Editor's Corner

Opportunities for Change in Correctional and Community Health

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Since the mid-1970s jail and prison populations within the United States grew fivefold (Tonry, 2004). America now has higher rates of incarceration than any other nation — with four to five times the average rate of other first-world countries (see Ruddell & Fearn, 2005; Walmsley, 2003). The presence of criminal and juvenile justice systems in our everyday lives is significant — in 2003 there were some 13.6 million arrests (Federal Bureau of Investigation, 2004). Most arrestees were detained, at least temporarily, in juvenile detention facilities or adult jails. Some of these persons are held on a long-term basis — on any given day some 2.1 million Americans are incarcerated in juvenile detention facilities, adult jails, or prisons operated by state or federal governments (Harrison & Beck, 2005). Another 6.9 million persons are supervised in the community on probation or parole (Glaze & Palla, 2004). The expense of maintaining such punitive social policies is tremendous – in direct financial costs (see Bauer & Owen, 2004) as well as opportunity costs — as the funds spent on incarceration might be better invested in vocational, or other health, education or welfare programs that may better respond to the problems of addictions, crime, and delinquency (Hagan & Dinovitzer, 1999).

One growing correctional cost is providing health care for the persons that we incarcerate (American Correctional Association, 2004). Many of the inmates of juvenile or adult correctional facilities have significant health problems, including mental illness, serious communicable diseases such as HIV/AIDS (Ross, 2001), tuberculosis, or sexually transmitted diseases. Other inmates, by contrast, suffer from long-term effects of living on the street, addictions, risky lifestyles, poor health-care, homelessness, poverty, unprotected sex, and chronic disease that is undiagnosed or untreated. A recent survey undertaken by the American Correctional Association (2004) found that up to one-quarter of all expenditures in one state prison system was used for health care.

Despite the direct costs of inmate health care, there is a greater economic hazard by not responding to the health problems within correctional populations. This installment of the Californian Journal of Health Promotion (CJHP) addresses a broad range of issues about correctional health, and draws upon the expertise of physicians, jail professionals, community health practitioners, and academics from the disciplines of criminology or criminal justice, health promotion, public health, social work, and sociology. The fact that so many academic disciplines are involved in the study of people ensnared in correctional systems — and the long-term health, social, and psychological effects of incarceration speaks volumes about the care we provide to the 2.1 million persons incarcerated on any given day.

A necessary first step in working towards successful health education and health promotion programming is to identify the structure of the correctional health services system in relation to external providers, to describe the health status of inmate populations (NCCHC, 2002), and examine opportunities for intervention. Given the high rates of special needs inmates within juvenile and adult correctional systems, we must shift our perceptions from temporary "Band-Aid" medical interventions to ones that promote

prevention through education and increasing awareness — not only in institutional and community corrections — but with the families of these inmates as well. Community health is slowly shifting from a reactive to proactive orientation and so should correctional health care.

There is considerable apathy about correctional populations, and their care. It is often difficult to explain to students in my classes — many of whom do not have health insurance — that investing in inmate care and health promotion can pay significant dividends in long-term community health. Correctional populations are transient: the average stay in a California jail, for instance, is 20 days (California Board of Corrections, 2005), while the average term served in prison is 26.1 months (California Department of Corrections, 2005). Thus, the health problems that develop (or go untreated) in jail or prison are likely to be transmitted to the community (Centers for Disease Control and Prevention [CDC], 2001).

While the public is generally apathetic to correctional populations (and some are downright hostile), there are several sub-groups that are not only more vulnerable, but may also elicit public sympathy. Juvenile offenders have historically been given more opportunities for rehabilitation than their older counterparts due to their immaturity, perceptions about their vulnerability, and acknowledgement of their likelihood of rehabilitation (Bernard, 1992). Helflinger and colleagues from the Tennessee Juvenile Justice/Mental Health Work Group within this issue examine the prevalence of incarcerated adolescents with special needs — including juveniles with mental illness, substance abuse problems, and co-occurring disorders.

Consistent with the health promotion goal of the CJHP, Wallace examines how healthy lifestyles and positive nutritional choices can be promoted while juveniles are incarcerated. Central to this approach is that incarceration represents a distinct opportunity for public health interventions with persons at high-risk (see Leach, 2004 for two perspectives on the costs and benefits of public health services in adult jails).

Approximately 19 percent of American jail or prison inmates have significant mental health problems (Ditton, 1999). The problems of mental health are exacerbated by homelessness, addictions, and in some cases, jail or prison inmates may have all three problems (see Hartwell, 2004) — making it unlikely that they will have a smooth re-entry into the community when released. Tyuse, in this issue, examines how jail diversion programs can link offenders with severe mental illnesses to federal benefits and housing. Ignoring the needs of persons with mental illness can have a significant long-term impact. Chandler Ford, also in this issue, explores the personal, offense-related and social characteristics of a small group of Florida jail inmates that had an average of 57 jail admissions each, and identifies the mental health and addictions problems of these high volume users in local corrections. These "frequent fliers" defy traditional mental health interventions — yet given their high demand on county services identifying this group is one step in forming effective interventions.

