on juveniles and/or inmates in jails. In terms of discussing what is known, and because many of the roundtable participants also took part in the August 15, 2005 Surgeon General's *Call to Action on Corrections and Community Health*—a forum designed to stimulate linkages between federal, state, and local stakeholders, public health and community organizations, and criminal justice agencies—he also asked that the findings of that symposium serve as a foundation for the roundtable discussion.

The Surgeon General's Call to Action on Corrections and Community Health
For those roundtable participants who did not attend the Surgeon General's *Call to Action*, Dr. Potter summarized the following key discussion points:

- Jails process the highest number of health-compromised individuals, yet have the lowest resource base.

- Two-thirds of the people who are under correctional control are in the community; primarily on probation, and some on parole.

- State and federal prisons house high proportions of health-compromised individuals for longer periods of time and have limited health budgets.

- The public health system has no affirmative necessity to treat anybody in the community—"When you are in the community, you are on your own."

■ Only in corrections is there a constitutional mandate to provide adequate health care.

■ "Public health is public safety and public safety is public health." There will be more victimization in and more costs to jurisdictions that are struggling with how to pay for health care.

Roundtable Agenda

The agenda for the roundtable discussion was organized into four discussion segments. Each segment included a set of guiding questions. In segment one, "Establishing the Profiles of Correctional and Public Health," the guiding questions included:

■ *What do we already know from past research and similar efforts?*

■ *What other information do all of us need to know before proceeding? Is there data or information that we need, but has yet to be gathered?*

■ *How do correctional health care delivery and public health care delivery differ in their models of delivery, financial structures and resource streams, information systems and records sharing, and cultures and attitudes towards clients?*

In segment two, "Issues of Interconnectivity," the guiding questions included:

■ *What problems are created for society if the corrections and public health systems do not work well together?*

■ *What linkages do exist between prison and public health systems (e.g., AIDS, TB)? How were these linkages formed, sustained, and funded?*

■ *Are there success stories of interconnectivity?*

■ *What do these case studies or existing linkages tell us about some of the critical ingredients for success?*

In segment three, "Future Steps Toward Interconnectivity I," the guiding questions included:

- *What is preventing us from connecting these two systems?*

- *What research, management, public governance steps, and structural issues (e.g., resource allocation, models of care delivery, and information sharing) would you say are the highest priorities in moving toward interconnectivity?*

- *Who are the key stakeholders who can serve a leadership role in both health care and the move toward interconnectivity?*

In segment four, "Future Steps Toward Interconnectivity II," the guiding questions included:

- *What should the corrections system do to make the job easier for the public health system? What should the public health system do to improve the corrections cycle as it relates to persons with health issues?*

- *How do we handle policy debates so that one system can be well credited for its contributions to real solutions?*

- *How would you increase public awareness and possibly garner public support for prisoner health care and the connection to care in the community? How does the broader issue of millions of uninsured law abiding citizens impact this charge? Where do legislators fit into this?*

Vanyur assured the roundtable participants that the questions in the four segments above were not intended to restrict discussion to answering only those questions nor in that exact order. Consequently, the discussions were free and wide-ranging across all four segments; and the comments have been grouped below around key themes that emerged.

DISCUSSION

Issues Related To Public Health and Corrections Interconnectivity

There was a general consensus that connectivity issues exist due to a lack of a "systems" approach to achieving the desired outcomes. There seems to be a "bright line" that separates the three levels of government—federal, state, and local—and the people/organizations in criminal justice, public health, social services (including grassroots organizations, the faith-based community, and medical services), and academia. A compounding factor is that corrections tends to be a "closed" system. In addition, there is a major transition underway in public health departments.

> *[Public health] used to be a care system; now it's a measurement and prevention system. We've got an increase in federally funded community health centers, but at most state levels, the provision of care to these target populations is decreasing rather than increasing. In addition to that, there's the whole disappearance of the mental health system. Mental health is in chaos compared to what it used to be 30 years ago, and many of the patients are ending up in the correctional health system. So we've got those two realities to deal with . . .*
>
> —Allan Noonan

There are "seams of care." On each side of the seam is a different system with a different focus. Public health focuses on diseases, social services on families, and corrections on inmates. The inmate, upon release, falls between these seams.

