Building the Table

A Right to Quality and Continuous Health Care for People Incarcerated and Returning from Incarceration

April 1, 2024

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Introduction

Lack of access to quality, culturally appropriate, and trauma-informed health, mental health, and behavioral care, in addition to the impact of social determinants of health, exacerbates the disparities faced by individuals with low-incomes and people of color. These challenges manifest in more severe and extensive health care struggles for people of color compared to their white counterparts.[1] In turn, incarceration itself is a major social determinant of health.

At the time of their arrest, half of individuals in state prisons lacked access to health care directly tied to the absence of material and financial resources to afford health care insurance, a lack of employer-sponsored health care insurance, and state policies denying access to health care for those with lower-incomes.[2] This, in turn, increases the likelihood of involvement with the criminal legal system in a person's life, driven bylaws that criminalize poverty and homelessness. Additionally, it amplifies the likelihood of individuals with mental health and substance use conditions being arrested and incarcerated. Furthermore, the lack of continuity of care following a period of incarceration increases the chances of individuals returning back to jail or prison.[3]

This vicious cycle not only perpetuates the United States' carceral system but also results in countless deaths, trauma, injury, and human rights violations inside carceral walls and within communities nationwide.

The health care needs of individuals incarcerated in the U.S—including mental health, substance use disorders, and chronic conditions such as asthma, diabetes, and heart disease—are high. Justice-involved individuals face disproportionately high rates of serious mental illness (SMI), substance use disorder (SUD), and infectious and other chronic physical health conditions.[4],[5],[6] An estimated 80 percent of those returning from incarceration grapple with chronic medical, psychiatric, or substance use disorders.[7]

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[1] Key Data on Health and Health Care by Race and Ethnicity, Latoya Hill, Nambi Ndugga, and Samantha Artiga, KFF, March 2023, Available: https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/#:~:text=Chronic%20Disease%20and%20Cancer&text=As%20of%202021%2C%20diabetes%20rates,than%20White%20adults%20(7%25).

[2] Chronic Punishment: The unmet health needs of people in state prisons, Leah Wang, Prison Policy Initiative, June 2022, Available: https://www.prisonpolicy.org/reports/chronicpunishment.html#physicalhealth.

[3] Reducing Recidivism: The Role of Healthcare in Re-Entry, SARC Foundation for Health Equity and Justice, Available: https://www.sarccenterfoundation.org/reducing-recidivism#:~:text=For%20those%20re%2Dentering%20society,a%20higher%20risk%20of%20recidivism.

[4] Maruschak LM, Berzofsky M, Unangst J. *Medical problems of state and federal prisoners and jail inmates, 2011-12*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2015: 1-22 [Last update 2016, Oct 4].

[5] Bronson J, Berzofsky M. *Indicators of mental health problems reported by prisoners and jail inmates, 2011-12*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2017: 1-16.

[6] Bronson J, Stroop J, Zimmer S, Berzofsky M. *Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009*. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention; 2017 [Last update 2020, Aug 10].

[7] Mallik-Kane K, Visher CA. Health and prisoner reentry: how physical, mental, and substance abuse conditions shape the process of reintegration. Research Report. 2008. Available at https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner- Reentry.PDF.

The increased need for health care continues long after individuals are released. In the period following release from jail or prison, individuals that were formerly incarcerated are 12 times more likely to die compared to others. Causes of death include heart disease, homicide, suicide, and cancer, with overdose rates extremely high immediately following incarceration, particularly the week after release, when overdose, suicide, and homicide are the leading causes of death.[8],[9] A study in North Carolina found that within two weeks following release, formerly incarcerated individuals were 40 times more likely to die of an opioid overdose than someone in the general population.[10]

Some groups experience risks over the long-term. Recent longitudinal research found higher mortality among Black individuals who had been incarcerated, suggesting a potential association between incarceration and lower life expectancy for Black populations in the U.S. Additionally, rates of hospitalization also are higher for individuals that are recently incarcerated compared to others.

The scope of the problem is profound. In 2020, 1.8 million people were incarcerated in the U.S., with over 1.2 million individuals serving sentences in state and federal prisons,[11] while nearly 550,000 individuals were held in local jails.[12] Over the course of the year, 8.7 million people cycled through local jails.[13] People who are incarcerated have significantly lower incomes and wealth accumulation than non-incarcerated individuals, and it is disproportionately composed of Black or other people of color.[14]

Values and Principles of the JustUS Coordinating Council (JCC)

These values and principles guide the JCC:

We amplify the power of people who have been directly impacted by the criminal legal system. We invest in, educate, empower, and elevate the voices of people impacted by the criminal legal system. Indeed, no movement for social, racial, or economic justice has ever succeeded without the full participation and leadership of those most affected.

