GRANT MAKERS IN HEALTH

GIH

HEALTH & JUSTICE:

Health Care for People Involved in the Justice System

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FOREWORD

As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of grantmakers, researchers, and practitioners on November 6, 2009, for a discussion on access to health care for people entering, in, or emerging from the juvenile and criminal justice systems. The program focused on successful front-end diversion, correctional health care, and community re-entry strategies for youth and adults. This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for Issue Dialogue participants.

Special thanks are due to those who participated in the Issue Dialogue, especially the presenters: Dan Abreu of the Center for Mental Health Services National Gains Center, Leslie Acoca of the National Girls Health and Justice Institute, Janice Bogner of The Health Foundation of Greater Cincinnati, Mike Dubose of Mike Dubose Consulting, Chris Koyanagi of the Judge David L. Bazelon Center for Mental Health, Scott Moyer of The Jacob and Valeria Langeloth Foundation, Laura Burney Nissen of Portland State University, Barbara Raymond of The California Endowment, and Steve Rosenberg of Community Oriented Correctional Health Services.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Osula Evadne Rushing, program director at GIH, planned the program, wrote the background paper, and synthesized key points from the Issue Dialogue into this report. Faith Mitchell, vice president at GIH, and Leila Polintan, communications manager at GIH, provided editorial assistance.

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EXECUTIVE SUMMARY

HEALTH & JUSTICE:

Health Care for People Involved in the Justice System

The issue of health and justice is especially pressing because people involved in the justice system are one of the most medically vulnerable groups in this country. They are often at-risk youth, children and adults with a history of physical and sexual abuse, low-income men of color, and people with high rates of chronic and communicable disease who may also be struggling with mental illness and substance abuse.

Health funders have found that focusing on people entering, in, or emerging from the criminal and juvenile justice systems increases the likelihood of connecting with vulnerable populations that are hard to pull into traditional health interventions. Successful initiatives targeting these groups improve health, reduce recidivism, and transform systems by building cross-sectoral partnerships among health, justice, mental health, and substance abuse systems, which may require policy change at the local, state, and federal levels.

WHY HEALTH AND JUSTICE?

Each year, nearly 700,000 adults in federal and state prisons and more than seven million adults in local jails are released to their communities. Most are low-income men of color who are returning to cities and towns with high concentrations of poverty. They reenter their communities with major barriers to success. About half struggle with substance dependence or substance abuse. More than half experience mental illness. About 25 percent have serious health conditions such as AIDS, Hepatitis C, and tuberculosis (Greenberg et al. 2007).

Statistics for young people in the juvenile justice system are just as compelling. Most offending youths are released after arrest, often returning to troubled families, stressed neighborhoods, and overwhelmed schools (Nissen et al. 2006). At least a decade of evidence has shown that these young people have numerous health problems, including substance abuse problems; mental disorders; post-traumatic stress disorder; and physical health problems, such as tuberculosis, dental caries, and sexually transmitted diseases (American Academy of Pediatrics Committee on Adolescence 2001).

From a public health perspective, the justice system would seem to be a perfect place for intervention because of the high number of high-risk people served. But "the justice system" is made up of innumerable separate systems, with major differences in configuration, concerns, function, and influence (Gallagher and Dobrin 2007). Each of these systems also has its own funding stream and constraints about how those

INTERVENTION OPPORTUNITIES

There are three main opportunities to intervene in the spectrum of justice system involvement: before people are placed in detention, jail, or prison; while they are detained or incarcerated; and upon their release back into the community.

Diversion programs, whether for juveniles or adults, identify people in contact with the justice system and redirect them by providing linkages to community-based treatment and support services (CMHS National GAINS Center 2007).

Correctional health care refers to the health care delivered in jails, prisons, and juvenile confinement facilities (NCCHC 2009).

Reentry programs manage individuals' transition from correctional settings into the community (CMHS National GAINS Center 2007).

resources are used. It may seem logical that expanding access to health services for juveniles and adult offenders can help improve their health, well-being, and prospects, while at the same time transforming communities and protecting the nation's health, but accomplishing this goal will require major changes in policy and practice.

HEALTH AND CRIMINAL JUSTICE

Jails and prisons are constitutionally required to provide medical and mental health care for millions of adults, most of whom are poor and many of whom enter correctional facilities with serious, unaddressed health needs. Some correctional facilities do a good job of meeting their obligation to provide health care. Others do not, and there are no federal regulations for the quality of health care provided by jails and prisons. The National Commission on Correctional Health Care sets standards for care, but prisons and jails can choose whether or not to follow these guidelines. The situation is worsened by the fact that correctional health care costs are high (since inmates have higher rates of infectious diseases and mental illness than the general population), and correctional health care is chronically underfunded (Commission on Safety and Abuse in America's Prisons 2006; View Associates 2006).

