CQ Researcher

Published by CQ Press, a division of Congressional Quarterly Inc.

www.cqresearcher.com

Prison Health Care

Are prisons dumping grounds for the mentally ill?

A high percentage of the more than 2 million inmates in U.S. jails and prisons suffer from mental illness, addiction or infectious and chronic diseases like HIV/AIDS and diabetes. About a quarter suffer from major depression and a fifth from psychosis. Many had little or no health care before being incarcerated. Providing treatment and preventive care for prisoners who eventually return to society can help stem the spread of infectious disease in communities and keep those with mental illness and addiction from landing back in jail, say public-health officials. While prisoners are, ironically, the only Americans who have a constitutionally guaranteed right to health care, most prison health systems are underfunded and understaffed, making the care they provide spotty at best. Meanwhile, strict sentencing guidelines and three-strikes-and-you're-out laws have created a burgeoning — and aging — prisoner population, which is driving skyrocketing health-care costs even higher.

Bobby Sutherland is among 300 inmates at an Alabama prison for the aged and infirm. He is serving 297 years on rape and pornography charges and expects to die behind bars.

INSIDE

This Report

CQ Researcher • Jan. 5, 2007 • www.cqresearcher.com
Volume 17, Number 1 • Pages 1-24

CQ Press

Recipient of Society of Professional Journalists Award for Excellence ◆ American Bar Association Silver Gavel Award

PRISON HEALTH CARE

Cover: AP Photo/Dave Martin

CQ Researcher

Jan. 5, 2007
Volume 17, Number 1

MANAGING EDITOR: Thomas J. Colin

ASSISTANT MANAGING EDITOR: Kathy Koch

ASSOCIATE EDITOR: Kenneth Jost

STAFF WRITERS: Marcia Clemmitt, Peter Katel

CONTRIBUTING WRITERS: Rachel S. Cox, Sarah Glazer, Alan Greenblatt, Barbara Mantel, Patrick Marshall, Tom Price, Jennifer Weeks

DESIGN/PRODUCTION EDITOR: Olu B. Davis

CQ PRESS
A Division of Congressional Quarterly Inc.

SENIOR VICE PRESIDENT/PUBLISHER: John A. Jenkins

DIRECTOR, LIBRARY PUBLISHING: Kathryn C. Suárez

DIRECTOR, EDITORIAL OPERATIONS: Ann Davies

CONGRESSIONAL QUARTERLY INC.

CHAIRMAN: Paul C. Tash

VICE CHAIRMAN: Andrew P. Corty

PRESIDENT/EDITOR IN CHIEF: Robert W. Merry

CQ Researcher (ISSN 1056-2036) is printed on acid-free paper. Published weekly, except March 23, July 6, July 13, Aug. 3, Aug. 10, Nov. 23, Dec. 21 and Dec. 28, by CQ Press, a division of Congressional Quarterly Inc. Annual full-service subscriptions for institutions start at $667. For pricing, call 1-800-834-9020, ext. 1906. To purchase a *CQ Researcher* report in print or electronic format (PDF), visit www.cqpress.com or call 866-427-7737. Single reports start at $15. Bulk purchase discounts and electronic-rights licensing are also available. Periodicals postage paid at Washington, D.C., and additional mailing offices. POSTMASTER: Send address changes to *CQ Researcher*, 1255 22nd St., N.W., Suite 400, Washington, DC 20037.

Prison Health Care

BY MARCIA CLEMMITT

THE ISSUES

Jail officials knew Bridgett Fogell was pregnant when she began serving a prison sentence in Delaware for traffic violations and driving under the influence. When she began having severe cramps and vaginal discharge, contract health-care workers checked on Fogell and deemed her healthy. [1]

When Fogell's water broke, a nurse told her that she'd simply urinated in her clothes. After nine hours in the prison infirmary, Fogell was finally taken to a hospital. She gave birth the next day, but her baby, Anna Lee, lived only a few hours.

As a prisoner, "you're helpless," said Fogell. She had called for help when Anna Lee's breathing became shallow and her heartbeat slowed, but it never came. "It's not like you can get in your car and leave, looking for competent medical care." [2]

AP Photo/Nashville Police Department via *The Tennessean*

Diabetic inmate Ricky Douglas died in a Nashville jail after failing to receive his medication. Poor prison health care has prompted the courts to order reforms in several states.

St. Louis-based Correctional Medical Services Inc. (CMS) — one of the country's two largest prison health contractors — lost its Delaware contract in 2002, shortly after Fogell's baby died, but regained it in 2005.

Health-care horror stories like Fogell's are common throughout the nation's jails and prisons. For example, in November 2006, a federal judge ordered Michigan to implement massive reforms in its prison mental health-care programs after the deaths of several mentally ill prisoners, including a 21-year-old man who died after being strapped naked to a concrete table for four days. [3]

America's prisons have become a dumping ground for the mentally ill and those with drug and alcohol addiction, in part because non-prison treatment facilities are unavailable or unaffordable. More than half of all prison and jail inmates in 2005 had mental-health problems, according to the U.S. Department of Justice — a problem some experts attribute to the decision beginning in the 1950s to replace mental hospitals with community-based facilities, which remain understaffed and underfunded. [4]

Moreover, because of a serious shortage of drug-treatment programs, a disproportionate percentage of the nation's inmates are addicts. In a 2004 survey, 56 percent of state and half of all federal prisoners said they had used illegal drugs in the month before they committed their offenses, and up to a third were using drugs when they broke the law. [5]

Prisoners also are sicker, in general, than the population as a whole. More than a third of jail inmates had medical problems in 2002, including 13 percent with arthritis, 11 percent with hypertension and 10 percent with asthma. [6]

The health problems are compounded by the stratospheric HIV/AIDS rate among prisoners — more than triple the rate in the overall population. [7] And other common inmate diseases — such as Hepatitis C — are expensive and not always able to be treated.

"That creates a quandary for systems on a tight budget," says William J. Winslade, a professor of the philosophy of medicine at the University of Texas Medical Branch at Galveston.

Caring for the nation's 2.3 million state, federal and jail prisoners costs the cash-strapped federal, state and local governments about $7 billion a year — and the price tag is expected to rise as prisoners age and develop age-related diseases. [8]

Aside from serious budget shortfalls, two of the biggest obstacles to delivering quality health care to inmates are the huge size of the nation's prison population and the high percentage of mentally ill inmates, which makes it difficult to hire enough trained staff. [9]

"Many mentally ill people are in prison who should not be there," says Jeffrey L. Metzner, a psychiatrist and clinical professor at the University of Colorado School of Medicine. Unless the country develops a good community mental-health system, "this will continue."

The problem extends to mentally ill children and teens, who often are

"parked" in juvenile corrections facilities — even when they haven't committed any offense, said Carol Carothers, executive director of the Maine chapter of the National Alliance for the Mentally Ill. Such "parking" typically happens when mental-health care is unavailable locally or exasperated parents can't cope with their child's behavior.

And incarceration can aggravate mental illness, as Maine officials found out in the case of a suicidal 13-year-old. During one of several stays in juvenile detention, Carothers said, "he was held in isolation for 152 of his first 240 days," which led him to mutilate himself, "spiraling deeper and deeper into his illness." The state settled a lawsuit on the child's behalf in 2004, said Carothers. [10]

Two-thirds of prisoners are merely serving life sentences "on the installment plan," says V. Morgan Moss, co-founder of the Center for Therapeutic Justice, which promotes inmate-run therapeutic communities in correctional institutions. "Inmates have substance-abuse problems, mental illness and few job skills" but get no help either inside or outside of the institutions, Moss says.

"With a 67-percent failure rate, people just go right back in," he laments. "We need to do something different. Instead, we just continue to build more jails and more prisons. It's a joke."

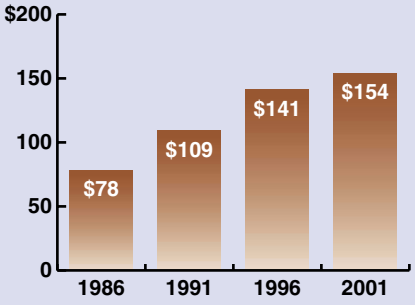
But resources and training to help ill prisoners are sparse, says M. Douglas Anglin, associate director of the Integrated Substance Abuse Programs at the University of California, Los Angeles (UCLA). For example, "you have correctional officers with no training in this area dealing with people with both mental illness and substance abuse."

There has been some improvement, however, in drug treatment, says Anglin. In the early 1990s, only about 5 percent of inmates received substance-abuse treatment, he says, compared to about 15 percent today. But "that's still a drop in the bucket."

Prison Health Costs Nearly Doubled

States' per-capita spending on health care for prisoners almost doubled between 1986 and 2001, according to the latest available data. Experts estimate that the figures have probably doubled again since 2001, based on the general rate of increase in health costs.

State Health Expenditures Per Prisoner
(for selected expenditures)



Source: "State Prison Expenditures, 2001," Bureau of Justice Statistics Special Report, 2004

As bad as prison health care usually is, it's often better than what inmates were getting in their communities. A large proportion of prisoners have no access to health care before being incarcerated, usually because they are uninsured and cannot afford health care.

"The average male in the New York prison system has 12 or 13 bad teeth, and the average woman two or three more," says Lester Wright, chief medical officer of the New York State Department of Correctional Services. "Most have never seen a dentist."

Yet, ironically, once people are incarcerated, they acquire the constitutional right to receive free health care — unlike other U.S. citizens. The Supreme Court in 1976 ruled that "deliberate indifference" to an inmate's medical needs is "cruel and unusual punishment" prohibited by the Eighth Amendment. [11]

Some Americans object to lawbreakers being entitled to free health care while more than 40 million Americans do not have health insurance. [12] Resentment over inmate health care erupted into a nationwide debate in 2002, after a California inmate received a $1 million heart transplant.

"The average Joe, who's getting squeezed by his chintzy HMO, has palpitations when he opens the paper to see that he just bought a Stanford [University] heart transplant for a con," wrote *Los Angeles Times* columnist Steve Lopez. The incident raised several ethical questions, Lopez noted, including, "What moral imperative says we should care more about the health of 160,000 inmates than of uninsured people, one-quarter of whom are children?" [13]

The case also sparked a nationwide debate over who should get scarce organs. At the time, 500 Californians and more than 4,000 people nationwide were waiting for heart transplants. "You have to wonder if a law-abiding, tax-paying citizen drew one last breath while Jailhouse Joe was getting a second wind," Lopez wrote. [14]

California officials said the 1976 Supreme Court decision compelled them to provide quality care for the prisoner. Indeed, lawsuits have been a driving force behind improvements in correctional health care. As recently as 2005, a federal judge in California placed jurisdiction over prison health care in the hands of a court-appointed administrator. [15]

The lack of adequate prison health care ultimately can lead officials to ignore even glaring matters of public health, says Dori Lewis, senior supervising attorney at the New York City-based Legal Aid Society's Prisoners' Rights Project. "The Department of Corrections is likely to say, 'What do we care about TB [tuberculosis] testing?' "

But as inmates cycle in and out of the community, they put correctional health care center stage in the fight against infectious disease and untreated chronic illnesses like diabetes. "The prisoner today is my neighbor tomorrow," says Timothy P. Flanigan, director of the division of infectious diseases at Brown Medical School in Providence, R.I.

