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Health Disparities and Prison/Jail Populations! A Review

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Introduction and Background:

Literature suggests that while there exists an extensive documentation on racial and ethnic differences and disparities across the continuum of medical care in disease prevalence, prevention, management and outcomes, little is known about how these health disparities relate and affect thousands of inmates in the nations Jails and prisons. Research has shown that individuals engaged with the Criminal Justice system are at risk of poor health outcomes (Journal of Urban Health, 2012). Epidemiological studies confirmed that jail and prison inmates have a similar burden of chronic diseases such as hypertension, asthma, and cervical cancer than the general population. These studies further reveal that inmates are particularly at risk for substance use disorder, psychiatric disorder, victimization and infectious diseases including hepatitis C, HIV and tuberculosis. But despite the prevalence of poor health status among inmates, the effect of criminal justice involvement on inmate population, health disparities has been largely overlooked. (Journal of Urban Health, 2012).

This paper thus examines health disparities and criminal justice system by reviewing what we know about the level of need for health care services provided to INMATES in the nation's jails and prisons and will highlight what is being done. The study will explore differences in health status of incarcerated persons versus non-incarcerated and will show how being incarcerated worsens the health of the incarcerated persons. The study will also explore the health status of incarcerated women and will highlight how incarceration affects the health of the women who are incarcerated in the nation's jails and prisons.

Literature Review

The section that follows provides an overview of the correction structures where the inmates transitioning into and out of the criminal justice system are kept. **The criminal justice system is comprised of a range of different types of correctional facilities** Correctional facilities include prisons, which typically house longer-term felons or inmates serving a sentence of more than one year, and jails, which house individuals awaiting trial or sentencing and those convicted of misdemeanors and serving shorter terms that are typically less than one year.

There also are several forms of community-based corrections, including probation, parole, and halfway houses. Offenders in community corrections often are required to adhere to strict conditions and rules, and failure to comply with these requirements may lead to incarceration or re-incarceration (Gates, Artiga, and Dubowitz, 2014). **Prisons are managed by the federal government and states, while jails typically are governed by the local city or county.** The federal correctional system consists of prisons controlled by the Federal Bureau of Prisons, which houses individuals convicted of a federal crimes and generally serving a term of more than one year. State correctional systems oversee prisons housing individuals convicted of state crimes and generally serving terms of more than one year. Each state governs its own prison system through a Department of Corrections. There are over 3,200 jails nationwide housing individuals awaiting trial or serving a short sentence for a misdemeanor, with most counties (2,977 out of 3,069) operating their own jails (Gates, et at, 2014).

Hispanic men. American Indians also have higher rates of incarceration compared to Whites (Gates, et al, 2014). In her report in The Sentencing Project Ashley Nellis (2016) came out with these key findings

- African Americans are incarcerated in state prisons at a rate that is 5.1 times the imprisonment of whites. In five states (Iowa, Minnesota, New jersey, Vermont, and Wisconsin), the display is more than 10 to 1
- In twelve states, more than half of the prison population is black: Alabama, Delware, Georgia, Illinois, Louisiana, Maryland, Michigan, Mississippi, New Jersey, North Carolina, South Carolina, and Virginia. Maryland whose prison population is 72% African American, tops the nation
- In eleven states, at least 1 in 20 adult black males is in prison
- In Oklahoma, the state with the highest overall black incarceration rate, 1 in 5 black males ages 18 and older is in prison
- States exhibit substantial variation in the range of racial disparity, from a black/white ration of 12.2:1 in New Jersey to 2.4:1 in Hawaii
- Latinos are imprisoned at a rate that is 1.4 times the rate of whites. Hispanics/white ethnic disparities are particularly high in states such as Massachusetts (4.3:1), Connecticut (3.9:1), Pennsylvania (3.3:1), and New York (3.1:1)