The "War on Drugs" has increased the number of women who fall under correctional supervision. Many incarcerated women are parents, some are pregnant, and others have given birth within the past year (Fearn & Parker, 2004). All of these characteristics pose challenges for correctional systems. These mothers face additional stress when their children must be placed in foster care, or with relatives. Johansen, in this issue, addresses the intersection of social welfare, jail programs, and immigration policy in her examination of an undocumented incarcerated mother in a county jail. Such examples place a "human" face on the persons who often become ensnared in criminal justice systems. Moreover, the ultimate outcome in this case challenges our ideas whether the punishments we mete out to people are more harmful than the original offense.

Historically, correctional health services have been delivered on experiences based on male populations — who require less comprehensive

care. The plight of these women was highlighted in March 2004 when Kimberly Grey gave birth over a toilet after Tampa jail officers refused to transport her to a hospital (Crawley & Greenwood, 2004). This tragedy resulted in the death of the newborn — but the case also underscores the types of health care treatment that some women inmates receive. Two articles in this issue by Fearn and Parker, and Franklin and colleagues examine the special problems of women's health problems in prison populations and HIV/AIDs in female inmates. One of the bright spots in correctional health is that while HIV/AIDS infection rates have stayed constant, AIDS mortality in prisons has decreased by over 75 percent between 1995 and 2002 (Maruschak, 2002).

Murphy provides CJHP readers with a "first-hand" description of serving five years in a Federal Prison, and the health care that an inmate might expect to obtain (or not receive). It is almost impossible to convey to readers the powerlessness and frustration that jail or prison inmates feel when imprisoned as they often are unable to take any meaningful action to care for themselves or their families. With no alternatives — and in order to survive — Murphy explains how inmates adopt "guerilla health care techniques" to maintain their health and well-being.

In some cases, jail or prison sentences are fatal. In September 2004, for instance, a 27 year-old first-time offender in Washington D.C. — a quadriplegic sentenced to ten days incarceration for possession of marijuana — died after being refused access to a ventilator (Cauvin, 2004). As Murphy observes, a term of incarceration shouldn't be a death sentence because health care services were rationed, unavailable, or taking an inmate to a hospital was inconvenient.

While the vast majority of prison inmates return to the community, some offenders die in custody. One challenging inmate group is the growing number of elderly persons in both jails and prisons. Our reliance on incarceration has led to large numbers of prison inmates growing old behind bars (Harrison & Beck, 2005; James, 2004). In some cases, state prisons have established separate units for these seniors, and many are infirm or wheelchair bound (Aday, 2003). In addition to costing taxpayers three times as much as a younger prisoner, many of these elderly inmates die in custody. Such cases have policy-makers questioning whether geriatric offenders pose any substantial risk to the community — and whether we should extend compassionate releases to this group (Legislative Analyst's Office, 2003). Kuhlmann and Ruddell examine how the population of elderly jail inmates has increased, and how jail administrators and health specialists report that this group is at high risk of self-harm, suicide, and victimization.

Incarcerated populations with unresolved health problems pose a significant challenge for community health. Millions of arrestees cycle through county jails, and some 650,000 persons are released from prison each year (Office of Justice Programs, 2005). Recently there has been increased attention paid to the connections between correctional and community health (Centers for Disease Control and Prevention, 2001; Conklin, Lincoln, & Wilson, 2002; Potter & Krane Rapposelli, 2002). The CDC (2001) observes that:

Many ties connect the community with prisons and jails. For one, inmates are constantly moving back and forth between corrections and the community. Problems or risky behaviors begun in prison or jail return with inmates to the community after release. (p. 2)

Thus, one goal of this special issue of the CJHP is to increase our understanding of the relationships between correctional and community health. Moreover, it is important to understand how modest investments in health education, health promotion, or public health interventions in correctional settings may have a significant effect on long-term community health.

Two articles in this issue address attempts at increasing health care to correctional populations living within our communities. Willmott and Van Olphen describe how community health workers are ideally situated to

provide help for persons recently released from jail or prison. Macher and colleagues, by contrast, describe the development of a forum that was developed to share information about health promotion and harm reduction amongst correctional practitioners and administrators from different agencies within the Washington, D.C. region. Such interventions enable physicians to educate correctional practitioners about emerging trends in illicit drug markets, problematic interactions between prescribed and illicit drugs, and correctional health care strategies that are effective or "best practices."