Listen and build power in local communities. We recognize that local communities are epicenters of hurt, healing, innovation, resilience, and resistance. Alongside our partners, allies, and collaborators we seek to listen and support people in their local communities.

[8] Rosen DL, Schoenbach VJ, Wohl DA. All-cause and cause-specific mortality among men released from state prison, 1980-2005. *American Journal of Public Health*; 2008; 98(12): 2278-2284.

[9] Lim S, Seligson AL, Parvez FM, et al. Risks of drug-related death, suicide, and homicide during the immediate post-release period among people released from New York City jails, 2001-2005. Am J Epidemiol; 2012; 175(6): 519-526. doi:10.1093/aje/kwr327. PMID: 22331462. PMCID: PMC7159090.

[10] Ranapurwala, S. I., Shanahan, M. E., Alexandridis, A. A., Proescholdbell, S. K., Naumann, R. B., & Edwards, D. (2018). Opioid overdose mortality among former North Carolina inmates: 2000–2015. American Journal of Public Health, 108(9), 1207–1213.

[11] E. Ann Carson, *Prisoners in 2020 – Statistical Tables*, 2021. https://bjs.ojp.gov/content/pub/pdf/p20st.pdf.

[12] Todd D. Minton and Zhen Zeng, Jail Inmates in 2020 – Statistical Tables, 2021. https://bjs.ojp.gov/content/pub/pdf/ji20st.pdf.

[13] Todd D. Minton and Zhen Zeng, Jail Inmates in 2020 – Statistical Tables, 2021. https://bjs.ojp.gov/content/pub/pdf/ji20st.pdf.

[14] Building the Table, Advancing a Sustained Federal Commitment to Ensure Economic Justice for Systems-Impacted Individuals, JLUSA, Author Melissa Young, https://jlusa.org/wp-content/uploads/2022/11/jcc-landscape-report.pdf.

Practice a shared liberation and human rights orientation. We are not free until everyone is free. This movement will not distinguish or discriminate against access to rights restoration or economic, housing, or health justice based on arrest, type of record, or felony conviction. All too often, the carceral system assigns labels and distinctions during arrest, conviction, and sentencing that carry a ripple effect of barriers for people labeled by the system. These distinctions have been historically leveraged to determine who is deserving or not deserving of rights restoration or opportunity. We seek to end this practice. We believe in the dignity and worth of all people, regardless of race, ethnicity, religion, gender, sexual orientation, physical or mental ability, immigration status, or involvement with the criminal legal system. We seek to have an impact on past harms and poor treatment of people whose fundamental rights have been violated and restore human dignity for all systems-impacted people.

Engage in collaboration to assure our success. It is critical that we collaborate in order to advance real and lasting systemic change. We recognize the intersectionality of our work and will collaborate with our allies, especially those working to dismantle systems that oppress Black and brown people and people living in poverty. Together we will build a system that is rooted in liberation.

Reimagine systems. We must optimize, retool, and reimagine existing systems, structures, and policies in order for all people to thrive. These policy reforms will create authentic and sustainable economic opportunity and justice for all.

The United States is at an Urgent Inflection Point

Too many people are dying while in carceral custody. Too many people are suffering needlessly under the weight of mental, physical, and behavioral health issues that could be remedied with access to care while incarcerated and upon release from incarceration. Moreover, as a result of inadequate care inside of correctional institutions, communities and health systems bear the brunt and costs associated with the lack of quality and coordinated care when someone is realized.

The work ahead to ensure access to quality, culturally appropriate, and trauma-informed health, mental health, and behavioral care for people who are incarcerated will require a myriad of reforms to policy and practices. And creating the conditions by which continuity of care for people returning to communities from incarceration is upheld demands action.

JustLeadershipUSA and the JustUS Coordinating Council recognize that states and the federal governments are taking steps to expand access to care for people who are incarcerated and those returning from incarceration and that progress is laudable. However, efforts by the federal government have been historically slow, inadequate, and piecemeal compared to the scope and scale of the overreach of the carceral system. And this needs to change.

No single jurisdiction of government has more ability to shift laws, fund new programming, and influence systems change than the federal government. Moreover, the federal government has a unique role in

setting national and state level agendas, leveraging its bully pulpit, and convening stakeholders to prioritize issues of national importance.