The consensus was that the lack of a systems approach resulted from, to a large extent, a lack of leadership at the top and to funding streams. For example, funding for public health departments usually is categorical—disease-specific. As a result, there are a lot of well-intended programs but how "we're organized and rewarded and how the money flows right now [means] we are really a collection of grants."

The reasons for the lack of a systems approach are multifaceted and complex. For example, from the prisoner perspective, successful reentry is not solely about the prisoner's health issues—it is about employment, housing, and other social issues and the need for emotional support; therefore, public health should be understood in this broader context.

One of the problems that we have to address is [that] having a serious or . . . fatal disease is not the worst thing that most of our patients face in their lives. And so, although these coordinations [public health and corrections] are essential, education of the public is essential. We suffered frustration when we had good interconnections, simply because of the demography of the people we treated. I mean, having HIV, having hepatitis C, having severe hypertension, just isn't as big a problem as daily life for many of our constituents.

—David Thomas

[T]here are some states now, where at the governor's cabinet level, they are defining and saying the release of this individual back into the community is not owned by a single organization within government.

—George Keiser

I'm going to agree with George's (Keiser) assessment of this notion of sharing accountability for this population coming out. It's a public safety issue; it's not solely a corrections issue.

—Thomas MacLellan

The consensus was also that government does a good job of warehousing but not a good job of providing emotional support. And, without emotional support, people will not be able to take care of themselves when they leave prison and reenter the community.

I think part of this is that we need to do a systems approach to a series of nonsystems processes. In criminology we talk about the fact that the justice process is not really a system, but it has systemic qualities. Part of our problem is that we already don't have a public health system, as such, in this country either. We have a lot of different little organizations that do different little things in different little locations, just like we have a lot of different little decisions that are made in the correctional process. The difference with corrections, as I always say, is, number one, corrections inherits the failures of everybody else, and two, corrections can't reject the clientele. . . . We really are talking about systems that interact with systems, and, in the end, the outcome is not always clear, I think, from a reality perspective.

—Hugh Potter

In terms of funding, if people were able to have a conversation about whether you spend it in this area or you spend it in that area—you're still making the expenditures and you're going to get a much better result, from a public safety standpoint and from a public health standpoint, if you more collaboratively identified what you're making that expenditure on . . .

<div align="right">—Roderick Hickman</div>

Barriers to Interconnectivity

The participants also identified the following as barriers to interconnectivity:

- *Use of existing resources.* There was discussion about not using existing resources wisely to attack root problems in order to have a real impact on measurable outcomes (e.g., linking Medicaid with public health programs).

- *Cultural issues.* The following cultural issues were considered to be a barrier to interconnectivity and a major cause of cynicism among public policy makers, public health care workers, and the custodial staff in corrections towards providing health care for prisoners:

  - ▲ The type of individuals who are hired into the corrections system and the training that custodial staff receive present special challenges. It was felt that the prevailing culture in prisons is to do whatever is necessary to "survive" within the corrections environment. This kind of culture, in turn, diminishes the importance of delivering health care services to prisoners.

For 25 years we've been telling people, you do not form a relationship with an inmate. Now we're going to tell them, you need to start being friends. This is going to take awhile. I think we are looking at major . . . changes in the way we have to get everybody to think about what we do.

<div align="right">—Hugh Potter</div>

. . . within the prisons . . . people describe [prisoners] as being a counterculture . . . there's got to be a bad guy in this thing. There's a bad guy here and this is a bad guy, and if he's a bad guy, then he doesn't have anything coming.

<div align="right">—Roderick Hickman</div>

There's also a major cultural issue, and that is, in medical care, you listen to the patient and you take them at face value. In corrections, the inmate is automatically gaming you. I don't care if he's got 15 doctors' notes that say he needs this medication, he just got that doctor to game the system. That's a bit of an overstatement, but I really think that in corrections, there's a distrust of the patient, so whatever can't be looked at objectively, or at least from the clinician's opinion of what's been presented to him, not just what's being presented by the patient, you get issues there too, beyond just liability.

