Issue 2 May 2008

# COCHS Connection



## A Message from the Editor

COCHS - Community Oriented Correctional Health Services - actively seeks out new ideas and opinions to help us foster effective partnerships that link community health and public safety. We are happy to announce that eight talented and respected individuals from across the country have agreed to serve on the COCHS Advisory Committee, which will provide guidance, expertise, and feedback as we work to influence how communities approach correctional health care.

Our Advisory Committee members represent a unique mix of skills and experiences from diverse backgrounds, including law enforcement; correctional health care; community health care; and local, state, and federal government. They include physicians, a nurse, two sheriffs, a retired assistant surgeon general, retired or active medical directors of state correctional agencies, and the director of a large community health center.

We greatly appreciate the willingness of our Committee members to lend us their expertise as we take our message around the nation. They are:

- Dick Bohrer, Partner, Martin, Blanck and Associates Inc., Washington, DC
- Thomas Dart, Sheriff, Cook County, IL
- Ed Dean, Sheriff, Marion County, FL
- Steven Spencer, MD, Independent Correctional Health Consultant, Santa Fe, NM
- Michelle Staples-Horne, MD, Medical Director, Georgia Department of Juvenile Justice
- Marc F. Stern, MD, Health Services Director, Washington State Department of Corrections
- Frederica Williams, President and Chief Executive Officer, Whittier Street Health Center, Boston, MA
- Jacqueline C. Zalumas, PhD, Corrections Director, Southeast AIDS Training Center, Atlanta, GA

COCHS anticipates exciting changes in the way communities provide health care to jail inmates in the coming years, as public officials and policy experts give increased attention to shortfalls in the existing correctional health care system and ever-growing health care budgets. The expertise of our new Advisory Committee will be invaluable to us going forward as we navigate this process and encourage communities to take this big step forward.

We hope that you've been enjoying *COCHS Connection*. However, if you wish to continue recieving this newsletter, we need to hear from you. Subscription is free. To subscribe, please send us an email. And don't forget to visit our website: www.cochs.org.

**Paul Sheehan**
*Chief Operating Officer*
*Community Oriented Correctional Health Services*

COCHS
COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES

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## A Message from the Jacob and Valeria Langeloth Foundation

The grantmaking program of the Jacob and Valeria Langeloth Foundation is centered on the concepts of health and well-being, with emphasis on improving the health of the underserved. People in prison and jail are among society's most disadvantaged populations, as reflected in nearly every aspect of their lives: health, education, poverty, and lack of social support.

For that reason, correctional health is one of our two priority funding areas. We see here an opportunity to make a difference for a population with a high need for public health services. In substantial ways, correctional health care programs are an extension of local public health systems. As such, they are important sites for improving the overall health and well-being of disadvantaged communities.

COCHS – Community Oriented Correctional Health Services – views the jail as one of many places in the community that provides health care, and it sees jailed offenders as community members who are temporarily displaced. As a population, inmates are at high risk for illness but tend to have limited access to regular health care before entering jail. The jail offers an opportunity for inmates to receive quality, consistent care that they haven't received in the community. COCHS takes a public health approach to correctional health, addressing both the health needs of individuals who are in jail and those of their communities, where, ultimately, these inmates will return.

As a foundation, we are constantly exploring various aspects of correctional health in search of innovative programs where our support can make a difference. For that reason, we are pleased to be a supporter of COCHS, along with the Robert Wood Johnson Foundation and the California Endowment.

Looking ahead, we hope that community health providers and local correctional facilities around the country will follow the COCHS example by finding common ground so that they can work together. We know this won't be easy. There is a need for flexibility on both sides. And although each has its own unique mission, there is also an important area of overlap here. By linking community health with public safety, we can reduce the burden of disease for everyone.