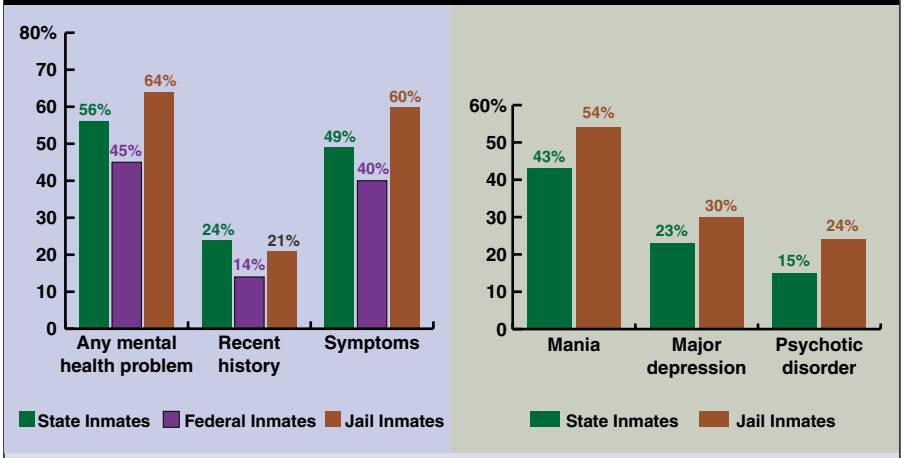
Despite some court victories and the efforts of dedicated health-care workers, "prison health care is, by and large, abysmal in this country," says David C. Fathi, senior staff counsel at the American Civil Liberties Union's (ACLU) National Prison Project. "When you cast somebody outside the human family, you don't care what happens to them."

As growing numbers of aging and mentally ill prisoners swell jail and prison populations, here are some of the questions being asked:

Inmate Mental Problems Are Widespread

More than half of all state prison and jail inmates had a mental-health problem in 2005. More than half of all jail inmates met the criteria for mania and 30 percent had major depression.

Percentage of Inmates With Mental Illness, 2005



Source: U.S. Department of Justice, Bureau of Justice Statistics, September 2006

Do correctional institutions provide decent health care?

Inmate populations suffer from high rates of mental illness, substance abuse and below-average physical health. Critics say prisoner care remains substandard because too few health professionals will work in prisons, and negative public attitudes toward prisoners keep public resources lean. Some corrections officials say, however, that institutions in recent years have beefed up mental-health staffs, launched health screenings and hired better-trained staff — albeit largely as a result of court orders.

"There are still some people who think nobody in prison gets any decent care, but that isn't true," says chief medical officer Wright, in New York state. While the quality of correctional health care varies widely, Wright acknowledges, at least some systems are making progress. For example, more than 90 percent of prison doctors in New York now are either board certified or eligible for certification — "a big difference from 15 years ago, when many were unlicensed," he says.

And prisons are getting a better handle on some infectious diseases, such as tuberculosis, which once ran rampant, says Wright. In New York, for example, the TB rate in prisons has dropped from 220 new infections for every 100,000 prisoners in 1991 to around 10 per 100,000 in the last several years — a rate comparable to New York City's general population, he says.

Lawsuits have helped improve mental-health services in Ohio, according to Gary E. Beven, a psychiatrist at the maximum-security prison in Lucasville. In the mid-1990s, Beven was the only psychiatrist at the facility, working part time, with one psychiatric nurse. "There was a psychology staff, but they were beleaguered and overburdened . . . no group [mental health] programs, no individual counseling," he said. [16]

In 1993, following a riot at the prison, a federal lawsuit alleged that Ohio prisons didn't provide adequate mental-health care. A court-imposed monitoring system triggered big changes, said Beven. Today "we have the staffing, we have the support from central office," as well as the training and the budget to provide "care that really is effective." [17]

"There were six psychiatrists for the entire Ohio penal system when the [*Dunn v. Voinovich*] lawsuit was filed," Fred Cohen, professor emeritus at the State University of New York at Albany and the prisons' court-appointed monitor, told "Frontline." By the time the case had ended, however, there were more than 40 psychiatrists. [18]

Other health-care experts point out that even the most basic prison health care is better than the low quality — or total lack — of mental and physical health care available in the low-income communities many prisoners came from. "It's sad to say, but if a jail has a decent mental-health system, people are getting better treatment than they do in the community," says Metzner, at the University of Colorado. "Correctional people almost always want to do the right thing" by mentally ill prisoners, he

Keeping Substance Abusers Out of Jail

By the time Altamese McIntosh faced Judge Jeri Cohen in Miami's drug court, she had been cycling in and out of the justice system for years, and five of her eight children had been born drug-dependent.

That was in 1999. Today, McIntosh, 44, has been clean for seven years. "I realized that [the judge] was . . . no-nonsense. You either did what she said or she would terminate your parental rights. She wanted me to live in society drug-free so that I could be a good parent." [1]

That's the kind of story substance-abuse experts — and a growing number of lawmakers and corrections officials — would like to hear more. Although American corrections officials have generally resisted drug therapy, the high cost of recidivism among abusers is forcing a re-evaluation.

About 85 percent of all incarcerated people have had substance-abuse problems at some point, says M. Douglas Anglin, associate director of the Integrated Substance Abuse Program (ISAP) at the University of California, Los Angeles (UCLA). And, with two-thirds of all inmates re-entering the criminal-justice system a few years after release, say many experts, it's time for new strategies.

"For the past 10 years or so, the consensus has generally been that prison-based treatment with after-care is effective," says Michael Prendergast, director of ISAP's criminal justice research group.

But ISAP researcher Betsy Hall says that little phrase "after-care" is awfully important, because to be effective, substance-abuse programs must stretch over time. Unfortunately, few people persist, either because after-care isn't available or because they drop out.

Moreover, despite general agreement that the right treatment can work, only a limited number of therapeutic options exist — either in correctional facilities or in communities. Nationwide, Anglin estimates, about 15 percent of prisoners (including those in local jails and juvenile facilities) who need assistance get it while incarcerated. Although that's up from a decade or so ago, it's still "a drop in the bucket," he says.

Corrections officials often balk at having their budgets siphoned off to therapeutic programs they don't control, Anglin says. And in the name of accountability, states may dump programs before they can be tweaked into shape, he says. Generally, it "takes about five years of cyclical improvements" to get a program working properly, he says.

Even interventions that prove effective in the community suffer from a "dilution of effect" when launched inside an institution, in part because the staff do not have an affinity for the work or don't believe they are worthwhile, Anglin says.

Strong staff commitment is crucial, agrees ISAP research assistant Jerry Cartier. "People in the program are being asked for commitment strong enough to change their lives," he says, but if the staff appears uncommitted, it can drain inmates' own will to change.

Some wardens "pay lip service" to substance-abuse therapy, but the real test of support is in the behavior of prison staff with direct contact with inmates, says ISAP Principal Investigator William Burdon. "I've seen people go back to the housing unit

says, "but unless they're in a very rich or liberal state, they have a hard time making the case" to legislators and the public.

Lawsuits have triggered important improvements in prison health care as well, Metzner says. For example, he says, "up-front health-care screening is now pretty standard. Most systems these days are pretty good at determining health-care needs," although "not all are good at meeting them."

Some institutions "are making significant progress" on HIV/AIDS, says Flanigan, at Brown Medical School. For example, in a longstanding collaboration with the local health department, the jail in Hampden County, Mass., delivers timely primary care and HIV education to detainees. "That model should be applied for other diseases, like severe hypertension and diabetes," he says.

But critics say the overall health-care picture is bleak. With a few exceptions, correctional health systems are "like the HMO from hell," says Fathi, at the National Prison Project.

Mental-health care is often "poorly understood, not paid for or treated," says Daniel P. Mears, an associate professor of criminology at Florida State University.

Many correctional staff are unfamiliar with the mental illnesses that afflict inmates, and "even those who are aware of the issues are massively hamstrung," says Mears. Low resources and tension between correctional imperatives and health imperatives leave most facilities without the ability to provide needed care, he says.

"The difference between theory and practice is just monumental," says Mears. "Prisoners weren't getting care 20 years ago, and when you quadruple the size of the systems that gets worse."

For example, all detainees are supposed to be screened for mental-health problems when they enter institutions, says Mears, but there is "extreme variation" across the country.

State and local bureaucracies don't effectively cooperate, he says. When jail health staff diagnose an offender with a disorder like serious depression, "it would be good to be able to call up a local mental-health agency and say, 'Please send somebody over,' since most jails can't afford an in-house

in the pouring rain" after a substance-abuse treatment "and have the guards not open the door for them," he says. "Some guards call treatment 'hug-a-thug' programs."

Moreover, even though a very high percentage of prisoners have both mental illness and substance abuse, mental-health programs "are not well integrated with substance-abuse programs, and they should be," says Hall.

But even if institutions develop better substance-abuse efforts inside the walls, the need for longer-term after-care — plus the hope of keeping some substance abusers and potential abusers out of jail altogether — means more and better community-based programs are needed. In California prisons, for example, most studies show that those who just get prison treatment without after-care "don't do any better than those who get nothing," says ISAP Principal Investigator David Farabee. "That's led to a reluctant consensus that we ought to be spending more on the re-entry phase" — after inmates are released, he says.

In addition, more and more experts believe that diverting substance abusers from prison altogether is more effective, says Anglin. The country now has more than 1,200 drug courts that require drug offenders to get — and persist in — treatment rather than go to jail. Both Arizona and California overwhelmingly passed ballot initiatives directing that substance abusers who commit minor offenses be diverted from incarceration.

Diversion programs are more effective than throwing abusers in jail, says Anglin. Such programs give people time to change, "acknowledging that there are inevitable slips" as people try to kick habits, says Anglin. ISAP research also shows that diverting substance abusers from incarceration saves money, beyond what is saved in pure incarceration costs, Anglin says. "I'm an advocate of things that give people doors out of their lifestyle," he says.

Treatment programs both within institutions and in community-based programs are getting a boost from a new idea about substance abuse: that people can be successfully pressured into treatment. "The old idea is that people had to be ready to accept change," says John Roman, a senior research associate at the liberal-leaning Urban Institute. But, "the evidence is pretty overwhelming that you can intervene with people with substance abuse," he says. "The criminal-justice system can push them to stay in treatment."

When substance abusers are diverted to drug courts, for example, "there's magic in those judicial robes," says Bruce J. Winick, a professor of law and psychiatry at the University of Miami and an originator of the "therapeutic courts" concept. Having someone as august as a judge personally involved with them, for the first time, "helps propel people through the inevitable difficulties" of overcoming addiction, he says.

Nevertheless, if people are to kick substance abuse for good, many more services must be available, in jails and prisons and in the community, experts say. But "accessible, evidence-based substance-abuse treatment is just plain hard to find," says Anglin.

[1] Arles Carballo, "A Juvenile Court Judge Is Helping Drug-Addicted Women Get a New Lease on Life Through an Innovative Approach to Administering the Law," *The Miami Herald*, www.herald.com, Sept. 3, 2006.

counselor." But local mental-health officials don't want to spend their money on patients who are the jails' responsibility, or they believe — rightly or wrongly — that they don't have the legal right to assist, he says.

Most university medical centers try to combat health disparities — such as the poor health of African-American men — by offering health care to low-income residents in their communities, says Flanigan. But colleges and universities ignore corrections health, he says: "Correctional health care has been removed from the mainstream of medicine, and particularly academia."

In fact, says T. Howard Stone, an associate professor of bioethics at the University of Texas Health Center at Tyler, there are no longer any academic programs to train health workers to deal with prison populations.

Low salaries, remote locations and lack of prestige make hiring staff difficult. "Recruiters try to keep salaries competitive with local government pay, but even for states and cities that try to keep up, it's very hard," says Edward Harrison, president of the Chicago-based National Commission on Correctional Health Care.

And correctional facilities constantly "deal with financial cutbacks," says Alvin Cohn, a Rockville, Md.-based consultant on conditions in correctional facilities. "Many were built long ago. They're outmoded and in disrepair." An ailing boiler or roof "takes precedence over hiring a psychiatrist."