—John Vanyur

▲ A dichotomy exists between the corrections and public health worlds, which each have a different mission and language. Related to mission:

We [in corrections] select staff that can follow instructions and follow rules. We have unsafe prisons if we don't follow rules. In medical care, we select our physicians for their ability to advocate for individual patients, for their ability to think independently. None of us wants to go to a doctor who is just going to follow the rules; we want them to be able to think autonomously and act for us in independent ways. That's naturally going to create tension. Add to that, that you've got a public health culture that's different from a medical care culture, a public health culture that is looking at population-based programs . . . So we've really got three cultures, at least, to think about, and if we don't create a common language, we're going to fail with all these programs.

—Robert Greifinger

Related to language:
For me, not coming from a corrections background and being involved in a corrections demonstration project, it took a good year or year and a half to know the language, with Hugh Potter and others helping me continuously. I couldn't get a sentence out without it being corrected . . . It's a learning curve.

—Lois Eldred

Let me offer a common term without common meaning, and this is "social justice." Each one of those sectors thinks they invented the term "social justice" and no two of them, particularly within criminology and criminal justice, have a common understanding of what social justice is. Reggie [Wilkinson] was saying earlier that you become an advocate for this, but what Reggie may advocate for may be different from what somebody in public health may advocate for. One's looking at a population base, and, I think you are talking about individual justice first and foremost. Then you move back out to overall social justice.

—Hugh Potter

[There's no] incentive [in terms of long-term financing strategies] to learn somebody else's language or to develop neutral language. There's no management of mutual self-interest because we haven't articulated what that policy is, and then what the self-interests would be that are compatible with each other. There isn't a demand on managers . . . to manage towards [policy] outcomes.

—George Keiser

▲ From a societal perspective, the "crime and punishment" politics also contribute to cultural challenges within corrections and public health.

In terms of data, the consensus was that "we don't have the information in the right place at the right time" and in terms of data collection, "we're woefully behind and under-funded." The following data issues were discussed:

■ **Lack of continuity of data and lack of data across the family.** In most jurisdictions, it is currently not possible to know that inmate "X'" has family number "Y" in the welfare arena or that family "M" has a child in child protective services. There is a lack of data that indicates an investment made in the correctional environment, the social services environment, or the public health environment is actually the same dollar. There is also a lack of even common data elements across the systems, so there is no common basis across systems of discovery.

We have a lot of data on prevalence, we just don't have much data on how effective interventions are.

—Robert Greifinger

We need a lot more [data] about the transmission of communicable diseases. . . When you look at HIV, hepatitis C, and tuberculosis, there's also a lot of communicability, but for HIV and hepatitis C, the data is very limited as far as prisons being an incubator. The important thing, from a public health standpoint, is not to just say there's no transmission, but also there's the data [to support] that . . . they're not acquiring [this data for the] vast majority of inmates within the corrections system.

—Newton Kendig

[T]here's that bright line between one system and the other system in which basically all those facts about me as a patient, as part of a community, maybe even as part of a disease community, is stripped away when I become a prisoner.

—David Zlowe

The issue of saving money vs. cost effectiveness is important. Participants agreed that studies should be performed to learn what it actually costs to transition former inmates into the community. Savings need to be calculated in the long-term not the short-term. The problem is that people look at the bottom-line budgets for the end of the year and it's hard to show, after a year or two or three, that there's going to be any immediate cost savings. Also, the unit of analysis should be societal, not individual programs.

Two related issues are cost containment—not squandering money that is invested while the person is in the institution and then essentially losing it quickly because the person reenters the community—and justice reinvestment strategies, which use money saved and put it back into corrections to improve operations.

- **Lack of sharing existing data.** The consensus was that there is a lack of sharing existing data largely due to legal limitations on sharing protected health information.