We believe that the federal government has the responsibility to advance sets of reforms and actions that uphold the human right to healthcare for people who are incarcerated and those returning from incarceration.

Spotlight on Medicaid Expansion

As of now, all but 10 states have adopted the Medicaid expansion of coverage to adults with low incomes established in the 2010 Affordable Care Act. Many individuals in jails and prisons fall within the low-income bracket and are eligible for Medicaid, underlining the significance of expanding Medicaid coverage.

While there are no national estimates detailing the Medicaid-eligibility status of those incarcerated, statistics indicate that 80-90 percent of individuals incarcerated in state prisons, in certain Medicaid expansion states, are likely eligible for Medicaid. In states that have not expanded Medicaid, this should be a priority and a critical step toward ensuring that individuals who are incarcerated have access to healthcare insurance coverage.

The JustUS Coordinating Council (JCC) has identified crucial legislative and regulatory reforms that demand immediate attention. These reforms, categorized into two broad areas—Health Care Rights and Access for Individuals in Incarceration and Ensuring Continuity of Care for Individuals Being Released from Incarceration—propose actionable steps to rectify the current gaps in healthcare within correctional facilities and upon release.

The JCC emphasizes the need for cross-agency and cross-system coordination at the federal level to support continuity of care, maintain consistent health standards, and assist states in this critical endeavor. Indeed, as we have elevated via examples in this report and in others, there is a dire need for the United States to utilize a whole-of-government approach and the full power of the federal government to address the health equity and justice interests and rights of justice-impacted citizens. The White House should reconstitute and empower the Federal Interagency Reentry Council that includes federal agency leaders from across federal agencies and others, their policy and program staffs, and authority to engage with national and local experts and people impacted by the criminal legal system. The Council could be modeled off other successful federal interagency bodies with carefully selected members to drive decision making, policy, and program development decision tables and federal policy.

Our Recommendations:
Health Care Rights and Access for Persons who are Incarcerated: As discussed in this report, access to health care coverage and services is severely limited for persons who are incarcerated and a lack of coverage often follows people when they are released from incarceration further exacerbating health care issues. Furthermore, the rights of persons who are incarcerated to act on their own behalf relative to healthcare concerns or malpractice is burdensome and often denied entirely. In order to restore necessary rights and access to health care for persons who are incarcerated, **we recommend:**

- Congress should swiftly take up legislation such as the *Humane Correctional Control Act* (S.1820) and amend Medicaid (42 U.S.C. § 1396d) by striking and repealing the "Medicaid Inmate Exclusion Policy" and the "Institutions of Mental Disease Exclusion" clauses. The clauses prohibit Medicaid payment for services received during incarceration which creates a disincentive for many correctional facilities to provide access to quality, culturally appropriate, and trauma-informed care while people are incarcerated. This exclusion often creates barriers to supporting transitions to health care services upon release for directly impacted citizens. The clauses are contrary to Medicaid's mandate of universal coverage for individuals with low incomes.

- Congress should swifty take up legislation such as the *The Due Process Continuity of Care Act* (H.R.3074/S.971) to allow pretrial detainees to receive Medicaid benefits at the option of the state.

- Congress should amend the The Prison Litigation Reform Act (PLRA) (28 U.S.C 191(b)) by striking the physical injury requirement, the administrative relief, and filing fee clauses. As outlined in this brief in detail, these clauses severely limit the ability for people who are incarcerated to file a lawsuit and seek remedy for healthcare, medical indifference or malpractice, or injury violations.

- Congress should fund and allow for necessary personnel, technology, and additional infrastructure expansions across the Centers for Medicare and Medicaid Services (CMS) to the scope and scale necessary to manage and process the pending increase in Section 1115 Demonstration waiver applications from states. Additionally, CMS should be funded at the scope and scale necessary to support states as they apply, gain approval, and move toward implementation of 1115 Demonstration Waiver applications.

- Centers for Medicare and Medicaid Services (CMS) should elevate examples from other states on implementation and emerging model frameworks for states who are in the pre-application phase of the Medicaid 1115 waiver. Among other things, examples should include:
    - Efforts where states are engaging in continuous efforts to re-engage and assess the effectiveness of services, models, and supports sought through 1115 demonstration waivers by centering the voices and experiences of directly impacted citizens.
    - Efforts where states are ensuring linkage to care post incarceration across a wide range of necessary reentry physical and behavioral health services.

- Centers for Medicare and Medicaid Services (CMS) should continue to highlight existing guidance to states directing that people impacted by the criminal legal system ought to be an engaged stakeholder group in the development of 1115 waivers. CMS should support states in centering the voices and perspectives of directly impacted people when developing 1115 waivers.