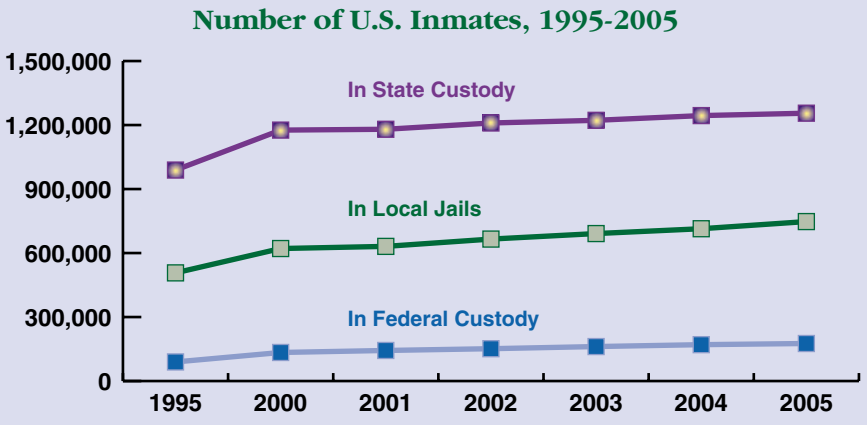
To save money, some states and localities use private health-care companies, but critics say oversight is often lax. Tennessee-based Prison Health Services (PHS), for example, often skimps on staff training, said a former PHS nurse. "When they hire someone, they don't even orient them but put them right on the floor," she says. "That is really scary for someone who's never been in a prison before." [19]

Should prisoners get the same quality of care as law-abiding citizens?

When a California court ruled in 2002 that a prison inmate could receive a publicly funded heart transplant, many people questioned whether prisoners should receive cutting-edge

U.S. Inmate Population Topped 2 Million

The number of federal, state and local prisoners topped 2.3 million in 2005 for the first time. The number of federal prisoners nearly doubled in the decade from 1995 to 2005 while the state inmate population grew by more than 25 percent.



Source: U.S. Department of Justice, Bureau of Justice Statistics, May 2006

care at taxpayers' expense — especially when many of those taxpayers cannot afford health insurance. Prison health officials say the government is obligated to provide health care for prisoners because incarceration prevents them from obtaining care on their own. Moreover, they say, it is shortsighted to allow the mental and physical health of prisoners to deteriorate.

But giving prisoners access to scarce resources like organ transplants is unwarranted, wrote David L. Perry, now a professor of ethics at the U.S. Army War College in Carlisle, Pa. "Imagine watching a loved one die for lack of a heart, then reading in the paper the story about our fortunate felon," wrote Perry, who formerly directed the ethics program at California's Santa Clara University. [20]

The 31-year-old prisoner who received the heart had been convicted of robbery, Perry pointed out, a crime that "implies at least the threat of injury or death to its victims. . . . In my view, those who deliberately threaten the lives of innocent persons thereby forfeit whatever moral claim they otherwise might have had to an organ transplant." [21]

The Supreme Court's 1976 ruling, in *Estelle v. Gamble*, that all prisoners must be given adequate health care does not require governments to give prisoners sophisticated treatments like heart transplants, argued George Mason University Law School student Carrie S. Frank in a 2005 law journal paper. To be unconstitutional, denial of medical treatment to prisoners "must be so egregious that it offends the evolving standards of decency and is repugnant to the conscience of mankind," said Frank. [22]

Because of the high cost and the scarcity of organs, transplants are only provided to "a select few" patients, she pointed out. So denying a transplant to a prisoner does not qualify as the kind of "deliberate indifference" the Supreme Court banned, she wrote. "There is no reason why criminals living inside prison walls should be given a financial advantage over law-abiding citizens." [23]

The outrage triggered by the prisoner's heart transplant highlighted the irony that in the U.S. health system prisoners are the only citizens guaranteed a constitutional right to health care, while many law-abiding Americans can't afford health care. "Medical care is better in jail than on the street," lamented a corrections medical director surveyed by Stone of Texas in a nationwide study. [24]

Some bioethicists analyze the transplant situation differently. "At first glance, one thinks, 'Why should they get transplants?' " says Winslade, at the University of Texas Medical Branch at Galveston. "But what if a guy's going to prison for three years, and he's the most medically suitable for an available heart? He hasn't been condemned to death, and yet depriving him of the heart could have that effect.

"I don't think people on death row should get a heart transplanted," he continues. "But it would be discriminatory not to give a medically eligible short-termer a transplant. If it's a lifetime prisoner, though, I can see how the cost and burden of the immunosuppressive drugs raises issues." Transplant recipients must receive costly drugs for the rest of their lives to prevent organ rejection.

"In a society in which we haven't decided that health care is a human right, I can see how prison health care becomes a more difficult decision," says Felicia G. Cohn, director of medical ethics at the University of California's Irvine School of Medicine and a daughter of criminologist Alvin Cohn.

Americans have decided to punish millions of people, not just violent criminals, by locking them away and making it impossible for them to get care for themselves, she says. The inability of prisoners, including the many non-violent prisoners, to procure care for themselves is what makes providing health care for incarcerated people a government responsibility, she

says. 'There are alternative ways of punishment that wouldn't require us to provide health care."

Despite what many think, prisoners have not been granted a right to health-care frills, the University of Colorado's Metzner says: The Supreme Court has said only that prisoners have a right to care for "serious medical needs, including mental illness."

Since the *Estelle v. Gamble* decision, lower courts and correctional systems have struggled to define "serious medical needs," but the definition remains fuzzy, many analysts say.

For example, while some prisoners do receive organ transplants, especially kidneys, in most cases "where prisoners have tried to sue for things like transplants, they've lost," says Brietta R. Clark, a professor at Loyola Law School in Los Angeles. "Cost is playing a role" in the medical decisions, "and courts have said that it's reasonable to look at the cost of alternatives. They aren't getting the best and the most expensive care."

To put inmates on a par with other Americans, some jurisdictions require them to make co-payments in order to receive care.

However, "no studies show that it saves money," says New York City internist Robert L. Cohen, who directed a health-care program for city jail inmates and has been a court-appointed monitor of correctional health-care settlement agreements in Connecticut, New York, Ohio and Michigan.

Kidney transplants usually are cost-effective, compared to the alternative — dialysis — with a transplant recouping its additional cost in three years, Cohen says.

The case for providing incarcerated people with decent health care is hard to make to the public, in part because most are "minorities that are despised," says Lewis, at the Prisoners' Rights Project.

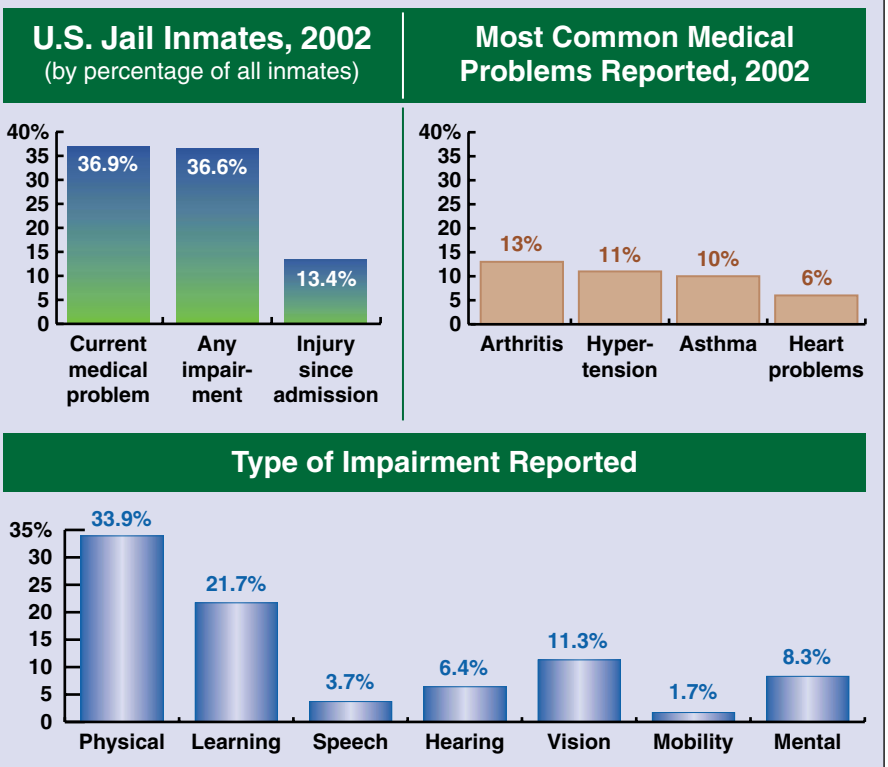
"Most people don't think it through," says Lewis. "Most everyone knows somebody who has done drugs at sometime in their lives," and it's drug users who currently swell the incarcerated population, she says. "Prisons are the dumping grounds for poor people." Some 80 percent of the women in state prisons were convicted of non-violent offenses, and they are not "the horrible people who should languish and die," Lewis notes.

"If you don't want to provide care for humanitarian reasons, do it to ensure that your neighbors" don't suffer from untreated infectious disease or mental illness, says Brown Medical School's Flanigan.

"Society benefits" if incarcerated people get treatment "and suffers if they don't," says Florida State's Mears. Untreated mental and physical diseases end up costing everyone more years down the line, he says. "So why wouldn't society demand that they get these things?"

Many Jail Inmates Have Medical Problems

Nearly 40 percent of jail inmates had a current medical problem in 2002 (graph at top, left), and 22 percent reported a learning impairment (bottom graph). Arthritis was the most common medical problem reported (top right).



Source: U.S. Department of Justice, Bureau of Justice Statistics, November 2006

Should correctional facilities require HIV tests?

The deadly HIV/AIDS infection can be spread within correctional facilities through sex and shared needles used for illicit drug use or tattooing. And infected prisoners can spread the disease in communities after their release. Thus, some analysts say, prisoners should be required to undergo HIV testing, either at entry or before release. Critics of mandated testing, how-

ever, argue that HIV education and optional testing can stop the spread of AIDS just as effectively without violating inmates' privacy or human rights.

"There's no question in my mind" that prisoners should be screened for HIV, says the University of Texas' Winslade. "Sex occurs in prison, and we should do everything we can to prevent the spread of HIV," he says. "Testing everybody in the free world would be silly, but prisoners are a much higher-risk population with drug users and high-risk sex."

"Public-health issues far outweigh the privacy issues" of individual inmates when it comes to HIV/AIDS, said Louisiana Democratic state Rep. Austin Badon Jr. in September, while introducing legislation to require testing for HIV and hepatitis for everyone who passes through the state prison system. [25]

Some states already require pre-release screening to keep HIV/AIDS from spreading in the community. But Barry Zack, an assistant clinical professor at the University of California, San Francisco, and executive director of Centerforce, a nonprofit agency serving California prisoners and their families, says that's too late. Released inmates who are HIV-positive are likely to find themselves without any access to health-care services, he says, adding, "Yet, you just had an opportunity to treat them and wasted it."