Grantmakers across the country are supporting a range of innovative programs and policy change efforts that address the health of adults in the criminal justice system by addressing substance use disorders and severe mental illnesses, linking correctional and community health, reintegrating returning prisoners, lending support to families of the incarcerated, and advocating for policy change.

HEALTH AND JUVENILE JUSTICE

In many ways, young people involved in the justice system are similar to other youth who foundation-funded programs hope to reach (Youth Transition Funders Group 2006). They often have a family background that includes abuse or neglect, unmet mental health and substance abuse needs, low family income, a limited or uneven history with the health care system, and probable eligibility for public insurance programs (National Academy for State Health Policy 2008). In fact, many young people in contact with the justice system are also in contact with several other public systems, such as Medicaid, special education programs, foster care, or child protective services (Clark and Gehshan 2006).

Grantmakers across the country are supporting a range of innovative programs and policy change efforts that address the health of young people in the juvenile justice system by increasing diversion and developing the workforce; helping teens overcome drugs, alcohol, and crime; identifying and addressing the health needs of girls entering the justice system; and intervening during detention and probation.

OPPORTUNITIES AND LESSONS LEARNED

The goal of funders working at the intersection of health and justice is for their investments to pay off, not only in helping people become healthy, productive, stable citizens, but also in reducing recidivism and its accompanying costs to society. There are several opportunities and lessons learned for health funders considering this area of work.

- Help communities understand the problem.
- Help convene necessary – often reluctant – stakeholders and allies.
- Work to strengthen the public behavioral health system.
- Bring innovative programs to scale.
- Help manage public perceptions.
- Invest in "in-reach" activities.
- Use foundation funding to build a bridge between fragmented programs or funding streams.

- Support training.
- Be intentional about collaborating with government.
- Help document actual or potential savings from different kinds of interventions.
- Recognize opportunities for noncriminal justice funders to invest in these issues.
- Recognize the overlapping issues plaguing people involved in the justice system.
- Insist on careful planning and evaluation.
- Think differently about sustainability.
- Recruit partners with different strengths to play different roles.
- Think about health and justice work as a social movement, as well as an initiative.
- Engage in conversations about what it means to design culturally relevant programs and policies.
- Be mindful of the common themes across all justice-involved populations, while paying attention to the distinctions.
- Focus on multiple levels of intervention.

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INTRODUCTION

The issue of health and justice is especially pressing because people involved in the justice system are one of the most medically vulnerable groups in this country. They are often at-risk youth, children and adults with a history of physical and sexual abuse, low-income men of color, and people with high rates of chronic and communicable disease who may also be struggling with mental illness and substance abuse. Correctional health care costs are high, and correctional heath care is chronically underfunded. Each year thousands of adults and young people are released from incarceration or detention with limited or no access to health insurance or basic health care. The situation is critical.

Health funders have found that focusing on people entering, in, or emerging from the criminal and juvenile justice systems increases the likelihood of connecting with vulnerable populations that are hard to pull into traditional health interventions. Successful initiatives targeting these groups improve health, reduce recidivism, and transform systems by building cross-sectoral partnerships among health, justice, mental health, and substance abuse systems, which may require policy change at the local, state, and federal levels. Grantmakers working at the intersection of the health and justice systems are eager to identify promising solutions, opportunities to innovate, and gaps in knowledge or practice that would benefit from philanthropic investment. This brief will review what we know about the health of people involved in the justice system, explore differences between the issues faced by adults and juveniles, and highlight opportunities for funding at several points along the spectrum of justice system involvement.

WHY HEALTH AND JUSTICE?

> I was always a dabbler in drugs. I had a wife, three kids, house, great job, and I just started doing heroin. It got out of hand really fast. My ex-wife left me, took the kids, then I lost the house, the job, ended up on the street and ended up in jail. When I arrived at Ludlow, I was 140 pounds, I was yellow, really bad yellow, and people would like, just stay away from me. And my teeth were falling out of my head because I was all rotting out. I started seeing Dr. Lincoln, and I really didn't want to start seeing a doctor. I just wanted to get out of jail. And he was telling me that I needed to do all these tests to find out how deep a problem I had. He said, "We have to start you on some type of a program to get your health back" because that was number one. Because while I'm trapped there he said, "You might as well get things done." When I got out they let me out on a prerelease for a work release first and they said I had to go see a doctor for after care. And that doctor happened to be Dr. Lincoln. And my health now is probably excellent. And my life: I'm remarried, I've got seven grandchildren now with the eighth one on the way, I'm working a machine job. Things are going good. I do my own program outside…and I do keep in touch with Dr. Lincoln; he gave me his beeper number and cell phone too if I need him. Who does that, you know?
>
> – Walter Chlastawa, former inmate (Robert Wood Johnson Foundation 2008)