- An Ombudsman office ought to be established and funded by the Department of Justice. The office should sit within the Centers for Medicare and Medicaid Services with linkages to the Department of Justice Office of Inspector General. We recommend that the office be structured like this report describes in order to create an anonymous way for people who are incarcerated and their families to report health care concerns and complaints happening inside of local jails, state, and federal prisons. The office should have power and ability to investigate concerns and

complaints, author and issue reports, involve legal authorities, and hold correctional settings accountable.

- The Centers for Medicare and Medicaid Services (CMS) should elevate best practices from states that are developing of standards of care for correctional facilities including but not limited to how correctional facilities are leveraging Medicaid standards of care to establish standards for screening for health services, assessment, continuation of services, and transition and reentry processes and services.

Ensuring Continuity of Care for Persons Being Released from Incarceration: As highlighted throughout this report, a lack of continuity of care for people returning from correctional control to the community results in poorer health outcomes for millions of people, injury, and possible death. In order to establish greater continuity of care for persons who are incarcerated, **we recommend:**

- Congress should swiftly take up legislation such as the "Humane Correctional Control Act" (S.1820) that establishes that no individual in the United States should be incarcerated for the purpose of being provided with health care that is unavailable to the individual in the individual's community and requires local entities to establish programs that offer quality, culturally appropriate, and trauma-informed health, mental health, and behavioral care in community-based settings.

- Congress, with technical assistance and guidance from the Centers for Medicare and Medicaid Services, Health Resources and Services Administration, the Department of Justice, and people directly impacted by the criminal legal system should codify a federal grant program targeted at states and communities with significant numbers of people with low incomes returning from incarceration to support the development of locally established health care centers and continuity of care options for people returning from incarceration. Special care should be taken to allow for government and nongovernmental organizations to be eligible for grants. Efforts led by directly impacted individuals should be prioritized for funding.

- The Department of Justice should issue federal level guidance on the duty to engage in discharge planning as a part of constitutional rights of persons incarcerated and best practices for engaging in discharge planning so as to ensure continuity of care for people returning from incarceration.

- The Sentencing Commission serves as a resource for Congress, the executive branch, the courts, criminal justice practitioners, the academic community, and the public. In this role, the Commission should take a leadership role in ensuring that new "compassionate release" guidelines are implemented. Their role should include issuing additional guidance, resources, technical assistance, and training to facilities and for people who are currently incarcerated.

Chronic Health Conditions

Chronic health conditions and diseases are defined broadly as lasting 1 year or more, requiring ongoing medical attention, limiting daily living activities or both. Unfortunately, many chronic health problems disproportionately affect people of color. And even when people of color are not overrepresented in certain chronic health conditions, they often are more likely to die as a result of chronic health conditions.

In a survey based on self-reported data collected through face-to-face interviews with a national sample of individuals currently incarcerated in state and federal facilities, an estimated 50 percent reported having experienced a chronic condition. The most common chronic conditions reported were high blood pressure (29%), arthritis (17%), and asthma (16%). About 1 in 10 currently incarcerated individuals reported ever having hepatitis C (9%).

Little is known about the status of chronic kidney disease among individuals currently incarcerated. In various population health surveys within correctional settings, the prevalence of self-reported 'persistent kidney problems' was highest in federal prisons, with 6 percent of those incarcerated, followed by 5 percent in the state penitentiaries and 4 percent in local jails. In a survey of individuals that were newly incarcerated in maximum-security prisons in New York, ages 16–64 years old, found a 2 percent prevalence of kidney disease. In a report published by the Bureau of Justice Statistics in February 2015, 6 percent of individuals incarcerated in state and federal correctional systems reported "kidney-related problems." However, these surveys may significantly underestimate the prevalence of chronic kidney disease.

Notably, there is also little peer-reviewed literature regarding dialysis and kidney transplantation during incarceration. There is no published data on the number of individuals on the transplant list from the criminal legal setting or those who have received kidney transplants while incarcerated. It is deeply concerning that Black Americans are more at risk for kidney failure than any other racial group, with more than 1 in 3 kidney failures in the United States being among Black people. The absence of data and peer-reviewed literature on kidney disease and treatment inside of the carceral setting highlights broader issues related to intake and screening for chronic conditions.

