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

A Focus on California
National Reentry Roundtable Meeting
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SECTION 1. Welcome and Meeting Overview

Gwen Foster, Joan Petersilia, Jack Riley, and Jeremy Travis

One of the most profound challenges facing California’s communities is the reintegration of more than 125,000 individuals who leave state prisons and return home each year. The increase in incarceration rates and high percentage of returns has had far-reaching consequences for the Golden State. Prisoners are leaving the correctional facilities with little preparation for life on the outside, no assistance on reintegration, and a high likelihood of return to prison for new crimes or parole violations. The damaging cycle of removal and return of large numbers of young adults--mostly men--creates specific health needs and health risks for returning prisoners, their families, and the community at large.

This roundtable meeting is aimed at generating state-focused dialogue on the public health dimensions of prisoner reentry in California. The Urban Institute has organized a series of Roundtables as part of a research and policy initiative to advance the understanding of prisoner reentry. The California roundtable is part of a national roundtable on the health needs and health risks of returning prisoners and their families.

In October 2000, the Urban Institute invited academics, practitioners, service providers, and community leaders to the first Reentry Roundtable in Washington, D.C. That meeting examined sentencing and public safety issues from health, substance abuse, labor market, racial, community, family, and gender perspectives. Dynamic discussion led to the organization of the second Reentry Roundtable in March 2001 in New York City, which explored the impact of state policies on returning prisoners, families, and communities. In March 2002, a third Reentry Roundtable focused on the role of society’s civil institutions in facilitating the reintegration process for former prisoners. The Urban Institute hopes to convene Reentry Roundtable meetings twice a year with the aim of promoting a national discussion on a variety of issues relating to sentencing and prisoner reintegration.

Little is known about the impact of current social and fiscal policies or the ingredients of successful transitions to community life. These discussions, along with publications and the Urban Institute’s reentry projects under way in many jurisdictions, offer policymakers a critical opportunity to improve outcomes for the individuals, families, and communities most affected by the consequences of current criminal justice policies. Today’s focus on California, a state with one of the largest incarcerated populations in the world, provides an opportunity for meeting participants to explore the areas where corrections, reentry, and health intersect.
HEALTH PROFILE OF CALIFORNIA INMATES AND PRISON

Marcus Nieto, California Research Bureau

Presentation:

Over the next decade, California’s prison population is expected to double. The state’s constellation of prisons has scrambled to accommodate the population boom, providing not just beds and bars, but also meals and health care. With the current budget crisis reaching unprecedented levels, the governor has asked the California Department of Corrections (CDC) to reduce its current budget by $12 million. Fortunately, the requested cut will not bear considerable weight, considering the overall budget for corrections is $3.9 billion. The correctional system clearly remains a priority for California, representing 6 percent of the state’s annual budget.

In 1998, Senator Richard Palanco challenged the CDC to be more accountable to its prisoners by commissioning the California Research Bureau (CRB) to look at health care delivery in California state prisons. The findings of this study shed light on the health status of the inmate population and the strengths and weaknesses of California’s system.

- Litigation has been the most effective tool and driving force to improve health care delivery in the state prison system. Between 1988 and 2001, six legal cases have transformed the face of inmate health care in California. Increased medical and mental health services, care for female prisoners, protection for prisoners with disabilities, staffing standards, and medication monitoring are just a few of the many improvements that have resulted from legal action.1

- Prior to 1992, wardens and gatekeepers essentially controlled access to care. Each warden had her/his own medical budget and staff and made decisions as to whom would receive attention.

- In 1993, reception centers became the focal points for screening. Approximately 93,000 prisoners entered the centers in 1993, and the budget for health care was $210 million. The Coleman and Shumate cases were instrumental in transforming what could be conducted in reception centers. Today, 200,000 prisoners are entering the centers and the health care budget has increased to $675 million.