In Florida, we knew we had about 6,000 people with HIV in the system [three years ago when I was there]. . . 3,000 that we had knowledge of and 2,700 or so under treatment . . . The ones we had knowledge of, we knew exactly who they were . . . but of the other 80,000 people, of which 6,000 had HIV, we only knew 3,000 of them. Many systems [are like that] but you can't talk about it, you can't communicate it. There is no mechanism to share it, because it's all internal risk management data . . . even unlinked data, you have a very, very difficult time sharing, which goes to the thrust of altering the research potential.
—David Thomas

HIV money comes in through the health department. The health department hires staff. It gets people in; they do a little testing of some folks. The testing is done. The health care people who work in the jail, providing the primary care, have no idea what the results are. Is my patient HIV-infected or not?
—Robert Greifinger

[T]he issue with us has been not aggregate data sharing but case data [sharing], so that when we pass the inmate out the back door, that case data information—you're talking more about aggregate data that's out there.
—John Vanyur

It sounds to me like almost everything that's perceived by the public is either wrong or goes against the kinds of solutions and interventions that we're talking about. So, how do you have a fact-based debate in the absence of facts? And you can't get the money to get facts because of public perception.

—David Zlowe

■ **Lack of empirical data about what works.** The consensus was that there are many opportunities for empirical research (practical vs. theoretical research) that will allow public health and corrections officials to make informed decisions related to public health and corrections practitioners, inmates, and funding.

I would really like to know whether or not . . . treatment in the community . . . prevents recidivism. I would want to know whether or not good mental health treatment inside a correctional institution does prevent a person from getting in trouble and causing breaches of security, for example.

—Reginald Wilkinson

We need academia to get to the plate and to say that this is important for us to be involving correctional populations that are leaving and reentering . . . the community. What actually does work? . . . To get the policy makers and the funders at the table, we need to show what works.

—Newton Kendig

[W]e find it even extremely difficult to do program evaluations, to do a model to see if the program is effective, even for those sites that have supported corrections and received the funding to do it.

—Lois Eldred

It is also difficult to do any kind of research at the present time other than on very broad social themes.

—Gregg Pane

Funding Issues

While there is an increase in federally funded community health centers, at most state levels the provision of care to the targeted populations is decreasing rather than increasing.

> *[T]he money isn't already there . . . If you come into my system and find 3,000 more HIV people, I've got to treat them, and the money isn't there for that . . . .*
>
> —David Thomas

> *Hospitals and doctors aren't bidding on corrections contracts, even if you had the money.*
>
> —Gregg Pane

Standards of Care Issues

There are no established standards of care, either through regulation or through accreditation.

> *[U]ntil we raise the bar . . . either through regulation or accreditation . . . it may be a little hard to get correctional systems to focus attention [on health care].*
>
> —Robert Greifinger

> *I don't think we're afraid of regulation, but I wish we'd call it something different, like "guidelines."*
>
> —Reginald Wilkinson

> *The more you stress them (institutions), the more you crowd them, and the less clean you keep them, the less trained your staff are, the more likely you're going to have intramural transmission, then transmission from behind bars, through the staff, out to the community.*
>
> —Robert Greifinger

Interconnections of Corrections and Public Health: A Case Study

To explore the barriers to interconnectivity further, a case example was presented by Dr. David Zlowe, a member of the Academy's Prisons Positioning Committee.

Case: Follow a person convicted of a felony, who has HIV and diabetes, as he moves from the public sphere—the social services sphere including nongovernmental organizations and faith-based organizations—into the prison sphere and (perhaps) back again. I'm away for five years and I show up at the [prison] doorstep. What happens to me?

Dr. Zlowe stated:

> I'm hearing a couple of different things, fundamentally, and I'm wondering that if we go further in the discussion without acknowledging some very different points of view that are inherent here, that are rather systematic, that we may end up, ultimately, when we start talking about solutions, talking past each other, or coming up with microsolutions that fit what we think we connect with, but not addressing things in a more holistic way. That's just a fancy way of saying that in public health . . . there is a perspective that looks at things by diseases, in prisons health the perspective tends to follow types of prisoners, and in social services… it's not quite the disease, not quite the prisoner . . . What are the commonalities among these points of view?

A major conclusion based on the case discussion was:

- Something is being done in most large jail systems to determine what the prisoner's current health care status is, but that information, depending on the state the prisoner is in, may or may not (and it generally does not) go with the prisoner who is leaving the system. It does, however, exist in some repository of data that is difficult for an ex-inmate to then access at a later date.

Success Stories

While the barriers to interconnectivity are substantial, participants identified the following success stories:

- In California, Senate Bill 626 allowed for the Department of Corrections and Rehabilitation to conduct three pilot projects with counties in the areas of both reentry and evaluation upon coming into the system, so that the county probation department and the county social services departments, at each end of the spectrum, would be the driver of the program for the individual that came to corrections.