  In their report "Prisoners in 2017" Bronson and Carson (2019) also noted that at the end of 2017 the imprisonment rate for sentenced black males (2,336 per 100,000 black male U.S residents) was almost six times that of sentenced white males (397 per 100,000 white U.S. residents. At year –end 2016, an estimated 60% of Hispanics and blacks sentenced to serve more than one year in state prison had been convicted of and sentenced for a violent offense, compared to 48% of white prisoners

As earlier pointed out, individuals engaged with the criminal justice system are at risk for poor health outcomes and criminal justice involvement may have direct or indirect effects on health and health care and they experience multiple health care issues. According to the Justice and Health Connects, people who are involved in the Criminal justice systems experience significantly higher rates of chronic, acute and behavioral problems than the general population. It further argued that arrests are concentrated in low-income communities where people are more likely to be medically underserved. Underlying behavioral conditions, such as mental illness and substance abuse may place people at higher risk of arrest. For people in custody according to this source, jail and prison overcrowding leads to overstretched healthcare services and increases the risk of the spread of infectious diseases.

Methodology:

The method of analysis for this study is Meta-Analysis and systematic review. According to Siegel (2018), Meta-analysis involves gathering data from a number of previous studies and systematic review is the collection of findings from previously conducted scientific studies and using the collective evidence to address a particular scientific question. This method is a legitimate and frequently used in criminological studies. In order to analyze the issues in question, the following prominent medical situations will be used as variables of analysis to determine health disparity of inmates in the Criminal Justice system: Substance abuse; mental illness; chronic diseases; infectious and sexually transmitted diseases;

Below presents a summary of the level of need for health care services among the jail and prison inmates:

Substance use:

According to James and Glaze, 2006; Fazel et al., (2006), most estimates place rates of drug dependence or abuse in correctional populations at well over 50 percent, with even higher rates among women. But despite such high rates of substance use in the criminal justice system and evidence that evidence-based treatment can significantly reduce drug use and drug-related crime, as little as 15 percent of those in need of treatment receive it while they are incarcerated (Belenko, 2005; Chandler, 2009). A recent meta-analysis of studies conducted in a number of countries found that people leaving prison experience a three-to-eightfold increased risk of drug-related death during the first two weeks following their release (Merrall et al., 2010).

Mental Illness:

Epidemiologic studies show that 14.5 percent of men and 31 percent of women in jail have a serious mental illness compared to 5 percent in the general population (Steadman et al., 2009; Substance Abuse and Mental Health Services Administration, 2012). Seventeen percent of incarcerated people with mental illness become homeless as opposed to 9 percent of incarcerated people without mental illness (Held et al., 2012). Post-traumatic stress disorder (PTSD) is highly prevalent among incarcerated women. Nearly one-third experience physical or sexual abuse prior to incarceration (Lewis, 2006). People with serious psychiatric needs are more likely to be victims of violent crimes, more likely to be housed in solitary confinement, and are at higher risk of suicide and self-harm while incarcerated (Haney, 2003; Fellner, 2006; Teplin, 2002). Suicide is the leading cause of death in prisons, accounting for roughly one-third of all deaths in custody between 2000 and 2009 (Bureau of Justice Statistics).

Chronic disease:

Using nationally representative health surveys, one study found higher rates of many chronic medical conditions, including hypertension, asthma, arthritis, cancer, cervical cancer, and hepatitis among people in jail and prison compared to the rest of the population, even after controlling for a range of socioeconomic factors (Binswanger et al. 2009). Among jail inmates in the United States, a higher proportion of women than men report a current medical problem (53 percent to 35 percent respectively), including cancer, diabetes, hypertension, heart problems, asthma, arthritis, hepatitis, depression, bipolar disorder, psychosis, posttraumatic stress, anxiety, personality disorder, drug abuse, and drug dependence (Binswanger et al., 2010). Prisons and jails are holding an aging population: from 1995 to 2010, the total state and federal prisoners aged 55 years or older increased by 282 percent, while the number of all prisoners grew by 42 percent (Fellner, 2011).