One of the first things a released inmate does is return to a wife or girlfriend and have sex, often unprotected, said Badon. "It's a no-brainer to do what we can." [26]

Optional testing, on the other hand, leaves "a substantial proportion of infected inmates . . . undetected," according to researchers at the University of North Carolina at Chapel Hill. [27]

Studies in Maryland and Wisconsin found that infection rates among inmates overall were twice as high as infection rates among inmates who volunteered to be tested. For instance, two-thirds of the HIV-infected inmates in Maryland — and 31 percent in Wisconsin — declined testing. [28]

The American Medical Association recommended mandatory HIV testing of prison inmates as early as 1987. The federal Bureau of Prisons advocates mandatory testing only of prisoners with clear risk factors, such as a history of injection-drug use. Many AIDS advocacy and human-rights groups oppose mandatory testing. [29]

Compulsory HIV testing of prisoners is "unethical and ineffective, and should be prohibited," according to the World Health Organization. Likewise, AIDS Action calls mandatory testing "unethical, ineffective and an invasion of privacy." [30]

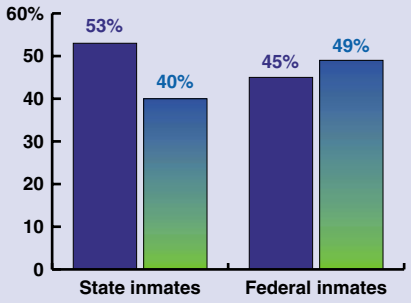
Compulsory universal HIV testing is "based on the paranoid position that prisoners are responsible for spreading HIV to a chaste public," wrote *Prison Legal News* contributing writer Gary Hunter. [31]

Correctional institutions should facilitate HIV prevention, not mandate intrusive testing, says internist and correctional-health monitor Cohen. Prison systems "should give out condoms, and prisoners should be offered testing when they want to be tested." ■

Inmate Drug Abuse Is Widespread

More than half of all state prisoners were drug dependent in 2004, and 49 percent of federal inmates received drug treatment or participated in a therapy program.

Percentage of Prisoners Who Abused Drugs, Got Treatment
(in 2004)



Source: U.S. Department of Justice, Bureau of Justice Statistics, Oct. 2006

BACKGROUND

Population Explosion

Two very large trends underlie the nation's prison health-care problems. One is the steady increase in the prison population, resulting in often-overcrowded facilities and the incarceration of high numbers of mentally ill and addicted inmates. [32]

The national inmate population is now more than six times the approximately 330,000 people incarcerated in 1972 — far outpacing overall population growth, which has not even doubled. [33]

At the same time, U.S. health care overall faces unprecedented challenges. Care has grown astronomically more expensive, hitherto undreamed of diseases like HIV/AIDS and antibiotic-resistant tuberculosis have developed, the incidence of chronic ills like diabetes has increased as the population has aged, and health care for mentally ill and lower-income people has continued to decline in quality and availability. [34]

All those trends are reflected, and magnified, in corrections, says Harrison of the National Commission on

Continued on p. 12

Chronology

1950s-1970s

More mentally ill people drift into jails and prisons as psychiatric hospitals are closed.

1955
Introduction of the first effective antipsychotic drug, Thorazine, begins the deinstitutionalization of the mentally ill.

1969
California becomes the first state to make it more difficult to involuntarily hospitalize the mentally ill.

1976
The Supreme Court's *Estelle v. Gamble* ruling declares it unconstitutional for prisons to show "deliberate indifference" to a prisoner's serious medical needs.

1977
At the first World Congress of Prison Medicine, corrections health officers pledge to keep inmates' medical information confidential, abstain from authorizing any physical punishment and give medical judgments priority over other concerns, like security.

1980s-2000s

Continued dismantling of residential mental-health facilities and get-tough policies on crime increase U.S. prison and jail populations. Infectious disease increases behind bars.

1980
Just over 500,000 Americans are incarcerated.

1981
First AIDS case is reported.

1987
American Correctional Health Services Association opposes mandatory AIDS testing for prisoners.

1989
Supreme Court's *Mistretta v. the United States* ruling upholds federal sentencing guidelines, barring judges from considering prisoners' amenability to treatment and rehabilitation during sentencing. . . . Dade County (Miami) experiments with a drug court to divert substance abusers from prison.

1994
Supreme Court's *Farmer v. Brennan* ruling defines its "deliberate indifference" standard for health care that violates prisoners' constitutional rights: Simple negligence isn't bad enough but prisons can violate the Constitution even if they don't knowingly do a prisoner harm.

1995
Federal government begins funding demonstration drug courts to steer substance abusers toward treatment rather than prison. . . . Nearly 1.6 million Americans are incarcerated. . . . In Ohio, a court-appointed monitor oversees a complete overhaul of mental-health care in state prisons.

1997
Broward County (Fort Lauderdale) opens the nation's first mental-health court to direct mentally ill offenders into treatment instead of prison.

1999
New York City jail inmates challenge the practice of releasing mentally ill detainees without helping them to continue treatment.

2001
Federal Bureau of Prisons says it will pay for some organ transplants.

2002
California court allows a convicted felon to get a heart transplant at Stanford Medical Center. . . . Erie County (Buffalo), N.Y., models the nation's first gambling-addiction court after drug courts.

2003
Federal Centers for Disease Control and Prevention recommends screening all at-risk prisoners for hepatitis C.

2004
Alabama settles lawsuit stemming from the death of 42 state prisoners from AIDS between 1999 and 2004 with an agreement to provide HIV- and AIDS-specific care and better nutrition to infected inmates.

2005
Federal judge places California's entire $1.1-billion-a-year prison health system under a court-appointed receiver, deeming the care it delivers "deplorable." . . . More than 2.3 million Americans are incarcerated. . . . Texas prisoners are required to get HIV testing before release. . . . Colorado prison audit finds that health contractor ignores inmates' cancers and prescribes medication without patient exams.

2006
Landmark Department of Justice report finds that more than half of jail and prison inmates have mental illness, a much higher rate than previously believed. . . . California bans shackling of women inmates during labor and delivery. . . . Delaware lawmakers reject $30 million bill requiring special care for pregnant inmates, infectious-disease screening and health training for guards.

Prisons Replace Hospitals for the Mentally Ill

When Catharine Harrold was arrested last summer, police wouldn't allow her to bring her best friends — two stuffed bunnies — to jail with her. "What I've been worried about is that they would send me to the hospital before Little and Big get here, she said." [1]

Harrold has had seizures, mood disorders and dementia — and has been arrested 24 times, mostly on drug and driving charges — since suffering severe head injuries in a car crash in the early 1990s.

Nearly six months later, Harrold is still being held in a Florida jail, even though state law requires that mentally ill inmates be moved to psychiatric facilities within 15 days of their arrest. She is only one of about 250 mentally ill prisoners in Florida who have been held for more than two weeks. In 2006, the average wait for a transfer was three months; some inmates waited more than five months. [2]

Now, some angry Florida judges are threatening to jail state officials themselves over the delays. "This type of arrogant activity cannot be tolerated in an orderly society," Circuit Judge Crocket Farnell wrote in an October ruling. [3]

Treatment of mentally ill inmates is not just an issue in Florida. An angry federal judge ordered Michigan officials in November to make sure state prisons are adequately staffed with psychologists and psychiatrists and that mental-health staff make daily rounds. [4]

"Here is the basic message," an angry U.S. District Judge Richard A. Enslen told state corrections officials, suggesting they say prayers for mentally ill inmates who have died in custody. "You are valuable providers of life-saving services and medicines. You are not coat racks who collect government paychecks while your work is taken to the sexton for burial." [5]

A recent U.S. Department of Justice study found that in 2005 more than half of all prison and jail inmates in the United States had a mental-health problem. Various analyses have traced some of the overall rise in the numbers of incarcerated mentally ill Americans to the closing of mental hospitals beginning in the 1950s.

For example, a 1972 California study found that the local jail population in Santa Clara County rose 300 percent in the four years after a local psychiatric hospital closed. And a 1992 survey by the advocacy group Public Citizen found that 29 percent of jails were holding people who had no charges against them but were waiting for mental-health services. [6]

"Jails and prisons have been viewed as the easiest place to park the severely mentally ill," says Morgan Moss, co-founder of the Center for Therapeutic Justice, which promotes development of therapeutic, inmate-run communities inside correctional institutions. "Jailing people helps us avoid the problems society needs to deal with. Instead, we just stick you there. And if we build 500 new prison beds, we never have to bite the bullet."

Jails and prisons are the worst possible places for the mentally ill, who often unwittingly break institution rules and end up in isolation. "The mentally ill in isolation . . . simply fall

Continued from p. 10

Correctional Health Care. "It's not that prisons or jails are a breeding ground for disease," he says. "They're a catch basin for poor people in the community with poor health histories." While prisoners are in poorer health than average Americans, prisoners' health status reflects conditions in the low-income communities from which many inmates come, he says.

"The only solution to the medical problem in California prisons [now under federal control] is to build fewer prisons," says health-monitor Cohen. That's because "they can't find the doctors to run them," he says.

To cut back on incarceration, more mental-health and substance-abuse treatment and prevention would have to be available inside current correctional institutions and in the community, many analysts say.

"Prior to the 1980s, rehab was a strong component in correctional health thinking," says Anglin, at the University of California's Integrated Substance Abuse Programs. "Then you had a huge philosophical shift. Rehab had shown only marginal results, and the thinking became, 'Let's throw a sentence at people,' " he says. [35]

"Various epidemics of drugs" over the years — from LSD and heroin to cocaine, crack cocaine and methamphetamines — combined with increased emphasis on penalizing drug use, "effectively criminalized whole generations of black people and now, increasingly, Hispanics," Anglin says.

Add this to "three-strikes-and-you're-out" laws and a trend toward longer prison sentences, "and you get a huge proportion of people who are growing old" behind bars, Anglin says.

In 2003, more than 20 percent of sentenced inmates were imprisoned for drug offenses. Offense rates varied by race, however, with 24 percent of black inmates and 23 percent of Hispanics serving time for drug offenses, compared to 14 percent of white inmates. [36]

The deinstitutionalization of mentally ill people, which began in the 1950s with the development of antipsychotic medication and accelerated through the 1980s, also has swollen prison populations. [37] Between 1955 and 1994, the proportion of the population living in public psychiatric hospitals dropped by more than 90 percent. [38]

apart," said Fred Cohen, professor emeritus at the State University of New York at Albany and a court-appointed monitor for mental health in Ohio prisons. "They have no support, they have no sensory stimulus, their hallucinations get worse." [7]

Some courts have required state and local corrections departments to improve care for mentally ill inmates. In Ohio, for example, prisons were ordered in 1995 to beef up their mental-health capacity. "There just wasn't enough staff," said Debbie Nixon-Hughes, chief of the Bureau of Mental Health Services in Ohio. "We had approximately 12 doctors, and now we have 67." [8]

Keeping as many mentally ill people as possible out of correctional institutions is a key goal, some experts say. "Jails simply cannot deal with these people," says Bruce J. Winick, professor of law and psychiatry at the University of Miami. Winick originated the concept of therapeutic courts, which offer a small but growing option, similar to drug courts, he says. Instead of jailing the mentally ill, judges refer them to treatment and exert continuing pressure to help them stay on their medications and out of trouble. More than 100 mental-health courts now operate nationwide, including a handful that handle felony offenders as well as people charged with misdemeanors. [9]

Creating more humane and socially oriented environments within correctional facilities also can provide options for mentally ill offenders, Moss says. He's helped set up special, inmate-directed living units in correctional facilities, where like-minded detainees agree to help each other improve their lives. "We set up a community inside the jail built on pro-social values like honesty and respect," says Moss. "Behind the walls, inmates mostly run things anyway."

Once a community is running, "the jail itself often will put mentally ill prisoners in there and have the other inmates look after them," reducing suicides and the isolation that often worsens the condition of mentally ill prisoners, says Moss.

Cohen cautioned that while jail and prison environments can be made more helpful for the mentally ill, the real support work is needed in the community. "The prison is simply not a place of first choice in which to provide mental-health care," he said. "We should be devoting ourselves to . . . keeping people out."