Over nine million Americans 18 and older were arrested in 2007, and over 7.3 million adults were under some form of correctional supervision, including probation, prison, jail, or parole (Federal Bureau of Investigation 2007; Bureau of Justice Statistics 2007). Many of these people cycle in and out of the correctional system. Each year, nearly 700,000 adults in federal and state prisons and more than seven million adults in local jails are released to their communities. Most are low-income men of color who are returning to cities and towns with high concentrations of poverty. They reenter their communities with major barriers to success. About half struggle with substance dependence or substance abuse. More than half experience mental illness. About 25 percent have serious health conditions such as AIDS, Hepatitis C, and tuberculosis (Greenberg et al. 2007). They frequently end up without work or in low-wage, sporadic jobs. Two-thirds of released prisoners are arrested again within three years, and about half return to prison.

The statistics for young people in the juvenile justice system are just as compelling. Nearly two million Americans under the age of 18 were arrested in 2007, and more than 95,000 were in juvenile correction facilities in 2006 (Federal Bureau of Investigation 2007; Office of Juvenile Justice and Delinquency Prevention 2008). Most offending youths are released after arrest, often returning to troubled families, stressed neighborhoods, and overwhelmed schools (Nissen et al. 2006). At least a decade of evidence has shown that these young people have numerous health problems. Approximately 80 percent of young people in the juvenile justice system have been found to be under the influence of alcohol or drugs while committing their crime, have tested positive for drugs, been arrested for committing an alcohol or drug offense, or have reported having substance abuse problems (National Center of Addiction and Substance Abuse at Columbia University 2004). Researchers have found that among youth in various types of juvenile justice settings, 50 to 65 percent meet criteria for one or more mental disorders (Grisso 2008). Studies report rates of post-traumatic stress disorder among youth in the juvenile justice system as high as 50 percent (Ford et al. 2007). Adolescents entering correctional care facilities have also been observed to be at high risk for physical health problems, including tuberculosis, dental caries, and sexually transmitted diseases (American Academy of Pediatrics Committee on Adolescence 2001).

Being incarcerated or detained can in and of itself be harmful to a person's health because of exposure to physical and sexual violence, substance use, communicable diseases, and social isolation. One example often pointed to is the practice of solitary confinement, which by some accounts is increasingly being used by correctional officials to maintain order in large, often overcrowded prisons. Recent research has found that while a brief stay in an isolated unit does not usually result in serious or permanent harm, more prolonged time in solitary can cause psychological problems, including psychosis and depression. According to one

estimate, 30 percent of people held in isolated units experience mental health problems, many of which are a direct result of being held without human contact (The Washington Post 2009; Gawande 2009).

From a public health perspective, the justice system would seem to be a perfect place for intervention because of the high number of high-risk people served. But "the justice system" is made up of innumerable separate systems with major differences in configuration, concerns, function, and influence (Gallagher and Dobrin 2007). Each of these systems also has its own funding stream and constraints about how those resources are used. It may seem logical that expanding access to health services for juveniles and adult offenders can help improve their health, well-being, and prospects, while at the same time transforming communities and protecting the nation's health, but accomplishing this goal will require major changes in policy and practice.

HEALTH & CRIMINAL JUSTICE

Jails and prisons are constitutionally required to provide medical and mental health care for millions of adults, most of whom are poor and many of whom enter correctional facilities with serious, unaddressed health needs. Some correctional facilities do a good job of meeting their obligation to provide health care. Others do not, and there are no federal regulations for the quality of health care provided by jails and prisons. The National Commission on Correctional Health Care sets standards for care, but prisons and jails can choose whether or not to follow these guidelines. The situation is worsened by the fact that correctional health care costs are high (since inmates have higher rates of infectious diseases and mental illness than the general population), and correctional health care is chronically underfunded (Commission on Safety and Abuse in America's Prisons 2006; View Associates 2006).