**Scott Moyer**
*President*
*The Jacob and Valeria Langeloth Foundation*

# DC Meeting Highlights Federal Policy Issues for Community-Based Health Care in Jails

## Bureau of Primary Health Care to Clarify Criteria for Health Centers

More than 50 leaders from many walks of government, law enforcement, and health care convened in Washington, DC, on March 10 for "Bringing Community-Based Health Care to Jails: A Policy Discussion," a meeting sponsored by Community Oriented Correctional Health Services (COCHS), the Jacob and Valeria Langeloth Foundation, and the Robert Wood Johnson Foundation.

Discussion during the day-long meeting focused on the relationship between federal policy and community health centers with respect to providing health care in jails. The Bureau of Primary Health Care (BPHC) of the federal Health Resources and Services Administration (HRSA) is clarifying its criteria for health centers operating in non-traditional settings – including correctional facilities – that want to qualify for federal funding and federal liability protection under the Federal Tort Claims Act. For many jurisdictions, the outcome of BPHC's deliberations could have a pivotal impact on efforts to form partnerships between community health centers and local jails.

Donald Weaver, MD, assistant surgeon general and deputy associate administrator for primary health care at HRSA, said that the "the bottom line is expanding [health care] access to the community" within the scope of federal law.

Meeting participants agreed that jail inmates are a unique population: diverse; with varying degrees of medical, mental, health, emotional, and substance problems; and with limited access to health care prior to incarceration. Participants also noted that jail inmates are temporarily displaced members of their communities, and not separate from them. Most inmates return to their communities after short stays in jail, bringing with them whatever health problems they have. Jails have a unique role to play by linking community health and public safety.

Sheriff Ed Dean of Marion County, FL, reported on the progress of Ocala Community Care (OCC) a community-based, not-for-profit organization charged with providing health care to 2,000 jail inmates. Launched on Jan. 2, 2008, with technical support from COCHS, OCC replaces a for-profit contractor that formerly managed the Marion County jail's medical unit. Already, average length of stay for inmates who are hospitalized has fallen two days, because of more efficient admission and better care coordination among providers, Dean said.

***At Ocala Community Care in Marion County, FL, average length of stay for inmates who are hospitalized has fallen two days, because of more efficient admission and better care coordination among providers, according to Sheriff Ed Dean.***

Dean said that's just one example of why bringing community-based health care into jails makes sense – both for jails and their communities. "Why not have the same people who treat the rest of us treat inmates in jail?" Dean said. "It's better for the health and safety of the community." In addition, reductions in length of stay, and, hopefully, recidivism ultimately will lower costs for jails, he said.

With more than 12 million people passing through our nation's 3,300 jails each year, a massive social investment is made in health care for inmates, meeting participants noted. But that investment is largely lost the moment inmates leave jail, because care does not continue upon release.

***For many jurisdictions, the outcome of BPHC's deliberations could have a pivotal impact on efforts to form partnerships between community health centers and local jails.***

With technical assistance from COCHS, the District of Columbia became one of the first major US cities to implement a community-based health care program for jail inmates. Vince Keane, president and CEO of Unity Health Care, the federally qualified health center that has partnered with the DC Department of Corrections (DoC) on this program, said that inmates have a constitutional right to health care. Delays in care are not acceptable. He also noted that by working with local health providers, jails have an opportunity to provide chronic disease management for a population that is at high risk for chronic illness.

Devon Brown, director of DC's DoC, said that universal screening for tuberculosis, HIV, and Chlamydia at DC jails is helping to detect these problems earlier and begin treatment and education sooner. "DC spends less now and inmates are being better served," Brown said. DoC officials are working to incorporate these screening protocols into their electronic medical record system.

Fran Zandi, program specialist for the National Institute of Corrections' Jails Division, said that more work needs to be done on re-entry, which is much different for jail inmates than for prison inmates. She noted that, traditionally, jails are not used to letting "outsiders" such as community health providers inside their walls. That, she said, needs to change. "Your jail is just one of many places in the community where individuals receive medical and mental health care. It needs to be part of the community."

Sheriff Andrea Cabral of Suffolk County, MA, said that she is interested in working with community health centers because of their vested interest in re-entry. It is not the job of private entities to "integrate people back into society," she said, adding that, with annual health care expenditures of $18 million for the county's jail and house of corrections, she wants to leverage that money as effectively as possible.