Infectious diseases and Sexually Transmitted Infections:

HIV prevalence in correctional facilities is nearly five times higher than in the general population. Research in New York revealed that as many as 25 percent of HIV-infected people do not know their status (Hammet, 2006; Freudenberg, 2001). Hepatitis C (HCV) is nine to 10 times higher among incarcerated populations. Studies of HCV in state prison systems report prevalence ranging from 23 to 34 percent (Freudenberg, 2001). Rates of syphilis among women who are incarcerated in New York were 1,000 times that is seen in the general population (Freudenberg, 2002). Studies have found 29.4 cases of tuberculosis per 100,000 prisoners compared to 6.7 cases per 100,000 people in the general population (Fazel and Baillargeon, 2011). It is becoming even clear that health disparities issues are impacting incarcerated women who are more vulnerable as it is for incarcerated men in American jails and prisons. In their eloquent editorial entitled 'Health Disparities and Incarcerated Women: A Population Ignored', Braithwaite, Treadwell and Arriola, 2005, seriously discussed the issues of health disparities among incarcerated women in American prisons most of whom are largely African American and bear the quadruple burden of their race/ethnicity, class, gender, and status as a criminal offender Braithwaite, el at, (2015). They argue that it is clear that being black, being female, being poor, and being a criminal offender confers serious health risks. Because incarcerated women are "invisible" there has been little in the way of research and policy development that would advance their health status. Thus it is no surprise that for the most part, the health of incarcerated women is worse than that of incarcerated men and that of women in the general population (Braithwaite, el at 2005). Historically, according to Braithwaite el at, (2005) women have been underrepresented at all levels of the criminal justice system.

This under representation of women has resulted in a criminal justice system created by males for males in which the diverse needs of women are insufficient and sometimes neglected in many correctional facilities. Prior to the 1980s, when the female prison population was relatively low, this was not an issue that received a significant amount of attention. However, over the past 20 years, the number of women held in state and federal prisons has increased more than 6-fold, out-pacing the growth rate of the male prison population. Statistics show that African American and Hispanic women constitute the fastest-growing prison population. Two thirds of women confined in local jails and state and federal prisons are Black, Hispanic, or members of other non-White ethnic groups. Despite the exponential in-crease in the number of female inmates, little attention has been given to their unique health concerns. For example, Braithwaite, el at (2005) argued that the gynecological needs of female inmates are often dismissed as not important by prison officials. Medical concerns that relate to reproductive health and to the psychosocial matters that surround imprisonment of single female heads of households are often overlooked. Women in prison complain of a lack of regular gynecological and breast examinations and say that their medical concerns are often dismissed. Many incarcerated women lacked health care prior to their imprisonment. In addition, a large proportion of this population are survivors of physical and sexual abuse, putting them at greater-than-average risk for high-risk pregnancies and life-threatening illnesses such as HIV/AIDS, hepatitis C, and human papillomavirus infection, which may increase risk for cervical cancer. Moreover, despite being imprisoned and presumably safe from harm, women in many prisons throughout the United States are victims of sexual abuse by prison staff. At times, such abuse occurs during routine medical examinations.

The increase in women's imprisonment is largely a product of minor property and drug-related crimes. During the 1980s, the percentage of women charged with drug offenses skyrocketed when crack cocaine was introduced across the United States. This inexpensive drug created addicts in low-income areas, increased demand for drugs in urban areas, and was associated with violence; a termed defined by CDC as a disease. Many crack cocaine addicts, especially low-income women of color, funded their addiction by engaging in prostitution, theft, and drug distribution. Like men's prisons, women's prisons are fast becoming warehouses for those who have committed drug-related offenses. Unfortunately, drug rehabilitation programs are virtually nonexistent in these institutions. Consequently, inmates who are released without receiving drug rehabilitation find themselves falling back into addiction because they are unable to resist the environmental pressures that led them to become addicted in the first place.