"I was diagnosed with a mental illness while I was in prison and, seven years later in my reentry, I was charged with disorderly conduct while I was experiencing a mental health crisis. The judge, the public defender, and the prosecutor all agreed my behavior was not illegal and dismissed the case, but my probation officer, who had no training in mental health, decided to move forward with the revocation process. During the nearly six months in custody for the revocation hearing, the correctional psychiatrist decided to put me on so much medication that I became very sick and started to sleep around 16 hours each day. I was afraid to stop taking the medication because I thought it would be viewed as a refusal to comply with my recommended treatment program and would greatly decrease the likelihood of release. Though I would later be released, during this six-month period I lost my job, my housing, my full-tuition scholarship, and still today deal with the ramifications of the medication's impact on my body - the same medication whose company would later be sued for harmful side effects."

JustUS Coordinating Council Founding Member

Statutory and Legal Barriers Prevent and Deny Access to Insurance Coverage

Insurance coverage plays a very small role in correctional health.[15] This is largely due to statutory and legal barriers surrounding the use of Medicaid, which have spawned administrative and operational challenges over time. The central obstacle is the "inmate exclusion," provision within Medicaid statutes, which prohibits Medicaid programs from providing any "payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution).[16] This prevents Medicaid from covering services for individuals in incarceration unless that care is provided in a medical institution, defined primarily as inpatient hospital stays of more than 24 hours. Medicaid can cover services provided to many individuals in the community corrections system, to whom the inmate exclusion does not apply. This includes individuals on probation and parole, and those who reside in "halfway houses."[17] While the "inmate exclusion" does not classify individuals in incarceration that meet Medicaid eligibility criteria ineligible, it prohibits Medicaid payment for services received during incarceration, discouraging many correctional facilities from providing access to quality, culturally appropriate, and trauma-informed care covered by Medicaid. Consequently, this exclusion creates barriers to supporting transitions to health care services upon release.

Moreover, because correctional facilities do not provide services or seek payment for services under Medicaid, they do not follow standards of care established through Medicaid. As a result, care standards

[15] State Prisons and the Delivery of Hospital Care: How states set up and finance off-site care for incarcerated individuals, Pew Charitable Trusts, July 2018, . https://www.pewtrusts.org/en/research-and- analysis/reports/2018/07/19/state-prisons-and-the-delivery-of-hospital-care.

[16] 42 U.S.C. Sec 1396d(a)(30)(A). https://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim

[17] Centers for Medicare and Medicaid Services, State Health Official Letter 16-007, RE: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities, April 2016, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf.

and types of services available to individuals in incarceration differ significantly, furthering disparate outcomes.[18]

The lack of Medicaid coverage inside of carceral systems makes coordinating care between carceral confinement and the community upon release challenging. This includes the ability for individuals to access and afford medications and treatment. Individuals returning from incarceration may navigate bureaucratic hurdles to reinstate Medicaid payment for benefits or reapply for Medicaid. Those residing in states without expanded Medicaid eligibility to the adult group, may be ineligible for Medicaid and may be unable to access and afford insurance from employers, through the federal Health Insurance Marketplaces, or state-based Marketplaces. Even with Medicaid coverage, some services crucial for individuals with mental health diagnoses and SUD - such as rehabilitative services and case management - are optional benefits under state plans and may not be covered.[19]

In my experience, individuals who are experiencing medical and mental health emergencies while incarcerated are not taken seriously. I've seen physicians and prescribers hurry through 7-8 individuals in a one-hour time span. Can you imagine only having five minutes to tell your doctor about your concerns? The lack of patient education regarding diagnosis and treatment is alarming. We expect the individuals to just trust we have their best interests in mind without any explanation and with very few consistent standards. It's time that we stop accepting the bare minimum when it comes to correctional healthcare. If we truly want directly impacted people to do better, they have to feel better first.

JustUS Coordinating Council Member & Correctional Healthcare Professional

Additional challenges to accessing health care include limited electronic data sharing of health records between justice system and community providers, scarce post-release resources, and systemic health system biases against individuals impacted by the criminal legal system - often rooted in racism.

Corrections and Health Care in the United States: Neglectful, Inconsistent and Fragmented

A stark reality confronts individuals entering state prisons, where half of them lack health care at the time of their arrest.[20]Furthermore, for each year that someone spends in prison, their life expectancy reduces by two years.[21] Indeed, the inconsistent, fragmented, and neglectful state of health care behind bars bears much of the blame.

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[18] Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons, Viaduct Consulting, October 2023. https://healthandreentryproject.org/wp-content/uploads/2023/10/Recommendations-for-Medicaid-Coverage-of-OUD-Services-in-Jails-and-Prison.pdf

[19] Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, A Report to Congress
Required by Section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; Pub.L. 115-271) U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, January 2023
https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf.