  I go to San Diego to a meeting and the presiding judge is there, the probation department is there, the department of social services is there, the country prosecutor is there, the public defender is there, and the Senate bill requires for all those people to be there before we can come into this partnership on evaluation and reentry.
  —Roderick Hickman

- Various pilot programs and seed money have produced promising results. For example, in Rhode Island, Brown University physicians are providing the health care in both prisons and jails, so there is an academic link.

- The Governor of Rhode Island established an executive order creating a Prisoner Reentry Commission. There are three tiers: an executive tier of all of the cabinet secretaries, a midmanager tier, and a front-line tier. They meet regularly. Their job is to create a state-level plan for reentry.

- In Jacksonville, Florida, John Rutherford, the Sheriff, has made an excellent business case for a "justice reinvestment strategy." This has led to tremendous cost savings. These savings are then used to improve jail operations.

- The Council of State Governments has been collecting information on a "broad swath" of programs that, while they may not be considered best practices, have done some kind of intervention related to reentry. A subset of these programs are health-related.

- The mental health piece of the *Consensus Report* provides many examples of promising programs.

- The Secretary of Corrections in Michigan, in conjunction with the National Institute of Corrections, has implemented a transition from prisons to communities initiative.

- The La Bodega de la Familia program in New York works with veterans coming back into the community—they treat the offenders within the context of the family.

SUMMARY

The effectiveness of future progress in improving and achieving connectivity between public health and corrections professionals and organizations will rely, first and foremost, on the commitment and ownership of this effort by leadership at all levels of government.

If the interconnectivity of public health and corrections is not a priority of leadership and if they, supported by the media, are not comprised of credible and involved spokespersons, the efforts to improve interconnectivity between public health and corrections are not likely to succeed. While correctional and public health officials can be credible spokespersons, their role is to aid, support, and provide empirical information to leadership. Without such strong executive leadership, "a constant force from start to finish," the Government Accountability Office cautions that even the "best process design may fail to be accepted and implemented."

> *The real challenge is to reach policy makers who are . . . safe enough in their positions . . . and are ready to champion that kind of public policy, and then holding their cabinets or the individuals under their oversight to the outcomes, not just to the effort.*
> —George Keiser

> *It's really important, this whole notion of leadership . . . It depends on the personality, how much you can get done sometimes.*
> —Reginald Wilkinson

With leadership commitment in place, and with support from the Academy, a model that synthesizes how public health and correctional health managers should work together should be developed. This model should include developing a common language, eliminating stove-piping in the budgetary process and synthesizing funding streams to deal with issues, developing guiding principles and a voluntary accreditation process, and dealing with risk management issues. To be successful, such an effort would involve the following:

- Supporting the revision of 45USC 46, Subpart C

- Doing long-term cost studies

- Developing an incentive strategy in order to build up more local capacity around mental health, public health, jobs, housing, etc.

- Understanding where the best practices are, disseminating the information, and replicating those programs, which is the best way to save time and money

- Educating the American public, with the support of victims groups, the National Coalition of Safe and Healthy Communities, a good logo, a celebrity spokesperson and others, so that the public ultimately understands that "public health is public safety"

In summary, if we can improve the physical and mental health of inmates and former inmates, then we will be helping to create safer communities for our children and everyone by reducing violence, sexually transmitted diseases including HIV, and drug use.

In the words of Michael Quinlan, chair of the Academy's Prison Positioning Committee, "We need to move beyond 'these people don't deserve what we're doing or trying to do for them,' if we are to have real innovation in this area."

APPENDIX A

ABOUT THE ACADEMY

The Academy is an independent, nonprofit organization chartered by Congress to improve governance at all levels: local, regional, state, national, and international. The Academy's membership of more than 600 Fellows includes public managers and scholars, business executives and labor leaders, current and former cabinet officers, members of Congress, governors, mayors, state legislators, and diplomats.