Jay Breines, executive director of Holyoke Health Center in Holyoke, MA, said that effective partnerships between jails and community health providers ultimately will benefit the entire community. "Poverty is what we're all fighting: you in public safety and us in public health," he said. "That's where we're all trying to go."

# Interview

Indianapolis Mayor Gregory Ballard on Inmate Re-entry

When Indianapolis Mayor Gregory A. Ballard (R) took office on Jan. 1, 2008, he made crime reduction his top priority. Noting that the city's crime rate has more than doubled since 1999, he vowed to restore public safety. Key to his strategy is a plan for supporting the re-entry of ex-offenders to society by providing them with job skills training and appropriate social assistance. Here, Mayor Ballard talks about the importance of inmate re-entry.

***Q: Why is inmate re-entry such an important focus of your administration?***

A: Approximately 5,200 people return from incarceration by the Indianapolis Department of Correction (IDOC) each year, as well as 50,000 people from the city jail. In order to address issues such as public safety, recidivism, and public safety appropriately, we must have a single point of contact focusing on inmate re-entry. Our efforts will measure services being provided to those returning, as well as longitudinal data relative to their quality of life after incarceration, the long-term impact on neighborhoods they return to, and the economic and employment outcomes realized from coordinated efforts. By collaborating with IDOC, probation, parole, and service providers, data will be collected and measured. We will conduct surveys of offenders receiving services, hold focus group meetings, and interview recipients at various stages.

***Q: How does successful re-entry benefit the community at large?***

A: I like to think of re-entry as a process of restoring ex-offenders to their communities, so that they can contribute to society. We envision a range of benefits to communities when offenders are employed upon release and prepared for long-term employment. These benefits include enhanced public safety, an increase in child support payments, and improved parenting that will have a positive effect on children's school attendance and performance.

***Q: What particular challenges does Indianapolis face in re-integrating former inmates and detainees into society?***

A: We face challenges such as data collection from various systems; securing employment, both transitional and long-term; identifying available services; and determining the how best to help ex-offenders access such services. Accountability is a large focus of our re-entry initiative, and the development of systems that manage data and outcomes must be instituted.

***Q: How are you approaching re-entry for jail inmates?***

A: We are looking very closely at re-entry for jail inmates. We plan to work with faith-based organizations, community centers, and volunteers to provide support for people returning from jail. We are also exploring the COCHS approach to community-based health care for jail inmates.

***Q: What do you see as the potential role of health care in promoting re-entry?***

A: If health care is addressed within the cycle of care during the re-entry process, we will have the ability to track services and resources more accurately and prevent duplication of services. In addition, by improving the health of returning prison and jail inmates, we hope to see improvements in their ability to maintain employment, reductions in recidivism, and general enhancement of public safety.

***Q: What goals do you hope to achieve?***

A: Our ultimate goal is to reduce recidivism. In accomplishing that, we also hope to increase public safety and enhance the quality of life for all citizens.

***Q: What advice would you offer other mayors interested in promoting re-entry of inmates and detainees?***

A: I've only been in office a short time, but I can tell you what steps we've determined to be crucial to our efforts. First, determine the populations that require the most attention. Then, hire the staff responsible for your re-entry initiatives and empower them with the necessary tools. Finally, establish benchmarks for performance, and measure the outcomes of your efforts.

## Congressional Forum Focuses on Re-entry from Local Jails

The John Jay College of Criminal Justice and The Urban Institute sponsored a May 7 congressional forum on re-entry of jail inmates into local communities. More than 12 million people pass through our nation's 3,300 jails each year. Re-entry from local jails therefore has an enormous impact on communities around the country. Recently, Congress passed the Second Chance Act, which increases resources to support inmate re-entry into society.

The May 7 forum explored the opportunities and challenges of local re-entry and featured the release of two national resources on this issue: "Life after Lockup: Improving Reentry from Jail to the Community" (http://www.urban.org/publications/411660.html) and "The Jail Administrator's Toolkit for Reentry" (http://www.urban.org/publications/411661.html).