[20] Chronic Punishment: The unmet health needs of people in state prisons, Leah Wang, Prison Policy Initiative, June 2022, Available: https://www.prisonpolicy.org/reports/chronicpunishment.html#physicalhealth.

[21] Incarceration Shortens Life Expectancy, Emily Widra, Prison Policy Institute, June 2017, https://www.prisonpolicy.org/blog/2017/06/26/life_expectancy/.

Health Care System Fragmentation

Across U.S. prisons and jails, there lacks a unified approach to providing health care services for individuals who are incarcerated or coordinating care for individuals upon release. Extensive research and first-person accounts from individuals who have experienced incarceration reveals lapses, outright denial of basic and routine health care, lack of health care oversight, standards, and accountability. Additionally, there is a notable lack of prescription continuity, highlighting various instances of neglect.

Governments have a constitutional mandate to provide people in prisons and jails with health care.[22] Yet with nearly 2,000 state and federal prisons, over 3,000 local jails, over 1,700 juvenile detention facilities, and other carceral settings operating under different laws, regulations, administrative structures, and budgetary constraints, there is significant variation in the quality of care and delivery models used.[23]

> *"During my incarceration, I injured my shoulder while weightlifting and knew I needed care. The standard at the prison I was in was only to do an X-Ray - nothing more. The X-Ray did not show an injury and I was told to rest and it would improve. Little did I know, my rotator cuff was torn and it wasn't until an MRI after my release that I was able to get the care I needed - after further injuring my entire bicep."*
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> ***JustUS Coordinating Council Founding Committee Member***

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Correctional settings employ a range of approaches when it comes to the provision of health care services. States and counties may provide medical services directly by employing their own health care providers, contract with outside organizations, or rely on a combination of in-house and contract providers. In some cases, community providers, such as hospital systems or community health centers, provide services in jails. Data on health care contracting in carceral settings—particularly in jails—remain scarce, and the financing of health services in prisons and jails varies widely, with most on-site care funded out of state and local correctional budgets. To control costs, some jurisdictions contract with service providers for a fixed amount of care per-person within their facility.

Within state facilities, a concerning reality emerges, more than 20 percent of people who are incarcerated with persistent medical conditions go without care. That percentage jumps to more than 68 percent in local jails.[24]

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[22] Estelle v. Gamble, 429 U.S. 97, 103, 97 S. Ct. 285, 290, 50 L. Ed. 2d 251, 256 (1976) (These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration.).

[23] Wendy Sawyer and Peter Wagner, Mass Incarceration: The Whole Pie 2020, Prison Policy Project, March 2020. https://www.prisonpolicy.org/reports/pie2020.html.

[24] The Health and Health Care of US Prisoners: Results of a Nationwide Survey, Andrew P. Wilper, MD, MPH, Steffie Woolhandler, MD, MPH, J. Wesley Boyd, MD, PhD, Karen E. Lasser, MD, MPH, Danny McCormick, MD, MPH,David H. Bor, MD,

Spotlight on the health needs of women who are incarcerated

This section directs attention to the health care needs of women who are incarcerated for several interconnected reasons. While recognizing the overall neglect within the correctional health care system for many groups, the focus here is on women due to various concerns.

Over the last 40 years, the imprisonment of women in the U.S. has increased by 475 percent, from 26,000 in 1980 to 153,000 by 2020—an alarming growth rate that is twice that of men. The United States prison system is predominantly built on a male-specific model, leaving many correctional facilities significantly unprepared to meet the distinct needs of women. Moreover, research continues to elevate that women - especially women of color - face acute economic marginalization that denies their access to quality jobs which, in turn, limits their access to employer-sponsored health care options and being able to afford basic health care.

The health care needs of women while they are incarcerated are profound and often compounded by inadequate and inappropriate health care prior to incarceration. We believe centering women's health is important for understanding the broader systemic issues. In short, if the carceral system fails to adequately and appropriately address the health care needs of women, it is likely falling grossly short of caring for the health care needs of many people with intersecting identities.

Among women who are incarcerated, rates of substance use disorder, prior trauma and abuse, and mental illness are higher than those of men in incarceration The conditions within correctional facilities – the possibility of physical or sexual abuse, solitary confinement, intimidation and harassment, inadequate trauma and restorative care, restricted access to counseling services and social support are conditions that build upon one another and worsen health outcomes for women during incarceration and upon reentry into communities. Past traumatic experiences layered with involvement with the criminal legal system can lead to lifelong mental health challenges, such as depressive disorders, stress disorders, anxiety disorders, learning problems, substance use disorders (alongside physical health problems), and behavioral health issues.