---

[1] Quoted in Sarah Lundy, " 'Humanity' " Put to Test as Mentally Ill Languish in Jails," *Orlando Sentinel*, Dec. 12, 2006, p. A1.

[2] *Ibid.*

[3] Quoted in Abby Goodnough, "Officials Clash Over Mentally Ill in Florida Jails," *The New York Times*, Nov. 15, 2006, p. A1.

[4] David Ashenfelter, "Fix Prison Health Care Now, Judge Says," *Detroit Free Press*, Nov. 14, 2006, p. 1.

[5] Quoted in *ibid.*

[6] E. Fuller Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* (1997), quoted in "Deinstitutionalization: A Psychiatric Titanic," "The New Asylums," PBS "Frontline."

[7] Quoted in "The New Asylums," *ibid.*

[8] *Ibid.*

[9] For background on drug courts, see Mary H. Cooper, "Drug-Policy Debates," *CQ Researcher*, July 28, 2000, pp. 593-624.

Many have ended up in jails and prisons, says Harrison. "When people get picked up for a crime, there's often an underlying mental illness that led to it. Correctional facilities have in a sense become the dumping ground for the mentally ill."

"Many are being punished for behavior that could be prevented," says Loyola Law School's Clark.

But "no one likes to spend money on preventive care," says Florida State's Mears. "It's hard to sell politically" when the monetary and social payoffs occur years down the line.

Legal Aid

Actually, it's a step forward in human rights for anyone to worry at all about prisoners getting health care. Throughout history, prison conditions have been atrocious, with inmates facing health-threatening conditions such as rotten food, no heat and cells flooded with raw sewage. As late as the 1970s, prisoner lawsuits complained about "health-care" incidents in which unsupervised prisoners were allowed to perform "medical" procedures like tooth pulling and suturing on their fellow inmates. [39]

In the landmark 1976 case that established prisoners' constitutional right to health care — *Estelle v. Gamble* — a falling bale of hay injured inmate J. W. Gamble while he worked on a prison farm in Texas. Gamble — who claimed that prison staff failed to adequately diagnose and treat his injury — lost his case. In its ruling, however, the U.S. Supreme Court did establish the fundamental principle that corrections facilities must not show "deliberate indifference to serious medical needs" of inmates. [40]

"The Supreme Court made it very clear that people on the outside and people locked up are in very different positions with regard to their entitlements," says the ACLU's Fathi. "When the state disables you from acting on your own behalf," as it does with prisoners, then there's a presumption that the state must provide you with health care.

In fact, all major initiatives to improve correctional health care have come from the courts, not from legislators or the public. "This is a population that nobody wants to interact with, that nobody feels a connection

HIV-Positive Inmate Population Declines

The number of HIV-positive prison inmates dropped to less than 2 percent of the nation's overall prison population in 2001 and dropped again in 2004.

HIV-Positive Prison Inmates

Year	Number	Percentage of State and Federal Inmates
1998	25,680	2.2%
1999	25,807	2.1
2000	25,333	2.0
2001	24,147	1.9
2002	23,866	1.9
2003	23,663	1.9
2004	23,046	1.8

Source: U.S. Department of Justice, Bureau of Justice Statistics, November 2006

with," says Centerforce Executive Director Zack. "That's why the court has to make these decisions."

Since 1976, the courts have struggled to define "deliberate indifference" and "serious" medical need. The broadest outlines are clear, says Fathi. Mental-health care and physical-health care both are covered, but substance-abuse and addiction treatment are not — except for treating withdrawal. "Once you're done withdrawing and just want help to get off opioids, no one's required to give you that," he says.

Lower-court decisions have clarified that it is not enough to prove that a correctional system was "negligent" with regard to a prisoner's care, says Fathi. One must prove "deliberate indifference" on the part of corrections officials who knew but ignored the fact that a prisoner was at serious risk due to a medical condition. "They're not entitled to care for a hang nail; they are entitled to care for a heart attack," Fathi says. Questions arise when a prisoner has a condition somewhere between those two extremes, he explains, "with something like a hernia being a prime example of a gray area."

The major role of lawsuits has been to ensure that prisoners get access to at least some health care, says Lewis of the Legal Aid Society. "One of the first goals of lawsuits has been to ensure sufficient staff," and most litigation has played out over many years, she says.

"Litigating quality of care is one of the hardest parts," says Lewis. "You can say you have to have a person who's a board-certified internist [on staff]. But this doesn't mean he's competent or cares or hasn't had his license suspended in three other states." Using legal means to improve care quality is "where we have a bad time."

Many cases are too narrow to offer much guidance, says the University of Texas' Stone. Most "are limited to a specific fact pattern — like certain levels of HIV care," he says. A ruling in such a case does nothing to help set care standards for other diseases like cancer or diabetes, or even for future HIV cases, as medical research and standards of care keep advancing, he says. So, despite the fact that lawsuits have been by far the strongest instrument for improving correctional health care, "litigation has only limited usefulness when it comes to setting real standards and broader goals for health care," Stone says.

In cases involving access to care, "the two most common themes are lack of resources and security interfering with medical treatment," says Fathi. When a federal judge ordered the court takeover of California's prisons last year, for example, a key issue cited was that health-staff salaries were too low, says Fathi.

"If lawsuits are done right, they can demonstrate problems [occurring] on a massive scale," says Loyola's Clark. "You have to be able to amass enough evidence and show that the problems aren't rare."

In addition, lawsuit allegations are not necessarily valid, said Martha Harbin, a spokeswoman for Prison Health Services (PHS), which provides contract correctional health care. "Inmates are one of the most litigious groups in society, and a vast majority of the suits filed against PHS are dismissed as baseless," she said. [41]

Meanwhile, correctional health professionals and researchers also work from within to improve correctional health care. Two main organizations — the National Commission on Correctional Health Care and the American Correctional Association — certify facilities and workers and offer training on care improvement.

For example, the commission accredits about 500 facilities, including prisons, jails and juvenile facilities, says Harrison. Its most important role is training and educating correctional health staff, through consultations, conferences and care guidelines, he says. The group issues care guidelines for many conditions, customizing diabetes-care guidelines created by the American Diabetes Association, for instance, by "adding a

description of the barriers to meeting those guidelines in correctional institutions and how they might be handled."

Population Health

Delivering health care in correctional institutions is difficult because funding is low, and prison bureaucracies focus primarily on providing security and punishment — not health care. And, inmates show a higher incidence of all types of illness, making prisons the "crucibles" for all the nation's health-care problems, says Florida State University's Mears.

In 2005, around 23 percent of state prisoners and 30 percent of jail inmates reported symptoms of major depression, while 15 percent of state prisoners and 24 percent of jail inmates had symptoms of psychotic disorders. [42]

Beyond the overall rate of mental illness, "at any given time, from 5 to 15 percent of inmates will need some kind of crisis intervention," says the University of Colorado's Metzner.

Some studies show that improving community mental-health treatment can keep people out of jail and save money. For example, an Arkansas program decreased patients' mean number of annual jail days to between 46 and 83 from well over 100. An Illinois program decreased both jail days and hospital days for a group of 30 patients, saving $157,000 in jail costs and $917,000 in hospital costs. [43]

Helping prisoners get off addictive drugs isn't part of prisoners' constitutional guarantee of health care, but with substance abuse being the reason many people end up behind bars in the first place, it's an inescapable feature of the correctional health landscape.

Twenty-one percent of state prisoners and 55 percent of federal inmates were being held for drug-law violations in 2004. Among state inmates who had been dependent on or had abused drugs, 53 percent had at least three prior sentences to either probation or incarceration, compared to 32 percent of other prisoners. [44]

AP Photo/Steve Pope

Female inmates take part in a substance-abuse program at a prison in Mitchellville, Iowa. About 15 percent of the nation's inmates participate in such programs, but many experts say more programs are needed in both correctional facilities and local communities.

That makes it important to try addressing prisoners' substance-abuse issues while they're inside, says Wright of the New York state system. "If 80 or 90 percent had these issues in the past, why not take advantage" of the fact that, while incarcerated, "they have time" to work on a substance-abuse program? "Once they're on the outside, they'll have the same problems as everybody else, going to work, trying to make ends meet. We have committed to giving it to everybody who needs it, at least before they get out," he says.

Prisoners and jail inmates also have high rates of infectious diseases, including AIDS.

In 2003, nearly 1-in-13 prisoner deaths was from AIDS-related causes. [45]

The percentage of HIV-positive prisoners varies by prior involvement with illegal drugs. Of prisoners who had never used drugs, 1.3 percent are HIV-positive compared to 2.8 percent who have used a needle to inject drugs and 5.1 percent of those who say they have shared a needle. [46]

Chronic diseases like diabetes and hypertension also are more prevalent in prisons, especially in their most serious forms.

"If you're 50 years old [and in prison], your condition probably makes you geriatric," says Metzner.

"The biggest problem is that they didn't have care before we got them," says Wright. "They come in with undiagnosed hypertension and pulmonary disease," often coupled with a history of unhealthy substance abuse, "and we see advanced cases of diseases like diabetes that we don't see in the community."

The high proportion of racial minorities among inmates increases the rate of some serious chronic diseases. For example, the prevalence of diabetes in African-Americans is 70 percent higher than in the white population, and the diabetes rate in Hispanics is nearly twice that in whites. [47]

The growing number of incarcerated women adds another burden to correctional health care, says Wright. "About 5 to 6 percent come in pregnant," he says.

Multiple Systems

Beyond the poor health of entering inmates, many aspects of institutionalized life make providing health care difficult. There's a constant

and probably unavoidable culture clash between security concerns and health concerns.

For example, "In many jails and prisons mentally ill people, because of their illness, don't follow rules," says Metzner. "So they get put into lockdown, which makes their illness worse, and where they again don't follow rules," ending up in more and more stringent segregation, which can greatly worsen their illness. "That's a tragedy.'

Pre-incarceration health-care regimens get disrupted because "offenders can't bring their own medication into a facility," says correctional-care consultant Cohn. "Often, they don't know what they were taking. It was 'a blue pill and a green pill.' "

And "offenders know how to manipulate," says Cohn. "They want to get out of their cells, and a significant number come to the infirmary when there's nothing wrong."

"Many problems are fundamentally structural," says the ACLU's Fathi. For example, often a serious medical problem requires a time-and-resource-consuming trip outside the prison to see a specialist, and "sometimes the security staff will keep this from happening."

In addition, as people move through different parts of the corrections system — juvenile-detention centers, jails, prisons, probation and parole — the health care they receive, if any, is completely disjointed.

"One of the biggest problems is the criminal-justice system is *not* a system," says Moss, of the Center for Therapeutic Justice. "Nobody talks to anybody else. Judges rarely ever talk to anybody. Most have never been inside a jail to look at what goes on in there. You'll find almost no one who'll tell you that this system is working."

> **"In many jails and prisons mentally ill people, because of their illness, don't follow rules. So they get put into lockdown, which makes their illness worse, and they again don't follow rules."**
>
> ***— Jeffrey L. Metzner, M.D., University of Colorado School of Medicine***

Since jails are the first stage in the criminal-justice process, typically 80 to 90 percent of their inmates "are pretrial," explains Cohn. Many small-town jails are small and have no on-site health staff.

There are 3,360 jails nationwide, and well under 10 percent "have any significant program of any kind" to assist inmates, such as education, therapy or substance-abuse treatment, says Moss.

"The smaller the jail, the less likely . . . you're going to have any kind of medical and mental-health care," said court-appointed prison monitor Cohen.