Congressman Danny K. Davis and Senator Sam Brownback co-hosted the event. A panel of experts presented, followed by brief responses from a bipartisan panel of congressional members.

## Study Explores New York City's Re-Entry Efforts

A new study released by the John Jay College of Criminal Justice and Bellevue Hospital finds that local communities in New York City frequently are not prepared to handle the ongoing medical and mental health needs of returning inmates. The study report, "Mapping the Innovation in Correctional Health Care Delivery in New York City," tracks results of a 2004 re-entry strategy designed by the New York City Department of Correction to address the health and non-health needs of the large numbers of inmates released each year. A major problem is that inmates return in disproportionate numbers to impoverished communities that lack adequate resources to serve them. To read the full report, go to: http://www.jjay.cuny.edu/centersinstitutes/pri/publications.asp.

# Establishing Best Practices in Jail-Based Health Care

## Electronic Medical Record Systems Offer New Framework for Care

In the health care world at large, there is a lot of talk about "best practices." Sometimes called treatment algorithms, practice guidelines or protocols, or, more loosely, "gold standards," they are the agreed-upon components of medical care for specific diagnoses, based on either the best available medical evidence or expert consensus, that lead to optimum patient outcomes.

For example, people with diabetes need to have their blood-sugar levels monitored regularly, and they should be screened for diabetic retinopathy, a disease of the eye related to diabetes. There are protocols for how best to treat patients who enter the emergency room with signs of a heart attack.

Efforts are being made to embed best practices into systems of care to help ensure that patients get the right care at the right time. The most common way of doing this is through electronic medical record (EMR) software systems, ideally with automated clinical decision supports that prompt providers on appropriate next steps and warn of potential adverse effects.

### Entering the Information Technology Age

For jails, the idea of automating medical records and clinical care processes is still very new. This lack of experience with integrated information technology (IT) systems can present serious barriers to jails that are trying to implement a community-based approach to health care. These integrated systems allow jails and community health providers to share information about their patients, coordinate care across a continuum, and ensure best practices.

Robert B. Greifinger, MD, professor of health and criminal justice and a Distinguished Research Fellow at John Jay College of Criminal Justice in New York, says that jails need to create organized systems to ensure access to needed care, continuity of care, and coordination of care. This is important because jails must meet a constitutional requirement of providing inmates with access to timely and appropriate health care.

In addition, the Supreme Court has ruled that jails cannot practice what is called "deliberate indifference" to serious medical needs. Greifinger explains: "Inmates are entitled to be protected against unnecessary death and unnecessary deterioration of function, so long as the institution was aware of the serious medical need, or should have been aware."

For example, if an inmate has diabetes, jail officials not only must ensure appropriate treatment of the diabetes, but they must also determine whether the inmate has conditions associated with diabetes, such as retinopathy, and treat those conditions appropriately to prevent loss of function. That means both controlling blood-sugar levels for the diabetes and ensuring that the inmate's vision is not deteriorating from possible retinopathy.

Step-by-step practice protocols can help providers identify inmates' medical needs in a timely fashion and treat them appropriately.

In one local initiative, the District of Columbia's Department of Corrections (DoC) has developed a best practice protocol to screen inmates for gonorrhea and Chlamydia with a urine test at booking. Jail officials are working to embed this protocol into the DoC's EMR system. DC is one of the first major cities in the US to implement a program bringing community-based health care to jail inmates.

By screening offenders at booking, jail officials protect both inmates and their communities from sexually transmitted disease (STD), according to Keith Barton, MD, medical director of Community Oriented Correctional Health Services (COCHS). "Most inmates in county jails are released within 14 days, and many are released within 48 hours," Barton notes. "If we wait for the standard sick-call process to identify inmates with these common STDs, it often won't happen." Meanwhile, infected inmates with few or no symptoms are contagious, particularly to their spouse or sexual partner upon release from jail. "A urine sample obtained at booking can identify these mild or asymptomatic cases in time for treatment to start in jail," Barton says.