Gates, Artiga and Rudowitz (2014) also point out that there are other important social factors that may be contributing to the health disparities among prison population. It is their position that people involved with the criminal justice system are generally low-income and uninsured. Contemporary research indicates that data on the income and insurance status of people moving into and out of the criminal justice system are limited. Furthermore, survey data from 2002 show that nearly six in ten jail inmates reported monthly income of less than $1,000 prior to their arrest. It also suggest that the population is largely uninsured. For example, a survey of San Francisco county jails found that about 90% of people who enter county jails have no health insurance. Survey of inmates returning to the community from Illinois jails found that more than eight in ten were uninsured after returning to the community at 16 months post-release. It was also found that the incarcerated population has significant physical and mental health needs. Over half of prison and jail inmates have a mental health disorder, with local jail inmates experiencing the highest rate (64%). These disorders include mania, major depression, and psychotic disorders. Prisoners and jail inmates who have a mental health disorder are more likely than those without a disorder to have been homeless in the year prior to their incarceration, less likely to have been employed prior to their arrest, and more likely to report a history of physical or sexual abuse. Moreover, the majority of inmates with a mental health disorder also have a substance or alcohol use disorder. These studies also found that Individuals moving into and out of the criminal justice system also face a variety of social challenges. Poverty, unemployment, lower education levels, housing instability, and homelessness are all more prevalent issues among criminal justice-involved population than the general population. This population also generally has higher rates of learning disabilities and lower rates of literacy. Sam Dolnik (2018) tells us that "In 1946, Life magazine published an exposé that declared most American mental hospitals "a shame and a disgrace." The report, by Albert Q. Maisel, featured scathing anecdotes of routine abuse, starvation diets, overcrowded bathrooms and cynical charades of treatment that mocked the very word… "Through public neglect and legislative penny-pinching, state after state has allowed its institutions for the care and cure of the mentally sick to degenerate into little more than concentration camps," according to Maisel.

Roth (2018) lamented on the indiscriminate arrests and incarceration of mentally illness offenders for misdemeanors and minor violations "like shoplifting or loitering, crimes that should have alerted mental health providers rather than pointed them toward prison".

Gates el at (2014) pointed out that Correctional facilities are required to provide health services to incarcerated individuals, but many inmates go without needed care. The provision of health care varies significantly across states and types of correctional facilities. Some larger prisons have infirmaries on-site, and many prisons hire independent doctors or contract with private hospital staff to provide care, with the majority of prisons creating a hybrid system. In jails, health care is primarily provided through contracts with local health care providers, such as public hospitals or other safety-net providers, who come to the jails to provide services. As with large prisons, some large jails have on-site primary care, pharmacy, and mental health and substance abuse centers. Even though these services are available, data show that many inmates go without needed health care while incarcerated. For example, Gates el at, 2014, pointed out that a 2009 study found that, among inmates with a persistent medical problem, approximately 14% of federal inmates, 20% of state inmates, and 68% of local jail inmates did not receive a medical examination while incarcerated. About two thirds of prison inmates and less than half of jail inmates who had previously been treated with a psychiatric medication had taken medication for a mental condition since incarceration. Cost is also a significant factor affecting health care provision to the incarcerated inmates. States have been facing rising costs in prison health care spending. As of 2011, it is reported that state spending on correctional health care was about $7.7 billion, accounting for about a fifth of total prison expenditures. Between 2007 and 2011, correctional health care spending rose in 41 states, with a median growth rate of 13 percent. This growth reflects a combination of an increase in the prison population and higher per-inmate expenses due to an aging inmate population, the prevalence of physical and mental health needs, and challenges in delivering health care in prisons, such as distances from hospitals and providers. However, in most states, spending peaked before fiscal year 2011 and has been declining since then due, in part, to a reduction in state prison populations. Medicaid has historically played a very limited role in covering inmate health care costs. Prior to the ACA, Medicaid eligibility was limited to low-income people who fell into certain groups, including children, pregnant women, parents of dependent children, and elderly and disabled adults. Overall, eligibility for non-disabled, non-elderly adults was very limited, with adults without dependent children generally excluded from the program and income eligibility limits for parents remaining very low in most states (Alexandra Gates, Samantha Artiga and Robin Rudowitz, 2014). As such, many inmates historically could not qualify for Medicaid since they did not fit into one of the categorical eligibility categories. Even for inmates who do qualify for Medicaid, federal law prohibits Medicaid payment for most health care services provided to individuals while incarcerated under a policy known as the "inmate exclusion" Given these limitations, previously, few states pursued Medicaid financing for eligible prisoners' health care services. Efforts to explain racial differences in health focus on factors ranging from structural conditions to employment and lifestyle choices to psychological factors (Bird et al. 2000).