An important issue that is seldom included in the health promotion literature is the reality of interpersonal violence within jails and prisons, and how assaults may have physical and psychological effects long after a person's release from custody. Most correctional administrators and officers work diligently to provide a safe and secure environment for offenders – yet incarceration is deadly for some inmates. McGuire, in this issue, addresses the subject of prison rape, and legislative efforts to reduce the prevalence of this crime. Not only can such assaults transmit communicable disease, but they have a powerful negative effect on self-perception, and may be highly associated with suicide (Human Rights Watch, 2001).

When we incarcerate someone, we also assume the responsibility for their basic needs, including health care. This volume also includes an analysis of legal cases by Tartaro that demonstrates how lawsuits have drawn attention to inmate suicides. This is a timely article as statistics from a recent federal study reveal that a state or federal prison inmate is over three times as likely to kill themselves as be killed in an assault (Maguire & Pastore, 2005). Yet, as Tartaro observes, families can successfully win a lawsuit, but it doesn't bring back the person who committed suicide. Accordingly, best practices in jails or prisons should focus on health promotion strategies that reduce the incidence of suicide.

While litigation is not a health promotion strategy per se, lawsuits have had a profound influence on the types of correctional health services that juvenile facilities, jails and prisons have developed. A recent analysis of litigation within both jails and prisons revealed that inmate health care was the foremost cause of lawsuits (Schlanger, 2003). Interestingly, the effect of these lawsuits was generally perceived to be positive amongst the jail and prison administrators who responded to Schlanger's (2003) survey. When health care services are better, staff morale in these facilities typically increased. There is an intuitive conceptual appeal to this finding — when conditions of confinement improve (including health care), inmate moral improves, and it is likely that this has a corresponding effect on the correctional officers who work with these prisoners.

A Note About Comprehensive Correctional Health Promotion Programming

There is much in the literature regarding what areas of inmate health should be addressed such as HIV/AIDS and substance abuse, but there is no consensus on coordinated correctional health programming. There is an accreditation program by The National Commission on Correctional Health Care (NCCHC, 2005) for detention and correctional facilities, but the accreditation is primarily focused on medical care rather then health education and health promotion. There is also much in the literature about how correctional facilities and public health agencies collaborate to improve of the overall community health of inmates. For a detailed description of the types of existing collaborations with public health, see the National Institute of Corrections (2003).

Table 1
Public Health Resources Available on Correctional Health

Web Site	Address
American Correctional Association Performance Based Standards for Correctional Health Care	http://www.aca.org/standards/healthcare/
Centers for Disease Control and Prevention National Center for HIV, STD, & TB Prevention Correctional Health Home Page	http://www.cdc.gov/nchstp/od/cccwg/default.htm
Institute for Criminal Justice Healthcare	http://www.icjh.org/
National Commission on Correctional Health Care, Inc.	http://www.ncchc.org/
National Institute of Corrections	http://www.nicic.org/

Much can be learned from school health programming that may be adapted to correctional health. For decades, K-12 school districts have used coordinated school health program models to guide professional practice in the public schools. These models include worksite health promotion and a standardized K-12 health curriculum. In California, for example, the California Health Framework (California Department of Education, 2003) is a curriculum guide used by school districts to assure students are meeting statewide health education learning goals and objectives. The Framework has a detailed health education scope and sequence. When it comes to correctional health promotion, however, there is no defined model to guide professional practice. Such a model needs to be implemented at the national, state, and local levels, and correctional populations need to have defined healthy goals and objectives identified in Healthy People (U.S. Department of Health and Human Services, 2005). This need for a linkage between Healthy People and correctional health is essential because of the health disparities obvious in correctional populations. Rates of incarceration, for example, are disproportionately higher for black and Hispanic men when compared to white men (Bonczar, 2003). Nearly a third of black men are expected to go to prison in their lifetime compared to one out of six Hispanic, and one out of 17 white males (Bonczar, 2003).

The political nature of punishment has contributed to an atmosphere where being "tough on crime" mandates that politicians are very unlikely to advocate for livable, rehabilitative, or safe jail or prison conditions. We challenge legislators and policy-makers to be "smart on crime" and acknowledge the permeable relationships between correctional well-being and community health. Each year, we discharge some 640,000 inmates from the prisons to our communities (Office of Justice Programs, 2005), and providing basic health education, preventative health care, and correctional facilities that are as free of violence as possible is an important long-term investment in community health. Travis (2005) outlines how the "iron law of corrections" is that with the exception of the few inmates who actually die in prison, some 98 percent return to their communities. These prison inmates become our neighbors – and it's in everybody's best interest if these persons return to the community healthier, saner, and well-adjusted citizens than when they were admitted.

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