Since its establishment in 1967, the Academy has assisted hundreds of federal agencies, congressional committees, state and local governments, civic organizations, and institutions overseas through problem solving, objective research, rigorous analysis, information sharing, developing strategies for change, and connecting people and ideas. Examples of the Academy's ongoing studies include the Federal Bureau of Investigation's transformation; a study of overcrowding for the U.S. Bureau of Prisons; a leadership development, succession planning, and diversity assessment at the Centers for Disease Control and Prevention; guiding the administrative restructuring at the National Institutes of Health; an assessment of NASA's human resources and administrative processes; and an evaluation of the organizational structure of the Patent and Trademark Office.

The Academy maintains a core professional staff that is regularly augmented by study teams recruited for their superior qualifications to contribute to specific projects. Panels composed of Fellows and invited experts from social science, criminal justice, business, labor and other relevant fields, direct project and study activities. Since its establishment in 1967, the Academy has responded to a multitude of requests for assistance from various agencies and has undertaken numerous studies on issues of particular interest to Congress. In addition, the Academy has conducted projects for private foundations, states, and other governments and has begun to develop some private-sector partnerships.

Most reports and papers issued by Academy panels respond to specific requests and needs of public agencies. Projects also address governmentwide and broader societal topics identified by the Academy. In addition to government institutions, businesses, foundations, and nonprofit organizations support the Academy.

The Academy's Board of Directors is committed to ensuring that Academy work is of high quality and consistent with the charter of the organization and the stature of its membership. The Board's objectives are to preserve the reputation of the Academy for high-quality work that reflects experience, solid empirical evidence, and independent research and analysis.

For Academy work, the term quality refers to the rigor of the analytical approach, the soundness and balance of the findings and recommendations, the clarity and persuasiveness of the communicative style, and the work's usefulness to the recipients. Academy work must also meet the commitments set forth in any contract or agreement while upholding the standards of the profession and the reputation of the Academy and the client.

APPENDIX B

SELECTED SOURCES USED IN THE INTRODUCTION OF THIS PAPER

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Hammett, T. M., C. Roberts, and S. Kennedy. "Health-Related Issues in Prisoner Reentry. *Crime and Delinquency* 47 (2001): 309-409.

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APPENDIX C

CORRECTIONS STATISTICS

There are 1.4 million adults in state and federal prisons and another 700,000 plus in jails. Growth in the prison population has slowed but is still increasing at about 2 percent per year. The number of noncitizens incarcerated is also increasing and now exceeds 6.5 percent of the total prison population. Thirty-one percent of state inmates report having a physical or mental health problem.

Prisons release about 600,000 inmates per year. Of this number, 91 percent are men, 33 percent are White, 47 percent are African American, and 16 percent are Latino. The average age of these released inmates is 34. Fifty-five percent of released men and 65 percent of released women have children who are minors. Sixty-seven percent of all ex-inmates will be re-arrested within three years of their release.

Of those released, about 75 percent report alcohol or drug use, 25 percent have histories of injection drug use, 18 percent are mentally ill—co-morbidity of substance abuse and mental illness is common—3 percent are HIV positive, and 18 percent are hepatitis C positive. Studies on post-release adherence to treatment range from 3 percent to 30 percent.

Both communicable and chronic diseases are prevalent among inmates:

Category	Condition	Prevalence Compared to U.S. Population
infectious diseases	active tuberculosis hepatitis C AIDs HIV infection	4 times greater 9-10 times greater 5 times greater 8-9 times greater
chronic diseases	asthma diabetes/hypertension	higher lower
mental illness	schizophrenia or other psychotic disorder bipolar (depression) disorder major depression	3-5 times greater 1.5-3 times greater roughly equivalent
substance abuse and dependence	alcohol dependence drug use	25 percent fit CAGE profile 83 percent prior to offense 33 percent at time of offense

Health care is delivered in prisons in different ways—22 percent of doctors contract out all health care, 38 percent have joint service provision between contract and internal care. In 12 percent of prisons, public health agencies provide all care; in 16 percent it is a combination of contract, public health, and internal care; and in 10 percent, doctors provide all care internally.

Thirty-nine doctors reported formal public health collaboration with state-level public health agencies, five doctors with county agencies. Most collaboration is in the area of communicable diseases. Ninety-two percent of prison systems report some discharge planning for HIV-infected inmates. There is little health care planning outside of HIV.