Additionally, the majority of women in incarceration are younger than 45, with specific reproductive health needs. Research on the provision of gynecologic and women's health care services in the carceral system has identified neglect of their gender-specific health care needs and inconsistent access to reproductive justice. A 2019 study reported that a total of 4 percent of women admitted to 22 state and federal prisons were pregnant, with 753 women giving birth in custody. Many lack access to the necessary prenatal care, screenings, and social support required for a safe, healthy, and comfortable pregnancy and delivery.

and David U. Himmelstein, MD, April 2009, American Journal of Public Health, Available: https://ajph.aphapublications.org/doi/epdf/10.2105/AJPH.2008.144279.

Research emphasizes the importance of mother-infant attachment for infant development and maternal well-being. However, parents giving birth while incarcerated face immediate separation from their infants, leading to higher rates of postpartum depression and emotional trauma. This separation takes an emotional toll on the wellbeing of many parents in incarceration and can have negative physical, psychological, and behavioral health implications for their children. A recently released survey on pregnancy policies and practices in 22 state prisons and six jails, including the five largest jails, highlighted concerning trends, including restraint use, prenatal care, delivery and birth, and other pregnancy accommodations. Notably, compliance inconsistencies with anti-shackling legislation are evident – identified as medically dangerous, a human rights violation, and against national and international standards of care. A third of the surveyed prisons and half of the jails did not have accredited health care services. All study facilities provided prenatal vitamins and most provided supplemental snacks. While most facilities stationed an officer inside the hospital room during labor and delivery, nearly one-third of facilities did not require a female-identifying officer. Addressing these issues is essential for the overall well-being of incarcerated women and their children. The numerous logistical hurdles, such as navigating processes to reinstate insurance or finding a healthcare provider willing to treat them, only further adds to the problem. Large numbers of released individuals will go without health insurance and seek medical assistance at hospitals further burdening social systems."

"Like many of the women I was incarcerated with, I made my own homemade menstrual products rather than beg for more from an unconcerned correctional officer or risk bleeding through my clothes. As a result of my creativity to survive with some modicum of dignity, I ended up needing an emergency hysterectomy when I got home because of toxic shock syndrome. My narrative is not unique or isolated.

JustUS Coordinating Council Founding Member

Barriers to Realizing Constitutional Right to Health Care Behind Bars: The Role of the Prison Litigation Reform Act

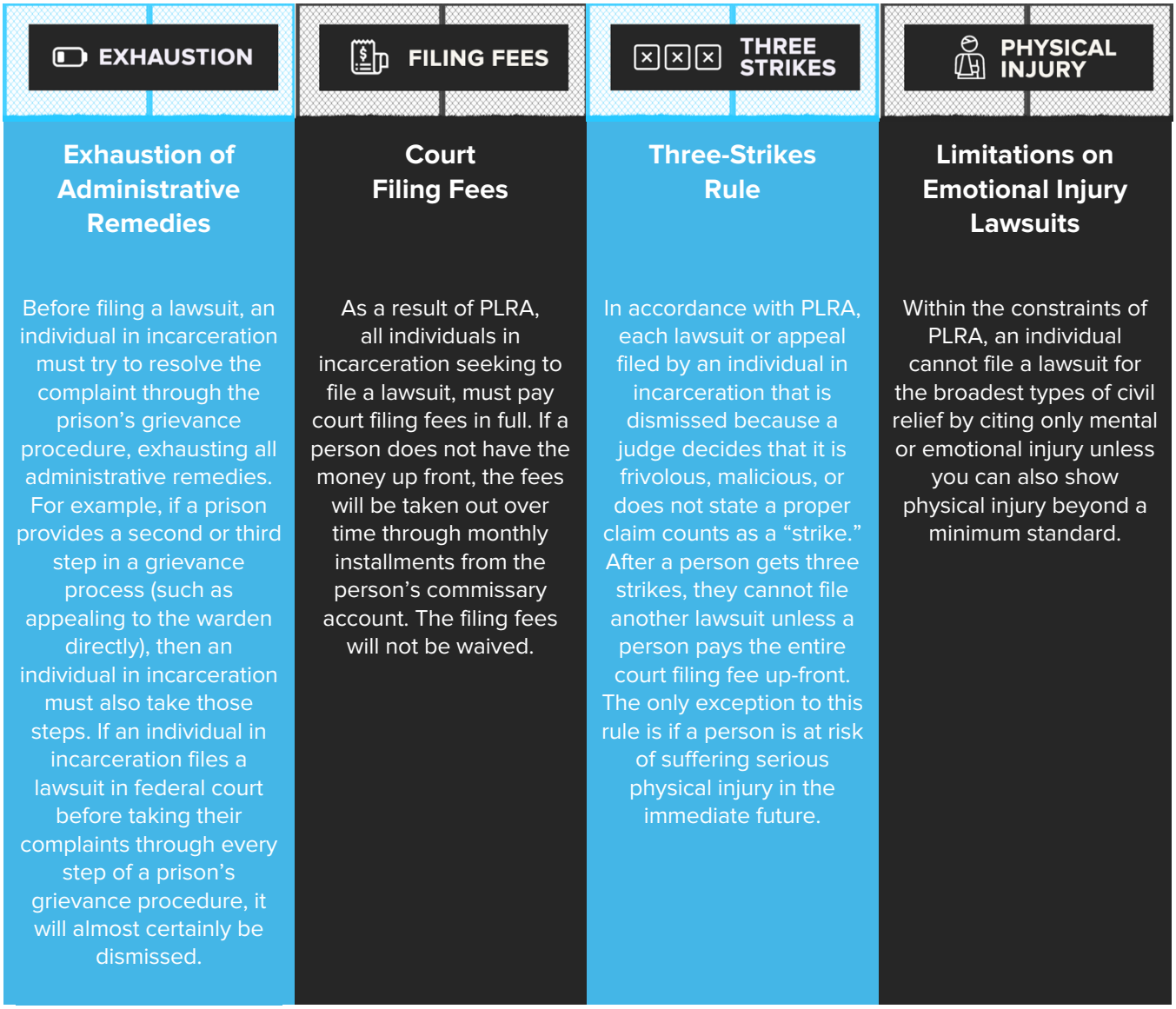
Despite the constitutional mandate to provide individuals in incarceration with care, it is very difficult to leverage the legal system to address or remedy medical malpractice or indifference.