STRUCTURAL Disadvantage: Structural racisms plays a significant role in health disparities across the country. Structural racism is defined as a system of public policies, institutional practices, cultural representations, and other norms that work in reinforcing ways to perpetuate racial inequality (The Aspen Institute, 2016). One area is racial disparities in home ownership rates between whites and blacks that is highly attributed to discriminatory practices. Blacks and other minorities are forced to live in older houses as renters and older homes can present threats to health such as lead based paints, mold, and asbestos. These factors can equally be responsible for the high mortality rate among African Americans and Hispanics, and African American women have a higher breast cancer mortality rate than white women. Another important area to look at is the differences in the rate of incarceration between blacks and whites. Krivo and Paterson (1996) noted that African Americans comprise a disproportionate share of those living in poverty-stricken neighborhoods and communities where a range of socio-economic vulnerabilities contribute to higher rates of crime, particularly violent crime. With the highest incarceration rate in the world what we observe is that the burden of contact with the system has fallen on African Americans and other minorities. Dumont (2012) noted that mass incarceration has long term physiological effects that contribute to a range of health issues, including mental health disorders, diabetes, asthma, hypertension, HIV, and Hepatitis C. As a result of structural disadvantages black youth are more likely to face unstable family life, high rate of unemployment, violence and consequently very high school dropout rate.

EMPLOYMENT AND LIFESTYLE CHOICES:

Employment plays a big role in one's life. Unemployment and job insecurity can affect health as well. People who are unemployed have the propensity of getting unattended health issues. Low income persons also experience greater residential crowding and noise. Overcrowding in the homes is more problematic for health than is area density. Research has shown that more minorities are unemployed and this has an untold impact on their health and life style. Low socioeconomic status has also been associated with unhealthy diet such as low consumption of fiber and fresh fruits. Heavy alcohol use is also associated with this class which is a very risky lifestyle that can cause cancer, and lower mortality risk. It is very important that these factors are carefully analyzed because these are the problems and issues this group of people take with them to prisons.

PSYCOLOGICAL FACTORS:

The American prisons is presently facing an unprecedented issues, ranging from the increasing rate of incarceration to prison overcrowding. Penologists have described this situation as crisis point. Presently, United States for the past several decades has retained the number one position in the rate of incarceration compared with other western modern nations like Japan, Netherlands, Australia, and the United Kingdom. The pains of imprisonment (Sykes, 1958) such as loss of autonomy, loss of security, deprivation of heterosexual relationship and other pains carry certain psychological cost. Welch (1999, p. 200) described the conditions in two super max facilities in Marion (Illinois) and Pelican Bay (California): "(In Marion, all prisoners are confined to their cells for 23 hours per day, granted 1 hour of exercise outside of their cell and allowed to shower 2 or 3 days in a week. Handcuffs are fastened to inmates while they are transported within the facility and they are chained "long-term to their beds". In Pelican Bay, inmates are confined to their 8 by 10 ft. cells, where the temperature registers a constant 85 to 90 degrees, for twenty –two and half hours per day. The unrelenting heat produces headaches, nausea, and dehydration and drains the inmates of their mental and bodily energy". These conditions in our prison carry with it a lot of anguish that the Human Rights Watch have described as a clear violation of human rights and a breach of international treaty. The same group of inmates when released will come back to the prison because being psychologically and socially crippled they cannot function in the free world and they return to prison with mental health issues and other ailments. Harney and Lynch (1997) listed some of the psychological consequences of long-term solitary like confinement: impaired sense of identity; hypersensitivity to stimuli; cognitive dysfunction (confusion, memory loss, ruminations); irritability, anger, aggression, and/or rage; other directed violence, such as stabbings; attacks on staff, property destruction, and collective violence; lethargy, helplessness and hopelessness; chronic depression; self-mutilation; and or suicidal ideation, impulses, and behavior; anxiety and panic attack; emotional breakdowns; and or loss of control; hallucinations, psychosis and or paranoia; overall deterioration of mental and physical health.