1 The six landmark cases are Gates v. Dukmejian 1988, Failure to provide medical and mental health care at the California medical; Coleman v. Wilson 1992, Failure to provide medical and mental health care services in the California correctional system; Shumate v. Wilson 1996, Failure to screen and provide care to females in California prisons; Clark v. Wilson 1997, Failure to provide inmates with disabilities adequate protection and services; Armstrong v. Davis 2000, Failure to provide services for prisoners with disabilities on parole; and Plata v. Davis 2001, Inadequate identification of prisoners in need of medical care.
Fortunately, wardens no longer hold the key to health services. The California health care system includes four licensed acute-care hospitals; one skilled nursing facility for women; twelve infirmaries; fifteen correctional treatment centers; and numerous contracts with acute-care hospitals.

The primary benefactors of the increased dollars and services have been the mentally ill. Increased screening for mental illness has detected a high prevalence within the prison population. Approximately 27,000 of California’s prisoners are mentally ill.

TB is the most infectious disease in the prison setting. There were 32 cases of TB in 2002. Screening is performed on a regular basis and prisoner containment facilities are available for contagious inmates.

There are 1,635 prisoners who are HIV positive. Approximately half are infected with AIDS. AIDS testing is not mandated in California, and there is heavy reliance on peer education. If testing were required, professionals estimate the number of known cases would be larger.

Women’s health care is another area of concern. There are approximately three hundred births in prison per year. The number of abortions has declined from 200 to 100 per year. Women do not receive pre-birth planning or counseling. In many cases, once a woman has delivered her baby, she is separated from the child and sent immediately to her cell. The county normally accepts responsibility for the child and the child is put up for adoption.

Redundancy and duplication of services are frequently found in California’s correctional health care system. Duplication of service costs can be estimated at $20 million per year and growing. The CDC has tried to identify a way to centralize information and avoid duplication, to no avail.

The full CRB report can be reviewed online at www.library.ca.gov under CRB reports on health care in California state prisons.

_Evalyn Horowitz, M.D., Chief of Public Health, California Department of Corrections_

Presentation:

- Over the past 10 years, the health care branch of the CDC has been reorganized nearly 10 times. The impetus for organizational change has come primarily from lawsuits. This continuously shifting environment has made it difficult to move forward with efforts to improve health services, particularly those which affect public health.

- Inside the prison walls, the constant challenge has been to develop more frequent contact between the prisoner and the health care professional. Without clearly
defined responsibilities and a strong infrastructure, it is very difficult for the health care professional to provide quality care to the patient.

- In the early nineties, the Public Health branch worked tenaciously to determine what could be done with infectious disease among the prisoner population. Over time, a model has been developed to effectively deal with TB. As a result of a hands-on approach to care, transmission has reduced from 100 cases in 1996 to 32 cases in 2002.

- With the advent of medications, more prisoners have stepped forward to be tested for HIV/AIDS. All prisoners can ask to be tested for infectious diseases. Prisoners are also entitled to an explanation of the test results and the appropriate care.

- Upon release, a prisoner with TB, HIV, or mental health problems normally leaves the facilities with an appointment to see a specific health care provider. The facility usually contacts the county health department to which the prisoner is being released to inform the department of the prisoner’s return. Due to community reluctance to see parolees, the specific health care provider is usually the county health department or the parolee mental health clinics run by CDC.

- As previously mentioned, duplication of services is a problem. Without the appropriate database management systems, it is difficult to detect what type of care an individual has received during previous periods of incarceration. Normally, when a prisoner is released on parole, his/her medical chart is archived, and the CDC does not have sufficient staff to pull the records out of the archives on a regular basis.

- The Department of Corrections (DOC) has made strides forward, but there is more to be done. Better coordination is needed to improve correctional care and ensure effective transition.

Discussion:

Budgetary Issues

- With a new prison in the works and a continued financial commitment to prisoners with life sentences, it appears that the correctional system has money and it is simply a matter of demanding an increased health care budget. Unfortunately, the situation is not that simple.

- The state deficit has had serious impacts on public health; payments to medical providers have been reduced and a proposal to reinstitute quarterly eligibility reports is in the works. These issues will affect the community side of care more than the prison side, but it is important to understand the magnitude of the problem.