### Providing a Spectrum of Care

STD screening is only one of many protocols that need to be in place to help ensure proper inmate care. For sheriffs and jail administrators, this presents a dilemma. Jail inmates are at high risk for a host of communicable and chronic diseases, as well as mental health and substance abuse problems. Many have had little if any contact with the health care system prior to entering jail.

But these factors do not relieve jails of their responsibility to provide good health care.

"Jails have to be full-service medical providers, because inmates have no access to any other health care while they are in jail," says John Abbey, president of Abbey Group Consultants, a consulting firm that specializes in developing and integrating IT for public safety organizations.

Abbey believes that automation of clinical practices through an EMR system offers the best solution. Whether a jail operates its own medical program or contracts with a private firm, it must establish practice protocols for standards of care that protect inmates' health, Abbey says. The best protocols are developed with the involvement of medical staff and then submitted to peer review.

Greifinger agrees that automation can make the job easier, but stresses that the key is to create effective systems for scheduling appointments, ensuring follow-up, and measuring quality to improve performance.

Also vital: linking the medical record system to the jail locator system, so that correctional officials know where their patients are – whether they're in custody or not. "Jail locator systems are almost all automated, but they need to be linked to the medical record," Greifinger says. "So if a person has a medical appointment for next Friday but he's going to be discharged before then, his name should come off the appointment book. Hopefully, he'll be seen in the community."

Abbey notes that, in correctional medicine, probably fewer than half of the

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processes involved in delivering care are clinical. Instead, they tend to focus on issues like initiating the medical encounter, generally through screening at booking; inmate classification; transportation; and security.

Abbey likes to describe correctional health care in terms of a continuum comprising a series of steps.

Ideally, the first step would be to prescreen inmates in the field before they are booked. "It is very inefficient to arrest someone and take them to jail, only to find out they have a medical problem and need to go to the hospital," Abbey says. "If we can do the triage in the field with the arresting officer, we can get the medical clearance first." With a properly designed system, options range from cleared to book to cleared for the general population. If there's a problem, the person being arrested may need to go to the infirmary or to the emergency room to get clearance.

According to Abbey, all this information should be tracked as part of a pre-booking system installed on the police unit or at the station, and that system should be connected to the jail system.

Quite often, screening takes place during booking, which can be a chaotic process. At booking, inmates may be disoriented, intoxicated, uncooperative, and even belligerent. Entering jail is a humbling experience for many people, and frequently triggers mental health problems, such as depression. Not all inmates are forthcoming about their health information at booking, either. All these factors present challenges to the nurses conducting the screening who are trying to get a complete picture of the inmate's health.

In the best of all worlds, the EMR and clinical reporting system would be integrated with the booking system. In that way, the health screener would be able to view the inmate's past events and health experiences and recommend appropriate medical, security, and scheduling actions.

This level of IT integration is new to correctional agencies, Abbey says. But he maintains it is absolutely critical if jails are to meet their legal mandates for providing proper health care. For example, if an inmate has been scheduled for a medical appointment at the same time he's supposed to be in court, the result could be catastrophic. Likewise, if an inmate is on a strict medication regimen, he needs to be present for drug rounds when medications are dispensed.

Jails also need a confidential way to accept and respond to medical requests from inmates in a timely fashion. The problem with traditional paper forms is that, even when processed regularly, they're not processed immediately. If an inmate has a severe complaint, a delayed response could have serious repercussions. Abbey has developed a touch-screen, interactive wall kiosk for inmates to enter requests about various concerns, from classification appeals to personal finances to commissary items to medical care.

In this way, the inmate can provide important information about his health and make medical requests electronically. The information is secure and immediately accessible to health care providers.

This means that medical events need to be tracked in a master calendar – both to ensure good care and to optimize medical resources, Abbey says. Again, this is difficult to do on paper, but fairly simple with an automated system that provides both case management and tracking.