Herman 2019, attributes health disparities in prisons and jails to federal government refusal to fund adequate treatment of mentally ill prisoners across America. Herman asserts that "When psychiatric institutions began closing down in the 1950s, they weren't replaced with mental health services in the community…. So, many people with mental illness have scrapes with the law, and end up in prisons that are ill-equipped to treat them". Federal data on state and federal prisons from 2011 to 2012 indicate that nearly 40 percent of inmates reported having been told by a mental health professional that they had a mental health disorder. "Yet among those who met the threshold for having serious psychological distress at the time of the survey, only about half were receiving treatment — medication, counseling, or both — for their illness".

The following data from National Institute of Mental Health 2016, paints a banal picture of neglect and ignominy.

- **8.3 million** adults with schizophrenia or bipolar disorder mental illness (3.3% of the population)[+]
  5.5 million – approximate number with severe bipolar disorder (2.2% of the population), 51% untreated[+]
  2.8 million – approximate number with schizophrenia (1.1% of the population), 40% untreated[+]
- **3.9 million** – approximate number untreated in any given year (1.6% of the population)[+]
- **169,000** homeless people with serious mental illness**
- **383,000** inmates with mental illness in jails and prisons
- **50%** – estimated percentage of individuals with schizophrenia or bipolar who attempt suicide during their lifetimes
- **44,193** suicide deaths in 2015

- **10%** – estimated percentage of homicides involving an offender with serious mental illness (approximately 1,425 per year at 2014 homicide rates)
- **29%** – estimated percentage of family homicides associated with serious mental illness
- **50%** – estimated percentage of mass killings associated with serious mental illness

Advocacy Treatment Center recommends commonsensical and evidenced-based solutions:

Promoting Assisted Outpatient Treatment

Assisted outpatient treatment (AOT) is court-supervised treatment within the community. To be a candidate for AOT, a person must meet specific criteria, such as a prior history of repeated hospitalizations or arrest. AOT laws have been shown to reduce hospitalization, arrest and incarceration, homelessness, victimization, and also to prevent violent acts associated with mental illness, including suicide and violence against others.

Improving Civil Commitment Laws and Standards

Voluntary treatment for any medical condition is always preferable. However, because of the nature of mental illness, involuntary treatment and hospitalization is necessary in certain circumstances, especially if the illness has impacted that person's ability to identify their own need for treatment.

Implementing AOT Laws

The Treatment Advocacy Center is dedicated to enacting compassionate, effective mental health treatment laws and equally determined to help state and local mental health systems implement these laws to take full advantage of their life-saving potential.

"Assisted outpatient treatment" (AOT) is a case in point. AOT is a practice of delivering outpatient treatment under court order to adults with severe mental illness who meet specific criteria, such as a prior history of repeated hospitalizations or arrest. By mid-2016, 46 states and the District of Columbia had AOT laws on the books.

Restoring Psychiatric Hospital Beds

Fifty years of public policy designed to eliminate state hospital beds have produced a psychiatric bed shortage unseen in the United States since the early 1800s – a gap between bed supply and demand that hurts individuals with serious mental illness and their communities and grows wider every year.

Known as "deinstitutionalization," the drive to eliminate beds was motivated by the ideal that every mental hospital patient would be better off in a small community setting than in a larger facility. The goal was achieved with federal economic incentives, consumer advocacy and state legislation that restricted bed access to people whose symptoms had made them dangerous. The ideal of equivalent community-based care was never realized, leaving many who weren't dangerous without hospital access.