"Yet, if prisons have become the hospitals, the jails are the emergency rooms," Cohen said. [48]

Nevertheless, jails must cope with serious health issues. Many detainees are in acute phases of mental illness and have committed relatively minor offenses like urinating on someone's lawn or leaving a restaurant without paying. In addition, "people in jails are withdrawing [from drug addiction], they get taken off their meds and they're dealing with the situational stress of just being arrested," says Fathi.

So-called supermax prisons or units keep presumably the most violent and dangerous inmates isolated and deprived of sensory stimulation. But supermax imprisonment carries special dangers for mentally ill people, who often end up there because their illness leads them to inadvertently break prison rules.

In one such unit in Indiana, "at least half the inmates were mentally ill," says Fathi. "They do therapy by locking the prisoner and therapist into adjacent cells." The prisoner bends down and talks through the floor-level slit through which food trays are passed, "The therapist sits on a milk crate on the other side. . . . It's been well established that mentally ill people break down" in such conditions, he says. The ACLU has worked with several states to keep mentally ill prisoners out of supermax, Fathi says.

"We've got to stop spending money to build [supermax] prisons," says Stone at the University of Texas. Building the prisons, then staffing and maintaining them over the facilities' lifetime drains money from other priorities, like health care, he says.

In recent years, juvenile facilities frequently have housed mentally ill children as they wait for mental-health services to become available.

Continued on p. 18

Are drug courts a good alternative to imprisonment for substance abusers?

JOHN ROMAN
SENIOR RESEARCH ASSOCIATE
JUSTICE POLICY CENTER
THE URBAN INSTITUTE

WRITTEN FOR *CQ RESEARCHER*, DECEMBER 2006

Drug-fueled crime is hard to conquer, but drug courts are a strategy that has been shown to work. For the past 15 years, judges have used a new approach to penalizing drug-involved offenders: requiring treatment under criminal-justice supervision, incarcerating those who fail and letting those who succeed return to the community for a new chance. The operating principle is that chronic criminal behavior — such as street crime, prostitution and domestic violence — results from drug dependence that can be addressed therapeutically, thus preventing future offending.

According to the best available research, drug courts not only work but also represent a solid investment. In a review of published drug-court evaluations, University of Maryland researchers found that future offending dropped an average of 20 percent. Reviewing 27 drug-court studies, the Washington State Institute of Public Policy found drug courts yield at least $2.83 in benefits for every dollar spent.

Despite complaints that drug courts are "soft on crime," analysis shows no reduction in jail time. Instead, jail beds are simply used more effectively, as those who continue to use drugs stay behind bars and those who do not are released. More important, addicts who succeed in drug treatment will commit fewer crimes, on average, while addicts sent to prison without treatment are likely to resume criminal activity after release. The effect of this approach on crime rates could be substantial because drug-involved offenders commit voluminous crimes.

Drug courts have evolved from a small, grassroots movement to business as usual in some — but not nearly enough — jurisdictions. The Urban Institute estimates that each year fewer than 5 percent of drug-dependent arrestees receive drug-court services. If drug courts reduce crime but serve only a small percentage of offenders, the effect on crime will be negligible and a great opportunity wasted.

The bottom line? We recommend a dramatic expansion in the number of drug courts, and, even more important, in the number of drug-involved offenders being served by drug courts. Experiences in New York City provide important insight. In the last decade, crime has declined there and — reversing the trend elsewhere in the United States — so has the number of people incarcerated. Not coincidentally, during this time more than 9,000 offenders — including almost 7,000 felony offenders — have been treated in a drug court in New York.

If policymakers expand access to drug courts, the level of crime in the United States can be expected to fall measurably.

STEVEN K. ERICKSON, J.D., LL.M., PH.D.
MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER FELLOW
YALE UNIVERSITY

WRITTEN FOR *CQ RESEARCHER*, DECEMBER 2006

Implementing alternative punishments to drug offenders is a noble attempt to stem the tide of recidivism that plagues our criminal-justice system. So, too, is the wish to provide leveraged, integrated treatment in the hope that our fellow citizens will quit abusing drugs. But in the zeal to do both the drug-court movement has become more of a dogmatic belief in therapeutic courts than an effective intervention program supported by science. Numerous taxpayer-funded studies about the effectiveness of drug courts leave much to be desired and do not answer many questions about the proper role of our court system.

While proponents frequently claim a large body of studies demonstrates the effectiveness of drug courts, a careful review of those studies reveals many troubling aspects. Most prominently, many fail to use "intent-to-treat" analysis. Simply put, defendants who leave the program before completion are routinely excluded from drug-court analysis. Thus, claims about the courts' effectiveness are highly questionable.

It is hardly beyond imagination that many drug-court defendants will leave the program for a number of reasons — chief among these is to use more drugs — and thus choose to suffer the traditional punishment of incarceration. Excluding these participants not only confounds the analysis of effectiveness but also is dishonest, since intent-to-treat analysis is the gold standard in outcomes research and mandatory in most published studies that appear in science journals.

The claims of effectiveness are plagued by other shortcomings as well. In addiction research, sustained sobriety is the benchmark of treatment success. Yet, few drug-court studies follow participants for any length of time, and none follow participants beyond the term of drug-court monitoring. Since research has consistently shown that internal motivation is largely responsible for sobriety success, the elephant-in-the-room question is whether drug-court defendants maintain their sobriety beyond their participation in the drug courts themselves.

More crucial, though, is the question of whether transforming courts into mental-health providers is wise and proper. Therapeutic courts, like drug courts, fundamentally alter the criminal-justice system in a manner that is at odds with our Constitution and traditions. Defense attorneys are relegated to passive-treatment advocates, judges are presumed behavioral experts and the judicial process becomes less about justice than about engineering social change. The good intentions of the therapeutic courts are not enough to overcome these troubling aspects.

Continued from p. 16

"On any given night, nearly 2,000 children and youth — some as young as 7 — languish in juvenile-detention facilities across the country because they cannot access needed mental-health services," Tammy Seltzer, senior staff attorney at the Washington-based Bazelon Center for Mental Health Law, told a Senate panel. [49]

According to a 2003 study, nearly 15,000 young people — around 8 percent of those in juvenile detention during a six-month period — were detained while they awaited mental-health services, said Seltzer. "Many had no criminal charges pending, while others were arrested for minor offenses, such as truancy or trespassing, generally traced to their mental-health problems."

The study authors believe their survey probably understated the extent of the problem, said Seltzer. Juveniles with mental disorders also stay in detention 36 percent longer than other detainees and have four times the rate of suicide or other self-harm, Seltzer said.

In addition, thousands of people in the criminal-justice system are on probation or parole every day, or are nearing their release date and a period that criminologists call community "re-entry." But few prisoners have access to adequate health care in the communities they return to, and even fewer get help finding and obtaining what services there are.

"I can't remember a parole officer calling me up and saying, " 'What do you recommend for this guy when he gets out?' " says Moss. "Parole people talk to jail people? It could happen, but hell could also freeze over."

So-called discharge planning isn't easy, says Flanigan, at Brown Medical School. To ensure that discharged inmates continue to get care for serious diseases, "people need a personal contact, not just the name of a clinic," and an initial appointment, he says. That's available to few inmates, however, because both institutional discharge planning and community services are scarce.

AP Photo/Rogelio Solis

Prison inmates in Mississippi talk with AIDS counselor Jackie Walker, of the American Civil Liberties Union. Civil liberties advocates argue that HIV education and optional testing can stop AIDS just as effectively as mandatory testing without violating inmates' privacy or human rights.

Increasingly, corrections officials want to provide those opportunities, says Colorado's Metzner. "A decade ago, you could talk to wardens about mental health, and they would say we're a prison not a hospital," he says. "They don't say that now. Sheriffs and wardens are in favor of adequate discharge planning." One big reason, says Metzner: "When mentally ill prisoners get it, they come back slower — or not at all." ■

CURRENT SITUATION

Prisoners and Research

Correctional health remains low on the political agenda, although a few initiatives may be bubbling up in state legislatures and Congress. However, lawsuits seeking better care are ongoing, and some corrections health systems are being overhauled under court supervision.

For example, in 2005 a federal judge placed California's entire $1.2-billion-a-year health system under a court-appointed receiver empowered to order new medical facilities built, charging it to the state treasury, and waive any law, regulation, contract provision, or labor agreement in order to bring care up to snuff. [50]

Also in 2005, Ohio settled a prisoner class-action suit, agreeing to hire 321 new medical personnel, add $7 billion to the annual health-care budget and overhaul prison medical facilities. [51] In July 2006 a Missouri court ordered all of that state's prisons to transport women prisoners to abortion facilities at their request. [52]

Also in 2006, an expert panel at the Institute of Medicine recommended changes to 30-year-old federal guidelines on research involving prisoners.

As late as the 1960s and '70s, "some very bad things" were done to prisoners recruited for research studies,

mainly because prisoners are powerless, says Harrison, of the National Commission on Correctional Health Care.

In a Pennsylvania prison, for example, a dermatologist reportedly gloated over the "acres of skin" the prison would provide for experimentation with cosmetics, Harrison says.

Such cases have spurred federal rules strictly limiting most research involving prisoners. But prisoners themselves eventually questioned those restrictions, says Harrison. Early in the AIDS crisis, many treatments were available only to people participating in research, and "prisoners were coming to us, saying that it's unfair we can't be in trials," he says.

Under the new guidelines, prisoners can be subjects in a much broader range of studies. Instead of strictly excluding prisoners from some kinds of research, the new rules stipulate that risks and benefits of each proposed study must be weighed, just as they are when the subjects are non-prisoners.

That change "is a major step forward," says the University of Texas' Stone. However, he says the new rules won't accomplish what ought to have been their most important goal: stimulating research to improve prisoners' health, decrease recidivism and find ways to keep the mentally ill, substance abusers, sex offenders and others out of prison in the first place. "The panel missed a big opportunity by not naming research priorities" related to criminal justice, he says.

Prison Politics

Politically, prisoners' health gets little attention and few resources, although some observers think that as lawsuits continue and prison populations and budgets keep rising, the lack of attention to health care will have to change.

Health care for this sicker-than-average population "is a big-ticket item at a time when legislatures are continually asking, 'Do we cut prisons, or something else?' " says ACLU's Fathi. "You often see the prison system just not get the money for health care, despite their sincere pleas to the legislature."

But it may be high costs that finally drive lawmakers to action on prison-related health care, such as community mental-health and substance-abuse services that could keep some people from being incarcerated.

"State legislators that have to deal with prison health are overwhelmed by the costs," says Winslade, the professor of the philosophy of medicine at the University of Texas.

Several Texas lawmakers currently are saying, "Rather than build two more prisons, divert that money to substance-abuse" treatment, says Stone.

While in recent years substance abuse has received little legislative attention, research on treating it has been piling up, says UCLA's Anglin. "We have a vast store of knowledge." Meanwhile, the public and lawmakers are becoming somewhat "more receptive" toward the idea of treatment rather than long incarceration, he says. "That shift will only be enhanced with the Democratic takeover" of Congress.

In the past few years, Congress has discussed but not acted on bipartisan legislative proposals to assist released prisoners with community re-entry, to help prevent recidivism.

In 2007, Congress also may move legislation to improve mentally ill detainees' access to Medicaid upon release. Without such insurance, mentally ill people can't get needed services and are likely to wind up right back in jail or juvenile detention, mental-health advocates say.

"Keeping detainees with severe mental illness on Medicaid can benefit the criminal-justice system as well as the mental-health system," said Joseph P. Morrissey, a professor of health policy and psychiatry at the University of North Carolina, Chapel Hill. [53] ■

OUTLOOK

Aging Behind Bars

As the incarcerated population ages, health costs will rise. But it's not clear where the money will come from.