The system should also be able to produce a report and instructions for the patient that he can take with him to another provider once he is released from jail. The report would document the inmate's medical problems and the treatment he received in jail so that his new provider could continue appropriate treatment.

Even better, in Abbey's opinion, would be a system that integrated information about care provided both in the jail and in the community. "We're trying to develop a system that could be used as the EMR at community health clinics that have a direct relationship with the jail," Abbey says. The jail would use the same system, which would include different functionalities for the two very different health care settings. Such a system would help ensure coordinated, continuous care for inmates both in and out of jail.

Griefinger notes that EMRs can be useful tools for jail administrators. However, he adds, "they have to have a system that defines what they want and they have to measure very carefully what they're getting."

But real success, he believes, has more to do with leadership and accountability. Recognizing the liability that jails carry for their inmates, local correctional officials must hold their employees or contractors accountable for their performance. "They need staff who are able to think critically – accept that everything's not perfect, identify problems, and find solutions."

## Jail Leaders Speak About Health Care

To provide the Bureau of Justice Assistance (BJA) with guidance for establishing jail-related funding strategies, the Center for Innovative Public Policies, Inc. (CIPP), held a series of focus groups with 45 sheriffs and jail administrators from around the country. CIPP is a not-for-profit corporation dedicated to improving criminal justice system processes and addressing issues related to public safety, public health, and public education.

Based on these focus group meetings, CIPP prepared a report to BJA regarding the immediate and future challenges of operating local jails. This resource, "Jail Leaders Speak: Current and Future Challenges to Jail Operations and Administration, A Summary Report to the Bureau of Justice Assistance" (available at http://nicic.org/Library/022934), is a one-of-a-kind look at what those who administer jails see every day, as well as what they anticipate in the next five to 10 years.

The report identifies health care as the most pressing challenge for jails. "The initial priorities identified for BJA by jail administrators from across the country clearly begin with the deteriorated medical and mental health condition of those arriving in local confinement facilities—a situation attributed to the displacement of community responsibility for physical and psychological health care, along with the fact that the jail is often the only 24-hour service provider," the report reads.

"In that regard, participants suggested that jails need to explore nothing less than a 'fundamental mission change' that extends their official role beyond traditional incarceration functions toward becoming an acknowledged community medical/mental health service provider for an underserved segment of the local population that is especially vulnerable to being arrested and incarcerated," the report continues.

The report calls for increased public awareness of and support for jails, so that collaborative community partnerships may be established and jail-related issues are brought to the forefront of policymaking.

# "1 in 100" Report Marks New High in US Incarceration Rate

Numbers Higher When Accounting for Those on Probation, Parole

A new report commissioned by The Pew Center on the States shows that a record 1 in 100 American adults is now behind bars. According to the report, "1 in 100: America Behind Bars 2008," the US jail and prison population continued its three-decade trend of growth in 2007, climbing to more than 2.3 million.

But "1 in 100" does not account for the more than 5 million people currently serving time on probation or parole in local communities, as accounted for in a 2007 report from the US Department of Justice. That means that more than 3 in every US 100 adults are under some form of "correctional supervision."

Equally staggering are the costs of housing and caring for these populations. "1 in 100" says that states spent more than $49 billion on corrections last year, up from $11 billion just 20 years ago. Despite the massive investment, however, national crime and recidivism and rates remain virtually unchanged. For the growing numbers who believe increasing jail and prison populations does not equate to increasing public safety, the report comes as little surprise.

"We are jammed up with this situation right now because we have fallen in love with one of the most undocumented beliefs: That somehow you get safer if you put more people in jail" said California Senate President Pro Tem Don Perata, whose state is among those most afflicted by prison and jail overcrowding.

### "Overflow" Problems Widespread, Jails Bearing Brunt of Load

Some states reported a flattening of growth, or even a decline, in 2007. The population of California's massive and frequently news-making prisons systems dipped by 2.3 percent. That leaves Texas, where the inmate population dropped slightly, as the nation's imprisonment leader. Others among the country's biggest systems reported declines as well.