Enacted in 1996, the Prison Litigation Reform Act (PLRA), imposes that individuals in incarceration must meet certain requirements before they can file a lawsuit. The PLRA requires individuals in incarceration to exhaust all administrative remedies by going through a correctional facility's internal grievance policy.

But these policies can be complex, onerous, and hard to understand. Furthermore, the PLRA limits the amount of fees attorneys can recover for representing individuals in incarceration. This limitation reduces the incentives for private attorneys to take these cases, leaving individuals to seek pro bono legal representation or represent themselves. The PLRA also increased filing fees for individuals, imposing another financial burden to filing suits. These hurdles, among others, mean many claims of malpractice may not be brought forward, legally challenged, and likely go unaddressed or corrected. And even if

incarcerated individuals overcome these obstacles, the PLRA places limits on the scope and duration of prospective relief, hindering the potential for legal remedies to generate systemic change.[25],

Understanding the Barriers to Seeking Legal Remedy under the PLRA



[25] Know Your Rights: The Prison Litigation Reform Act (PLRA), Available here: https://www.aclu.org/sites/default/files/images/asset_upload_file79_25805.pdf

Conclusion

The healthcare rights of individuals who are incarcerated and those returning from incarceration have long been fragile and incomplete. Presently, recent court decisions further threaten even the basic healthcare rights of individuals in incarceration. As we look ahead, it is imperative to codify comprehensive rights and access to care for those who are incarcerated and those in the process of reentry. Failure to do so will undoubtedly lead to more countless deaths, trauma, injury, and human rights violations.

The JCC has identified a set of recommendations to secure and protect the healthcare rights of individuals who are incarcerated and those returning from incarceration. Our recommendations begin with the dire need for the federal government to operate in ways that reflect a whole of government approach.

Additionally, we believe that there are critical legislative and regulatory changes that must be advanced to ensure health care rights and access for individuals in incarceration and to ensure continuity of care for individuals being released from incarceration. Advancing our shared agenda will require eliminating harmful legislative precedents, the identification of new resources, a commitment to building the capacity of federal agencies, leaning into innovation and new approaches to establish accountability, and leveraging the creativity of federal agencies to support access to health care in a greater number of states for people who are returning from incarceration.

The urgency of the situation cannot be overstated. Too many lives are at stake, and the time for comprehensive reforms is now. The JCC urges Congress, federal agencies, and other stakeholders to prioritize these reforms and work collectively toward a system that upholds the human right to healthcare for individuals who are incarcerated and those returning from incarceration.