- When preparing for inevitable cuts, the governor gives the CDC an amount with which to work. Deputy directors are then asked to identify areas where potential
cuts can be made. Budget cuts normally affect staffing and administrative allocations.

- Interestingly, California and Texas have approximately the same number of prisoners in their systems. However, the budgets for correctional operations differ considerably. California’s overall budget is $3.9 billion, with $657 million going toward health care. Texas, on the other hand, operates with an overall budget of $2.5 billion, $250 million for health services.

Data Management Systems

- Centerforce has witnessed various accounts at San Quentin of vital information slipping through the cracks and significantly affecting a patient’s plan of treatment. While the Public Health section has the ability to access records, that does not happen on a regular basis due to administrative constraints. The CDC has made various attempts to create an internal data management system, to no avail.

- The Parole and Community Service Division of the CDC has developed an electronic database where medical information can be tracked and transferred to the appropriate institutions upon release. The afternoon discussion will focus on transitional case management program and the positive impact it has had in the areas of mental health and HIV.

- There are a small number of jail facilities where the Department of Public Health is the health service provider. In San Francisco, there is a system in place that allows released individuals to take their medical records with them. There is also an institutional relationship between the jail and state system to transfer records.

Health Care Services

- Most prisoners opt not to be tested unless they are forced to be. However, when peer education and proper orientation to screening are in place, Centerforce has witnessed a 60 percent voluntary testing rate for HIV.

- Tensions often emerge from clashes of the multiple cultures in a prison setting: the culture of corrections, the culture of the physicians, and culture of the public health field. These tensions make it difficult to provide effective services.

- With regard to women’s health, the CDC has two programs that allow imprisoned women to have their children. The Family Foundation is a facility where women are provided services for pregnancy and delivery. Another program allows women who qualify to have their children who are 6 years old and under in the facility with them. Unfortunately, most women do not qualify for either program.
Summary:

This discussion has enabled the roundtable to paint a picture of what the health status and health care delivery system look like inside the walls. We have fleshed out the health profile of the inmate population, the complex operational issues involved, the challenging political dynamics at work, and the periodic clashing of cultures. Now we will shift our perspective by asking our colleagues to paint another picture. Barry Zack will begin the discussion by talking about what lies outside the prison gates and how links are being creating on both sides of the fence.

COMMUNITY HEALTH SERVICES AND LINKAGES BETWEEN PRISON AND COMMUNITY

Barry Zack, Centerforce

Presentation:

Establishing the linkages between prison and community health services is a complex process. The disconnect between a prisoner’s expectation of the services available to him/her upon release and the community’s expectation of what parolee reentry will entail requires careful navigation. Traditional approaches to discharge planning and case management that do not take into consideration the nuanced experiences of the prison population will not facilitate effective reentry. This cultural dimension is essential when attempting to make the linkages between prison and community health services. Several examples illustrate the factors that either help or hinder increased ties.

Factors that facilitate linkages:

- An innovative approach to connecting the prison population to community resources has enabled Centerforce to make considerable headway. Centerforce organized a resource fair where the organization researched the communities to which the prisoners at San Quentin were returning. Centerforce invited agencies from those areas to be part of a resource fair held at the correctional facility. A significant increase in access and use of service, as a result of the face-to-face contact, was made at the fair.

- Another successful program is the clinic for parolees with mental illnesses. The program started with the false expectation that counties would happily embrace the parolee population. Centerforce hoped that by directing parolees directly to the mental health division of the public health department, parolees would receive care. The public health system quickly responded that parolees are the responsibility of corrections and not the public health department. Rather than transferring parolees to community treatment, Centerforce created a parolee clinic.

- Finally, there is an exciting project that will be making beds available for post releasees. During his/her stay, the parolee will be connected to the various service providers in the area and will have the opportunity to interact with the police
correction team. The interaction between parolees and the police will enable both actors to see one another in a different light.

- The three key factors for successful linkage are:
  1. Early identification of needs and services;
  2. Established contacts and relationships from release to parole to reentry; and
  3. Increased consciousness and education about the parolee population and parolees’ rights to services as human beings.