But "1 in 100" notes these declines are not likely due to reductions in overall crime or recidivism. Rather, major increases in the number of arrests and convictions for drug-related offenses have helped push prison populations past what state facilities and budgets can accommodate, and many convicts are now being diverted to local jails or probation and parole programs.

### Mental Illness a Rising Problem in Jails and Prisons

As a result, jails are inundated with housing and health care costs they were not designed to handle. Historically, jails have served as holding quarters for those awaiting trial or serving sentences for minor crimes, but are now often primary state facilities for housing offenders with mental illness or suffering from drug addictions. Jails and local law enforcement must also pay for and provide health care to those on probation or parole living in communities.

The Pew Center's findings join a chorus of other major research organizations that have voiced similar concerns recently.

"Jails and prisons are swollen with people suffering some form of mental illness," says a 2008 report from the Justice Policy Institute. "The nation's largest mental health facilities are now found in urban jails in Los Angeles, New York, Chicago, and other big cities."

***Jails are inundated with housing and health care costs they were not designed to handle. Historically, jails have served as holding quarters for those awaiting trial or serving sentences for minor crimes, but are now often primary state facilities for housing offenders with mental illness or suffering from drug addictions.***

But "1 in 100" does note, however, that states are increasingly viewing these problems through a public health lens and showing support for research-backed and community-based corrections strategies, touted by some experts as more effective and cost-efficient ways to provide supervision, treatment, and rehabilitation programs and services.

"1 in 100" singled out changes Texas made to its corrections system as a positive example for other states to consider. The Lone Star State invested $2.3 billion between 1985 and 2005 to add 108,000 beds to its corrections facilities, but again filled to capacity within a few years. In 2007, however, legislators authorized a series of sweeping changes to the state corrections system, including a significant expansion of drug treatment and diversion facilities, as well as expanded parole programs and drug courts.

So far, the results are promising. The reforms are expected to save Texas at least $210 million over the next two years, and could more than double if recidivism rates drop. In addition, projections by the Texas Legislative Budget Board for the next five years show flat spending on corrections.

### Public Perception, Disparities Along Age, Racial Lines Seen as Key Obstacles

The report finds that concerns about appearing "soft" on crime deter many policymakers from adopting community-based strategies for managing corrections. But, in recent months, a number of high-profile public officials have thrown their political weight behind these new approaches.

In January, Connecticut Governor Jodi Rell gave perhaps the strongest public endorsement yet. "Community release programs that are conducted under strict guidelines and conditions enhance public safety," said the first-term Republican. "Offenders who re-enter society under parole supervision are far less likely to re-offend than those who are released without the benefit of a supervised release."

Another challenge is reversing severe trends among certain age and racial demographic groups. For example, among men between the ages of 20 to 34, 1 in 30 is behind bars. Even more staggering is this statistic: 1 in 9 African-American adult males is incarcerated.

To download the full report "1 in 100", including state-by-state analyses, visit the Pew Center on the States at www.pewcenteronthestates.org.

# In Brief

## Court Rules for Orange County's Disabled Jail Inmates

The U.S. 9th Circuit Court of Appeals has ordered the Orange County (CA) Sheriff's Department to make fundamental changes in the way it houses and cares for disabled inmates to comply with federal standards. The court held that the Sheriff's Department improperly segregated disabled inmates at the men's and women's central jails, which do not offer the same recreational and educational programs available to able-bodied inmates at its newer jail facilities. In addition, the appellate court ruled that one of the plaintiffs in the case, a disabled inmate named Timothy Conn, can pursue damages for medical injuries he claims that he sustained while in county custody. He claims that he suffered repeated bladder infections because sheriff's officials did not give him enough catheters, forcing him to reuse them. To read the full article, go to: http://www.latimes.com/news/local/la-me-ocjails26mar26,1,1446438.story.