Over the past several decades, longer and longer prison sentences have been handed out, and people have been required to serve more of their sentences. Couple that with the huge size of the baby-boom generation and the frail health of many prisoners over age 50, and you have a cost nightmare.

"The geriatric problem is going to be huge," says Florida State University's Mears. "When someone's on tubes with five different diseases, it sucks up a lot of money."

One wave of the future is already beginning, as some prisons erect units for dementia patients, train inmates to work as hospice volunteers and plan for assisted-living sections. In October 2006, New York state's corrections department "opened its first 30-bed unit for people who've developed dementia," says Deputy Commissioner Wright. An assisted-living center is in the planning stages.

Many jurisdictions are struggling with how to care for a coming generation of older prisoners. The average cost of housing an elderly inmate is estimated at $70,000 per year, three times the cost of a younger inmate. [54]

For example, California has a "compassionate early release" program for sick inmates who are expected to die within six months and are low risks to the community; about a dozen people per year are released under the program. But California, like most other jurisdictions, is reluctant to commute sentences or risk being accused of "dumping" sick released prisoners on the community. [55]

Other options being discussed by corrections experts include shifting aging prisoners into hospices and other medical facilities in the community. In recent years, some analysts have recommended that large states like California build special geriatric prisons. However, except for a few small facilities, such as the dementia ward in New York, corrections systems haven't gone that far. [56]

Hospice care or the "early release of terminally ill prisoners" also are in corrections systems' future, says medical ethicist Cohn at the University of California, Irvine.

Wright, of New York's Department of Correctional Services, would like to see public-health agencies set up branches in jails and prisons to treat inmates for chronic and infectious diseases so that prisoners will be healthier when they return home, reducing disease in the general population. "My [prison] patients are all insured, and I can find them," he points out.

But the prison-building boom of the last three decades is siphoning off a lot of cash that otherwise might go to health care, says Mears. Texas, for example, "quadrupled its system in just over a decade, from 40,000 to 160,000" inmates.

Besides paying to erect the buildings, their staffing and upkeep "is a substantial expense — billions of dollars you can't spend on other needs," Mears says. Thus, while some prisoner advocates would like to see drug-addicted and mentally ill prisoners diverted into a more therapeutic system, Mears says that's not likely now, because states are so invested in the current prison system. "We can't close the beds."

Analysts point to better preventive health care and a rethinking of long sentences as potential solutions, but there's no easy way out, they concede.

"To change things, there has to be real leadership," says prisoner-advocate Zack, "and this is not a constituency that people care about." ■

Notes

[1] David M. Reutter, "Privatized Medical Services in Delaware Kill and Maim," *Prison Legal News*, December 2005, p. 1.
[2] Quoted in *Ibid.*, p. 3.
[3] David Ashenfelter, "Judge Orders State Prisons to Clean Up Act," *Detroit Free Press*, Nov. 13, 2006.
[4] Doris J. James and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates," Bureau of Justice Statistics Special Report, U.S. Department of Justice, September 2006.
[5] Christopher J. Mumola and Jennifer C. Karberg, "Drug Use and Dependence, State and Federal Prisoners, 2004," Bureau of Justice Statistics Special Report, October 2006.
[6] Laura M. Maruschak, "Medical Problems of Jail Inmates," Bureau of Justice Statistics Special Report, U.S. Department of Justice, November 2006.
[7] Laura M. Maruschak, "HIV in Prisons, 2004," *Bureau of Justice Statistics Bulletin*, U.S. Department of Justice, November 2006, p. 5.
[8] Maureen Milford, "Inmates grow old, health costs rise," *The* [Wilmington, Del.] *News Journal*, March 26, 2006.
[9] That figure includes those in state and federal prisons, jails, juvenile detention centers and other facilities, such as Bureau of Immigration facilities and jails on Indian reservations.
[10] Testimony before Senate Governmental Affairs Committee, July 7, 2004, www.nami.org.
[11] The case is *Estelle v. Gamble*, 429 U.S. 97 (1976).
[12] Keith Epstein, "Covering the Uninsured," *CQ Researcher*, June 14, 2002, pp. 521-544.
[13] Steve Lopez, "The Prisoner With the Million-Dollar Heart," *Los Angeles Times*, Feb. 13, 2002.
[14] Steve Lopez, "Doin' Time With a New Ticker," *Los Angeles Times*, Jan. 28, 2002, p. 1.
[15] For background, see James Stemgold, "U.S. Seizes State Prison Health Care," *San Francisco Chronicle*, July 1, 2005, http://sfgate.com/cgi-bin/article.cgi?file=/c/a/2005/07/01/MNGOCDH-PP71.DTL.
[16] "Frontline" interview with Gary Beven, "The New Asylums," October 2004, www.pbs.org.
[17] *Ibid.* The case is *Dunn v. Voinovich*.
[18] "Frontline" interview with Fred Cohen, *ibid.*
[19] Quoted in John E. Dannenberg, "PHS Redux: Sued in a Dozen States, Contract Losses, Stock Plummets, Business Continues," *Prison Legal News*, November 2006.
[20] David L. Perry, "Should Violent Felons Receive Organ Transplants," Markkula Center for Applied Ethics, www.scu.edu.
[21] *Ibid.*
[22] Carrie S. Frank, "Must Inmates Be Provided Free Organ Transplants? Revisiting the Deliberate Indifference Standard," *George Mason University Civil Rights Law Journal*, spring 2005.
[23] *Ibid.*
[24] T. Howard Stone and William J. Winslade, "Report on a National Survey of Correctional Health Facilities: A Needs Assessment of Health Issues," *Journal of Correctional Health Care*, spring 1998.
[25] Quoted in Ed Anderson, "Badon Presses for HIV Tests in Prisons," *Times Picayune* [New Orleans] and *Nola.com*, Sept. 15, 2006; www.nola.com.
[26] *Ibid.*
[27] David L. Rosen, Victor J. Schoenback and Andrew H. Kaplan, "HIV Testing in State Prisons; Balancing Human Rights and Public Health, Infectious Diseases in Corrections Report," April 2006, www.IDCRonline.org.
[28] *Ibid.*
[29] *Ibid.*
[30] Quoted in Jeffrey Young, "Waters Seeks to Sway AIDS Groups on Prisoner Testing," *The Hill*, Nov. 27, 2006, http://thehill.com.
[31] Gary Hunter, "Texas Legislature Requires

About the Author

Staff writer **Marcia Clemmitt** is a veteran social-policy reporter who previously served as editor in chief of *Medicine and Health* and staff writer for *The Scientist*. She has also been a high-school math and physics teacher. She holds a liberal arts and sciences degree from St. John's College, Annapolis, and a master's degree in English from Georgetown University. Her recent reports include "Climate Change," "Controlling the Internet," "Pork Barrel Politics" and "Cyber Socializing."

HIV Testing for Prisoners," *Prison Legal News*, www.prisonlegalnews.org.

[32] For background, see David Masci, "Prison-Building Boom," *CQ Researcher*, Sept. 17, 1999, pp. 801-824.

[33] Marc Mauer, "Comparative International Rates of Incarceration: An Examination of Causes and Trends," The Sentencing Project, paper presented to the U.S. Commission on Civil Rights, June 20, 2003.

[34] For background, see Marcia Clemmitt, "Rising Health Costs," *CQ Researcher*, April 7, 2006, pp. 289-312.

[35] For background, see Peter Katel, "War on Drugs," *CQ Researcher*, June 2, 2006, pp. 481-504.

[36] Harrison and Beck, *op. cit.*, p. 9.

[37] For background, see "The New Asylums," PBS "Frontline," *op. cit.*

[38] *Ibid.*

[39] William J. Rold, "30 Years After *Estelle v. Gamble:* A Legal Retrospective," *CorrectCare*, National Commission on Correctional Health Care, summer 2006, www.ncchc.org.

[40] *Ibid.*

[41] Quoted in Dannenberg, *op. cit.*

[42] James and Glaze, *op. cit.*

[43] J. Steven Lamberti, Robert Weisman and Dara I. Faden, "Forensic Assertive Community Treatment: Preventing Incarceration of Adults With Severe Mental Illness," *Psychiatric Services*, November 2004, p. 1285.

[44] Mumola and Karberg, *op. cit.*

[45] Maruschak, *op. cit.*, p. 8 ("HIV in Prisons, 2006").

[46] *Ibid.*, p. 10.

[47] Lois M. Davis and Sharon Pacchiana, "Health Profile of the State Prison Population and Returning Offenders: Public Health Challenges," *Journal of Correctional Health Care*, fall 2003, p. 303.

[48] "Frontline" interview with Fred Cohen, *op. cit.*

[49] Testimony before Senate Committee on Governmental Affairs, July 7, 2004, http://hsgac.senate.gov.

[50] Marvin Mento, "Federal Court Seizes California Prisons' Medical Care; Appoints Receiver With Unprecedented Powers," *Prison Legal News*, www.prisonlegalnews.org.

[51] John E. Dannenberg, "Ohio DOC Stipulates to Vastly Improved Medical Care," *Prison Legal News*, www.prisonlegalnews.

[52] "ACLU Applauds Decision Allowing Women Prisoners in Missouri to Access Abortion Care," American Civil Liberties Union, July 18, 2006, www.aclu.org.

[53] Joseph P. Morrissey, "Medicaid Benefits and Recidivism of Mentally Ill People Released From Jail," National Institute of Justice, Dec. 8, 2004, www.ncjrs.gov/pdffiles1/nij/grants/214169.pdf.

[54] Jonathan Turley, testimony on "California's Aging Prisoner: Demographics, Costs, and Recommendations," before California Senate Subcommittee on Aging and Long-Term Care, February 2003, www.sen.ca.gov/ftp/SEN/COMMITTEE/SUB/HHS_AGE/_home/AGING_PRISONERS_TRANSCRIPT.DOC.

[55] Sandra Kobrin, "Dying on Our Dime — California's Prisons Are Teeming With Older Inmates Who Run Up Staggering Medical Costs," *Los Angeles Times*, June 26, 2005.

[56] Turley, *op. cit.*

FOR MORE INFORMATION

American Civil Liberties Union National Prison Project, 915 15th St., N.W., 7th Floor, Washington, DC 20005; (202) 393-4930; www.aclu.org/prison/gen/14759res20010131.html. Founded in 1972; litigates to secure prisoners' constitutional rights, including adequate health care.

American Correctional Association, 206 N. Washington St., Suite 200, Alexandria, VA 22314; (703) 224-0000; www.aca.org. Sets standards for corrections health care and advocates for corrections professionals.

American Correctional Health Services Association, 250 Gatsby Place, Alpharetta, GA 30022-6161; (877) 918-1842; www.achsa.org/index.cfm. Trains corrections staff and informs other health-care workers and the public about corrections health issues.

Bureau of Justice Statistics, U.S. Department of Justice, 810 Seventh St., N.W., Washington, DC 20531; (202) 307-0765; www.ojp.usdoj.gov/bjs/welcome.html. Federal agency that compiles and publishes statistics on U.S. correctional systems.

Human Rights Watch, 350 Fifth Ave., 34th Floor, New York, NY 10118-3299; (212) 290-4700; www.hrw.org/prisons. Nonprofit advocacy group that monitors treatment of prisoners in the United States and internationally, including prison health care.

Integrated Substance Abuse Programs, University of California, Los Angeles, 11075 Santa Monica Blvd., Suite 200, Los Angeles, CA 90025; www.uclaisap.org/index.html. Conducts research and training on substance abuse and substance-abuse treatment, including in corrections facilities.

Legal Aid Society of New York Prisoners' Rights Project, 199 Water St., New York, NY 10038; (212) 577-3300; www.legal-aid.org/supportDocumentIndex.htm?docID=19&catid=45. Lawyers' group that litigates and advocates for better conditions in New York correctional facilities.