Rethinking Mental Health Policy

Congress and the White House have the power to pass meaningful mental health reform to repair America's broken treatment system. Until recently, mental illness has been largely ignored by federal decision makers. The last time substantial legislation and regulation focused on the most severely ill was in the 1960s.

21st Century Cures Act

President Obama signed HR 34, the 21st Century Cures Act (2016), which incorporates monumental bipartisan reform of our nation's mental health system. These reforms include a host of Treatment Advocacy Center priorities, including provisions to increase the number of psychiatric beds nationwide, elevate the federal focus on mental illness by creating a federal position of assistant secretary for mental health and substance use disorders and to address the criminalization of untreated mental illness.

Reform SAMHSA

- Creates a new Assistant Secretary for Mental Health and Substance Use Disorders to be presidentially appointed with Senate confirmation, who will oversee SAMHSA and coordinate related programs and research across the federal government, with emphasis on science and evidence based programs, and with the aid of a newly established Chief Medical Officer.

- Establishes a new federal policy laboratory for mental health and substance use, to elevate and disseminate policy changes and service models that work based on evidence, research, and science.

Funding and Strengthening Evidence-Based Treatment Programs for Severe Mental Illness (SMI)

- Strengthens and expands critical Assisted Outpatient Treatment (AOT) programs to help break the revolving-door cycle through a grant reauthorization and funding increase for states to implement AOT and permits states to use Department of Justice grant funding for AOT in civil courts as an alternative to incarceration.
- Establishes, hand in hand with AOT, a grant program for Assertive Community Treatment (ACT) teams to provide critical wrap-around services in the community to people with SMI.
- Provides states with new innovative opportunities to deliver much-needed care in IMDs to adult Medicaid patients with SMI.
- Requires states to expend not less than 10 percent of their community mental health services block grant funding each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.
- Strengthens community response systems with a grant program to create databases on psychiatric beds, crisis stabilization units, and residential treatment facilities.
- Directs CMS to outline for states innovative opportunities to use Medicaid 1115 waivers to provide care for adults with serious mental illness

Decriminalizing mental illness

- Allows DOJ funding to be used for civil AOT programs to provide treatment opportunities before incarceration.
- Allows DOJ funding to be used for Forensic Assertive Community Treatment Programs (FACT) for individuals with severe psychiatric disorders in the criminal justice system.
- Directs the Attorney General to establish a pilot federal mental health court, and provides avenues for better screening and assessment of people with mental illness in the criminal justice system.
- Allows DOJ funding to be used to provide assistance to individuals with SMI transitioning out of jails and prisons, including housing assistance and mental health treatment.
- Provides additional grant opportunities to provide law enforcement and the court system with Crisis Intervention Team (CIT) training and programs to divert people with SMI from the criminal justice system.
- Reauthorizes the Comprehensive Justice and Mental Health Act, which provides a host of beneficial programs, including grants to continued support for mental health courts and crisis intervention teams, training for law enforcement on mental illness, and teams to address frequent users of crisis services.

Mandating data collection on the role of SMI in public issues

- Requires the SAMHSA Assistant Secretary to award competitive grants to develop databases on psychiatric beds, crisis stabilization units, and residential treatment facilities.
- Requires federal government reporting on federal, state, and local costs of imprisonment for individuals with serious mental illness, including the number and types of crimes committed by mentally ill individuals.
- Requires Attorney General data collection and dissemination regarding the involvement of mental illness in all homicides, as well as deaths or serious bodily injuries involving law enforcement officers.
- Requires the Secretary of Health and Human Services to conduct a study on the impact of recent federal regulations providing coverage of treatment in IMD facilities in Medicaid managed care plans.

Clarifying the HIPAA quagmire

- Requires the Secretary of Health and Human Services to issue guidance clarifying the circumstances under which healthcare providers and families can share and provide protected information about a loved one with SMI.
- Requires the Secretary to develop model programs and trainings for health care providers to clarify when information can be shared and trainings for patients and their families to understand their rights to protect and obtain treatment information.