- Categorical funding can be perceived as both a barrier and opportunity for creating linkages. Oftentimes, funding is available for prisoner reentry with specific diseases. For example, AIDS patients receive funding for reentry, but the vast majority of prisoners are not diagnosed with AIDS.

Discussion:

- The current system requires the releasee population to be extremely self-determined. The transition points are very difficult for most returning prisoners. However, if an individual has access to a person they trust outside with whom to follow-up, services can be accessed more readily. Parolee advocates are a key part of the equation when trying to make the linkages.

- When envisioning linkages, it is also important to understand what individuals are returning to. We are sitting at ground zero right now. There have been approximately six hundred violence-related deaths in Los Angeles County this year. At the same time, the county is facing a huge deficit that has required the closure of eleven clinics and two hospitals.

- Behavioral issues (such as exposure to violence and substance abuse) prohibit many individuals from being able to effectively reenter society. Preventive health care is rarely part of correctional services. If prisoners were empowered with information about preventive health, they would be able to take this information when they leave the gates and bring it to their communities.

- In counties such as Los Angeles, where supervisors play a central role in the decision making process, it is important to engage supervisors in dialogue about linking services. To date, most supervisors do not feel a moral responsibility to provide services to parolees. However, it is important to pursue continued dialogue in a place like L.A., when 40,000 of the 116,000 parolees in California who are mentally ill, reside in L.A. County.

- Interestingly, Los Angeles has a transition program run by the sheriff’s department. The program is connected with the VA hospital and school districts.

- The deficiencies in treatment are magnified for the juvenile incarcerated and released populations.
- It is important not to lose sight of the cultural competency dimension of service linkage. In San Francisco, bilingual services are offered. Translation is a huge issue for statewide programs.

**Summary:**

After a morning of discussion, Ted Hammett was asked to summarize the key discussion points. Mr. Hammett organized the points in two categories: macro- and micro-level issues.

At the *macro-level*, the following points were highlighted:

- Given the large numbers of individuals returning to communities in California, there is a tremendous opportunity to address the specific needs of this population.

- The movement to provide services for AIDS patients sheds considerable light on what needs to happen to secure services for the prisoner and releasee populations. At the moment, prisoners and releasees do not have the force to launch a campaign of this magnitude and are in need of advocacy on their behalf. There is a need to strengthen the ethical, moral, and legal commitment to provide services and make linkages. The first step should be to identify, document, and present the public health benefit of addressing the health needs of the parolee community.

- Current treatment systems place an emphasis on disease control and pay very little attention to preventative health approaches. A shift of thinking in this area is needed.

- The involvement and responsibility of community-based organizations in linking prison and community health systems is essential.

At the *micro-level*, the following points were highlighted:

- If transitions are to work, information systems need to be streamlined. Duplicated services will be avoided as a result.

- Facilitating relationships between individuals who are coming out of jail and those who are from community service organizations is essential. Establishing appointments for prisoners prior to their release is also an important approach.
BARRIERS AND OPPORTUNITIES FOR IMPROVED HEALTH SERVICES

Johnny Walker, Parole and Community Services Division, California Department of Corrections

Presentation:

From financial restraints to cultural differences, the barriers to improved health services for the prisoner and parolee communities are plentiful. However, amid the barriers lie promising opportunities to improve health services. Johnny Walker from the Parole and Community Services Division of the CDC shares his experience as the manager of an innovative transitional case management program.

- In 1992, the CDC launched two pilot projects to evaluate the effectiveness of HIV/AIDS treatment. The evaluation revealed that treatment had been very effective, and as a result, funding for HIV/AIDS programs was secured. The programs provide services to prisoners and provide outside referrals for patients upon release. Soon there after, a program for mentally ill patients was created and modeled after the HIV/AIDS program.

- The CDC has integrated advanced technology to ensure the necessary coordination of services between the correctional facility and community service providers. Every prisoner is asked to sign a consent form to release medical information to community health providers. Advanced database technology enables the medical information of a prisoner to be transferred to the county to where he/she will be released. All the transactions occur via a laptop that is encrypted and password protected.