National Commission on Correctional Health Care, 1145 W. Diversey Pkwy., Chicago, IL 60614; (773) 880-1460; www.ncchc.org. Sets standards for correctional health care and trains correctional staff.

The New Asylums, Frontline, PBS, http://149.48.228.121/wgbh/pages/frontline/shows/asylums. Web site of PBS documentary; contains interviews with corrections mental-health experts and data on mentally ill prisoners.

The Real Cost of Prisons Project, The Sentencing Project, 514 10th St., N.W., Suite 1000, Washington, DC 20004; (202) 628-0871; www.realcostofprisons.org/blog. Activist group that educates and provides news about prison issues, especially through its news weblog.

Understanding Prison Health Care, http://movementbuilding.org/prisonhealth/barriers.html. Education and advocacy Web site that archives audio and video interviews with physicians, activists and correctional health experts.

Bibliography

Selected Sources

Books

Anderson, Lloyd C., *Voices From a Southern Prison*, University of Georgia Press, 2000.

A professor of law at the University of Akron who led a legal team representing inmates at the Kentucky State Reformatory recounts the prisoners' decades-long fight for better conditions.

Hornblum, Allen, *Acres of Skin*, Routledge, 1999.

An instructor in urban studies at Temple University recounts the history of medical experiments carried out on prisoners at Philadelphia's Holmesburg Prison.

Jacobson, Michael, *Downsizing Prisons: How to Reduce Crime and End Mass Incarceration*, New York University Press, 2005.

A former chief of the New York City Department of Corrections — who argues that mass incarceration fails to reduce crime and has created a permanent criminal underclass — suggests political strategies to develop an alternative system.

Kupers, Terry, *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, Jossey-Bass, 1999.

A psychiatrist and professor at the Wright Institute in Berkeley, Calif., describes the lives of mentally ill inmates in overcrowded prisons.

Latessa, Edward J., and Alexander M. Holsinger, eds., *Correctional Contexts: Contemporary and Classical Readings*, Roxbury Publishing Co., August 2005 (3rd edition).

Criminal-justice professors at the universities of Cincinnati and Missouri assemble readings on the history of corrections, including sections on treatment programs, prison conditions and community re-entry.

Petersilia, Joan, *When Prisoners Come Home: Parole and Prisoner Reentry*, Oxford University Press, 2003.

A professor of criminology at the University of California, Irvine, describes the plight of the more than half a million prisoners released each year after receiving little treatment or training while incarcerated.

Articles

Lundy, Sarah, " 'Humanity' Put to Test as Mentally Ill Languish in Jails," *Orlando Sentinel*, Dec. 12, 2006, p. A1.

A mentally ill woman spends weeks in jail because beds in local mental hospitals are filled.

Von Zeilbauer, Paul, "A Spotty Record of Health Care for Children in City Detention," *The New York Times*, March 1, 2005, p. A1.

A for-profit company makes questionable health decisions for mentally ill children in New York City juvenile facilities.

Reports and Studies

"Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes," Government Accountability Office, February 2005.

Congress' nonpartisan research and analysis agency found that drug courts that divert adults from prison into substance-abuse treatment prevent many from committing subsequent offenses.

"Confronting Confinement," Commission on Safety and Abuse in America's Prisons, June 2006.

A national expert panel reports on dangerous cultures inside prisons, including poor health and bad health care, and argues that prison health deficiencies harm communities as well.

"The Health Status of Soon-to-be-Released Inmates: A Report to Congress," National Commission on Correctional Health Care, 2002.

The main accrediting and training organization for correctional health care details the prevalence of infectious, chronic and mental disease among inmates.

"Mental Health in the House of Corrections: A Study of Mental Health Care in New York State Prisons," Correctional Association of New York, June 2004, www.correctionalassociation.org.

An independent advocacy group found that New York state prisons have too little space and provide too little treatment for their many mentally ill inmates, whose numbers increased by 71 percent between 1991 and 2004.

"The Public Health Dimensions of Prisoner Reentry: Addressing the Health Needs and Risks of Returning Prisoners and Their Families," Urban Institute Justice Policy Center, December 2002.

Criminal-justice and health-care analysts summarize the presentations and discussions from a national symposium on health concerns related to prisoner re-entry.

Mears, Daniel P., Laura Winterfeld, John Hunsaker, Gretchen E. Moore and Ruth M. White, "Drug Treatment in the Criminal Justice System: The Current State of Knowledge," Urban Institute Justice Policy Center, January 2003.

Analysts affiliated with a liberal-leaning think tank describe the recent history of substance-abuse treatment in prisons, including a decline in treatment-program enrollment through the late-1990s, after which participation began to increase.

The Next Step:

Additional Articles from Current Periodicals

Drug Courts

Brulliard, Karin, "Uncertain Future For County's Drug Court," *The Washington Post*, June 19, 2005, p. T1.

Commonwealth's Attorney James E. Plowman (R) has been vocal about his lack of support for Loudoun County's pilot drug program in Virginia.

Hahn, Valerie Schremp, "Drug Court Marks Success," *St. Louis Post-Dispatch*, June 5, 2006, p. B1.

A young, former cocaine addict charged with marijuana possession successfully graduated from a drug court in Lincoln County, Mo.

Tilghman, Andrew, "Alternate Offender Program Growing," *The Houston Chronicle*, March 27, 2005, p. B1.

The drug court in Harris County, Texas, is getting a boost from President Bush's faith-based initiatives, which include money to expand drug courts by giving addicts the option of treatment with church-based groups.

Elderly Prisoners

Ove, Torsten, "Growing Old in Prison," *Pittsburgh Post-Gazette*, March 6, 2005, p. A1.

Because a growing number of baby-boomer prisoners are getting older, policymakers are debating whether to continue keeping so many older prisoners incarcerated.

Sterngold, James, "California Bracing For A Flood of Elderly Inmates," *The San Francisco Chronicle*, Dec. 25, 2005, p. A21.

California's legislative analyst's office projects that by 2022 there will be at least 30,200 inmates 55 and older, compared with 7,580 now.

Wright, Gary L., "As Inmates Age, Cost of Health Care Climbs," *Charlotte Observer*, April 17, 2005, p. A1.

The cost of providing health care to prison inmates in North Carolina has nearly doubled in less than 10 years because of a growing elderly population and rising medical costs.

Yamaguchi, Mari, "Japan's Prisons Adapting to Rapidly Graying Populations," *The Houston Chronicle*, Feb. 12, 2006, p. A28.

Japan's 67 prisons are being forced to adapt to a new trend of an aging population — with the number of inmates 60 years old or older tripling in the past decade.

Infectious Diseases and Prisons

Fox, Maggie, "Prisoner Medical Research Lacks Oversight, Group Says," *The Houston Chronicle*, Aug. 6, 2006, p. A15.

The U.S. prison population needs more protection from potential medical-research abuses, according to a panel of experts from the Institute of Medicine.

von Zielbauer, Paul, "A Company's Troubled Answer for Prisoners With H.I.V.," *The New York Times*, Aug. 1, 2005, p. A1.

Prison Health Services, the nation's largest commercial provider of prison health care, has a turbulent record in many of the 33 states where it has provided jail medicine.

Mentally Ill Prisoners

Lopez, Steve, "Mentally Ill in the Jail? It's a Crime," *Los Angeles Times*, Dec. 11, 2005, p. B1.

Lopez says jails have become dumping grounds for the mentally ill because there is often nowhere else to put them.

Puente, Mark, "Care of Mentally Ill Prisoners Costly For Jails," *Plain Dealer* (Cleveland), Jan. 20, 2006, p. B1.

Jails across Northeast Ohio say mentally ill inmates who used to be sent to psychiatric institutions are filling up prison cells needed for more traditional criminals.

Scott, Rebekah, "Three-Year-Old Program For Mentally Challenged Prisoners To Be Reviewed," *Pittsburgh Post-Gazette*, June 2, 2005, p. EZ-7.

Two mental-health caseworkers at Pennsylvania's Westmoreland County Prison have helped about 60 prisoners connect to services and get out of jail sooner.

Wachtler, Sol, "A Cell of One's Own," *The New York Times*, Sept. 24, 2006, p. 15.

A former judge with bipolar disorder writes about why he supports alternative confinement for disruptive mentally ill prisoners.

CITING *CQ RESEARCHER*

Sample formats for citing these reports in a bibliography include the ones listed below. Preferred styles and formats vary, so please check with your instructor or professor.

MLA STYLE

Jost, Kenneth. "Rethinking the Death Penalty." CQ Researcher 16 Nov. 2001: 945-68.

APA STYLE

Jost, K. (2001, November 16). Rethinking the death penalty. *CQ Researcher, 11*, 945-968.

CHICAGO STYLE

Jost, Kenneth. "Rethinking the Death Penalty." *CQ Researcher*, November 16, 2001, 945-968.

In-depth Reports on Issues in the News

Are you writing a paper?

Need backup for a debate?

Want to become an expert on an issue?

For 80 years, students have turned to *CQ Researcher* for in-depth reporting on issues in the news. Reports on a full range of political and social issues are now available. Following is a selection of recent reports:

Civil Liberties
Voting Controversies, 9/06
Right to Die, 5/05
Immigration Reform, 4/05

Crime/Law
Patent Disputes, 12/06
Sex Offenders, 9/06
Treatment of Detainees, 8/06
War on Drugs, 6/06
Domestic Violence, 1/06
Death Penalty Controversies, 9/05

Education
Academic Freedom, 10/05
Intelligent Design, 7/05
No Child Left Behind, 5/05

Environment
The New Environmentalism, 12/06
Biofuels Boom, 9/06
Nuclear Energy, 3/06
Climate Change, 1/06
Saving the Oceans, 11/05
Endangered Species Act, 6/05

Health/Safety
Rising Health Costs, 4/06
Pension Crisis, 2/06
Avian Flu Threat, 1/06
Domestic Violence, 1/06

International Affairs/Politics
Understanding Islam, 11/06
Change in Latin America, 7/06
Pork Barrel Politics, 6/06
Future of European Union, 10/05
War in Iraq, 10/05

Social Trends
Philanthropy in America, 12/06
Privacy in Peril, 11/06
Video Games, 11/06

Terrorism/Defense
Port Security, 4/06
Presidential Power, 2/06

Youth
Drinking on Campus, 8/06
National Service, 6/06
Teen Spending, 5/06

Upcoming Reports

Factory Farms, 1/12/07
The Catholic Church, 1/19/07
Slow Food, 1/26/07
U.S. Foreign Policy, 2/2/07
Treating Addiction, 2/9/07
Future of Television, 2/16/07

ACCESS

CQ Researcher is available in print and online. For access, visit your library or www.cqresearcher.com.

STAY CURRENT

To receive notice of upcoming *CQ Researcher* reports, or learn more about *CQ Researcher* products, subscribe to the free e-mail newsletters, *CQ Researcher Alert!* and *CQ Researcher News*: www.cqpress.com/newsletters.

PURCHASE

To purchase a *CQ Researcher* report in print or electronic format (PDF), visit www.cqpress.com or call 866-427-7737. Single reports start at $15. Bulk purchase discounts and electronic-rights licensing are also available.

SUBSCRIBE

A full-service *CQ Researcher* print subscription—including 44 reports a year, monthly index updates, and a bound volume—is $688 for academic and public libraries, $667 for high school libraries, and $827 for media libraries. Add $25 for domestic postage.

CQ Researcher Online offers a backfile from 1991 and a number of tools to simplify research. For pricing information, call 800-834-9020, ext. 1906, or e-mail librarysales@cqpress.com.