## Mental Health Courts Gain National Attention

Earlier this year, *US News & World Report* brought national attention to the issue of mental health in corrections with feature-length coverage of the Allegheny (PA) County Mental Health Court. The article profiles this burgeoning alternative to traditional criminal courts and its success at keeping mentally ill offenders out of jail. Reporter Emma Schwartz wrote that mental health courts now number about 175 nationwide and operate on a simple premise: Instead of receiving a jail sentence or standard probation, defendants go to treatment programs and remain under supervision for a fixed period. Schwartz noted that, among graduates of the Pittsburgh court, which started in 2001, only 10 percent of 223 persons were rearrested, well below the 68 percent national average for all defendants. To read the full article, go to: http://www.usnews.com/articles/news/national/2008/02/07/mental-health-courts.html.

## US Leads World in Incarcerations

Although the United States has only 5 percent of the Earth's population, it houses nearly a quarter of the world's prisoners – more than any other country, *The New York Times* reported April 23. The article characterized the statistics as "a reflection of a relatively recent and now entirely distinctive American approach to crime and punishment. Americans are locked up for crimes ... that would rarely produce prison sentences in other countries. And ... they are kept incarcerated far longer than prisoners in other nations." The article notes that America's incarceration rate is six times higher the global median. An especially tough stance on drug-use offenders is cited as a partial driver behind this phenomenon. To read the full article, go to: http://www.nytimes.com/2008/04/23/us/23prison.html?ei=5088&en=359cc0d79ee0ace2&ex=1366603200&partner=rssnyt&emc=rss&pagewanted=all.

## Richmond Considers Funding Programs to Address Mental Health in Jails

Richmond (VA) should spend nearly $3 million to bring more treatment and medication to jail inmates with mental illness in an attempt to lower area recidivism rates, according to a Community Criminal Justice Board. The recommendation received immediate support from Mayor L. Douglas Wilder. "We have to prioritize, and this is a priority," said Wilder. Less than one-quarter of inmates with mental illness in Richmond receive needed medication, and most are housed in the city jail's 100-plus-person dormitory cells, where fear, extortion, and violence are part of daily life. The Board recommended that a series of "before, during, and after" steps be taken to better treat inmates suffering from mental illness. To read the full article, go to: http://www.inrich.com/cva/ric/news.apx.-content-articles-RTD-2008-02-01-0152.html.

## Dozens of Seattle Jail Inmates Hit with Superbug

In a five-month period, 65 inmates at a Seattle jail were diagnosed with MRSA, a sometimes-deadly bacterial infection. A report released last November by the U.S. Department of Justice suggested that jail officials in King County, Washington, were failing to take basic measures to prevent the spread of such diseases. Jail officials said they have taken steps in recent months to improve conditions. All inmates are now screened by nurses at booking, while a new electronic health records system is expected to help better track treatment of sick inmates. "What you try to do is minimize the risk of disease transmission, and this is an attempt to try and do that," said Ben Sanders, medical director for Jail Health Services. To read the full story, go to: http://seattlepi.nwsource.com/local/355903_jail21.html.

## US Prisons Failing on HIV Services

The US corrections system is not doing enough to provide HIV testing, education, and prevention services to the 2.3 million Americans behind bars, according to the American Foundation for AIDS Research. The Foundation notes that prisoners are three times more likely to be HIV-positive than the general population, and that more than 90 percent of prisoners are eventually released, thereby heaping on communities a significant "public health burden." During an April panel discussion hosted by the Foundation, Barry Zack, a correctional health consultant, said it is crucial to reform the country's prison release system to provide inmates with access to health care, mental health care, affordable housing, and job programs. Panelists said that prisoners awaiting release should be given copies of their prison medical records and information about how to access HIV/AIDS treatment. To read the full story, go to: http://www.kaisernetwork.org/dailyreports/repindex.cfm?DR ID=51690.

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Community Oriented Correctional Health Services (COCHS) is a non-profit organization established to help communities around the country connect the health care provided in local correctional centers with health care provided in the community. Ultimately, COCHS hopes to help local communities around the country reduce the incidence of chronic disease and the cost of of health care.

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