- The HIV/AIDS database has been up and running for two years. The program for the mentally ill deals with somewhere between 13 and 13 thousand individuals per year. Social workers speak with the prisoner 90 days before the individual is released on parole. An appointment with a community health provider is made for the prisoner. Thirty days before release, the social worker checks in to help with transitional details (housing, medication, etc.). The goal is to facilitate a smooth transition and to take steps to keep these individuals out of prison.

- The automated database offers tremendous opportunity. By centralizing medical information in one place and making it available to the necessary parties, a former prisoner is ensured effective transitional care. Social workers work to make sure that treatment can continue for the parolee. The program has also proven to be cost-effective.

Clarinifications:

- Given the program’s success, the CDC would like to bring the initiative up to scale for all types of illness. Emergency placement is the first area that will be integrated.
A prisoner or parolee who suffers from a severe health condition and needs to get from Sacramento to San Diego will be able to have medical information transferred electronically through the system. As models are added, the CDC will be able to clearly demonstrate to the legislature what has been done and how it can be further developed.

- For individuals enrolled in the mental health program, the conditions of parole are linked to program compliance. The HIV/AIDS program does not link the two.

- The CDC covers the cost of treatment when a prisoner is released and connected with a community provider.

- Most mentally ill prisoners finish their time in jail and are not paroled when they leave prison. These individuals normally cannot be part of the transitional program, since they are not parolees. However, a correctional physician can request that a patient be added to or subtracted from the program.

- The program does not have an advisory board made up of prisoners and/or parolees, but this is an interesting idea for the future.
Section 3.  
Next Steps for Research and Policy

Jeremy Travis, Urban Institute

Following a rich dialogue about the public health dimension of reentry, Jeremy Travis asked roundtable participants to share the specific action steps individuals will take home to assist the group in moving the agenda forward in California.

Identified Action Steps:

1. Increase the capacity of community service providers to receive the reentry population.
   - Encourage correctional facilities and community service providers to create a shared mission to provide connected care for the returning prisoner.
   - Expand the knowledge about corrections into California’s communities.
   - Create better mechanisms to share information about returning prisoners with community organizations that serve this population.
   - Include former prisoners in the process of defining core health concerns at the local level.
   - Utilize individuals who are inside and outside the gates to build bridges between the prisoner population and the community.
   - Create an advisory board of prisoners and parolees for the transitional case management program.
   - Channel more thought into the creation of an agency that would coordinate the transition process.
   - Create incentives that prevent parolees from returning to prison merely for health services.

2. Heighten awareness among local officials, policymakers, and funders about reentry and the public health dimensions.
   - Package health care for prisoners and releasees as a service that benefits society as a whole.
   - Market transitional programs as a cost-saving activity for overall public health.
- Work with local officials (police, mayor, etc.) to create greater awareness of reentry issues.
- Encourage a collective paradigm shift in our current ways of treating reentry.

3. Improve health services for the prisoner population.
- Launch an educational campaign to educate prisoners on the health services they are entitled to and empower them to demand needed health services.
- Facilitate greater coordination within the walls of prison around health issues.
- Create health interventions for the juvenile population.
- Ensure that cultural competency permeates the CDC system.
- Identify ways to integrate behavioral and preventive health interventions with high-risk populations. Launch an educational campaign focused on healthy lifestyles.
- Strive to ensure that every person leaving the system has a specific appointment with a health care provider in the community.

4. Conduct more research on the public health dimensions of reentry.
- Research the possible reduction of restrictions on Medicaid to allow eligibility to follow an individual into prison.
- Research the possibility of creating a voucher system for parolees to access services.
- Conduct a comprehensive cost analysis of what it would take for California to support successful reentry programs.
- Maintain closer contact with the prisoners themselves as members of the research team. Engage prisoners in the research process.

5. Continue forward with the California Roundtable.
- Use the Little Hoover Commission’s recommendations as a point of departure.
- Invite prisoners to lead the roundtable discussion.
- Involve service consumers, county representatives, policymakers, funders, and advocates.