Ensuring accountability for Protection and Advocacy organizations

- Requires a detailed accounting of Protection and Advocacy funding sources and how such funds are spent.
- Commissions a GAO study of Protection and Advocacy programs to ensure compliance with statutory and regulatory responsibilities, including such responsibilities related to family engagement and investigations of alleged abuse, neglect and availability of adequate treatment of persons with mental illness.

Mental Health Parity & Medicaid

- Clarifies that Medicaid is to permit same-day billing for the provision of both primary care and mental health services.
- Requires new federal guidance on parity compliance and requires a public meeting of stakeholders to create an action plan to improve federal and state coordination on parity requirements.
- Requires the GAO to conduct a study on parity enforcement and provide recommendation for increasing enforcement results.

Establishing a federal adult suicide prevention program.

- Requires the assistant secretary to award grants to implement suicide prevention and intervention programs for individuals who are 25 years of age or older, to include screening for suicide risk, suicide intervention services and treatment referrals.

Invest in Real Diversion

There has been a rise in the use of diversion programs such as mental health courts or drug courts across the country. These courts work in collaboration with mental health and substance use treatment providers to help individuals who have mental health or substance use problems.

Invest in Services

If there is a correlation between access to mental health care and incarceration the next important step is to research how systemic changes in access to mental health care can cause a reduction in incarceration. Treatment such as Assertive Community Treatment and Multi systemic Therapy already have strong evidence for reducing days of incarceration. Investing in mental health and substance use services for all people will reduce the likelihood that individuals will ever face incarceration in their lifetime.

Ensure Continuity of Care

When people enter into the criminal justice system, their access to treatment changes. Many will lose insurance benefits and services. For those who begin receiving services while incarcerated, many lose access, sometimes immediately, when they return to the community. This can be particularly dangerous for people who suddenly lose access to prescribed medications. To ensure the best possible outcomes for individuals, which includes keeping them out of jails and prisons, it is essential that we create systems that support people as they transition both in and out of incarceration. People should receive appropriate supports while incarcerated and have a plan that connects them to community-based services and with adequate insurance coverage prior to returning to the community.

Start Early

To prevent incarceration, we must begin early and support students in schools. Students with disabilities are more than twice as likely to be suspended. Students who are suspended or expelled are almost 3 times as likely to be involved with the juvenile justice system within the next year. Ultimately, students who have been in the juvenile justice system are more likely to end up in the criminal justice system. Lack of supports in schools, which often lead to suspension or expulsion, also results in students with disabilities having the lowest graduation rate of any group at 63%— about 20% lower than the national average. Dropping out of school is another factor that puts individuals at high risk for incarceration.

Fellner; Ali, Teich (2006); Mutter (2018) argued that mentally ill individuals are now becoming the largest population found inside jails and prisons, and the conditions inside these facilities actually debilitate the minds of those with mental health disorders. Knowing how to properly identify, relate, and punish these individuals is crucial to helping them rehabilitate and get the proper care both inside and outside the prisons and jails facilities. These authors lamented on the lack of knowledge associated with the criminal justice system in handling individuals with mental illness from processing to release which affect issues of acquired good time and punishments such as isolation. "Most prison systems do not provide correctional officers with more than minimal mental health training" (Fellner, 2006, p. 396). Ahonen (2019) tells us that there is lack of knowledge in what God wants for us and how we treat those who need our assistance.

Our position suggests training for law enforcement community including police and corrections personnel so they can recognize mentally ill offenders in the streets and prisons. Furthermore, a Christian worldview integrated into previously enumerated and discussed solutions and recommendations.

We conclude that racial and ethnic health disparities is woven into a delicate and complex set of cognitive, socio-behavioral and bio-chemical variables yet to be scientifically and carefully examined. Additionally, eliminating or at the least reducing health disparities must be an emergency priority for the overall health of our society, national and economic security. It is our position that scientific analysis of racial and ethnic health disparities in America jails and prisons will offer clarity in disparities and for research informed recommendations.

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