> ***Health care is [considered] a privilege except for two classes of Americans: people behind bars and Native Americans by treaty. For those two populations, health care is a right.***
>
> – ***Steven Rosenberg, Community Oriented Correctional Health Services***

In jurisdictions without sufficient or effective community-based mental health services, police often take people with mental illnesses to jail. It has been estimated that there are at least 350,000 mentally ill people in jail and prison each day; in some places, there are more mentally ill people in correctional facilities than in psychiatric hospitals (Commission on Safety and Abuse in America's Prisons 2006; View Associates 2006). When incarcerated, people struggling with mental illness may not obtain sufficient care. Many localities have been taking on this issue with joint strategies engaging both the criminal justice and mental health systems. One popular tool has been the Sequential Intercept Model, a conceptual framework for communities to organize targeted strategies for justice-involved individuals with serious mental illness (Figure 1). The model identifies five opportunities for intervention (law enforcement, initial detention/initial court hearings, jails/courts, reentry, and community corrections), and details action steps for service-level change at each stage. For example, strategies for improving law enforcement strategies include:

- training 911 dispatchers to identify calls involving persons with mental illness and refer to designated, trained respondents;
- training police officers to respond to calls where mental illness may be a factor;
- documenting police contacts with persons with mental illness;
- providing police-friendly drop off at a local hospital, crisis unit, or triage center;
- providing service linkages and follow-up services to individuals who are not hospitalized and to those leaving the hospital; and
- monitoring and evaluating services through regular stakeholder meetings for continuous quality improvement.

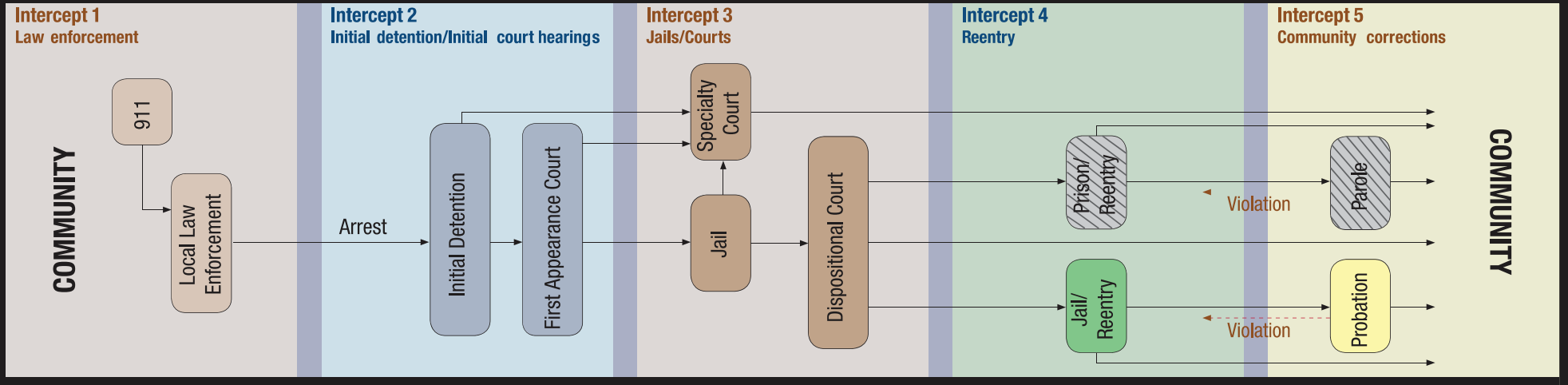
The model has been used by many states and communities to assess available resources, determine gaps in services, and plan for community change (CMHS National GAINS Center, 2009).

Another major problem is prison and jail inmates' lack of access to health insurance coverage. No U.S. correctional facility receives federal Medicaid or Medicare reimbursement for health services, even though most people in prison and jail would meet the programs' eligibility requirements and many were enrolled in the programs before they were incarcerated. States have the option of suspending or terminating Medicaid benefits while a person is in prison or jail. Allowing correctional facilities to receive federal Medicaid and

FIGURE 1: SEQUENTIAL INTERCEPTS FOR DEVELOPING CJ-MH PARTNERSIPS

Action for System-Level Change

- Develop a comprehensive state plan for mental health/ criminal justice collaboration
- Legislate task forces/commissions comprising mental health, substance abuse, criminal justice, and other stakeholders to legitimize addressing the issues
- Encourage and support collaboration among stakeholders through joint projects, blended funding, information sharing, and cross-training
- Institute statewide crisis intervention services, bringing together stakeholders from mental health, substance abuse, and criminal justice to prevent inappropriate involvement of persons with mental illness in the criminal justice system
- Take legislative action establishing jail diversion programs for people with mental illness
- Improve access to benefits through state-level change; allow retention of Medicaid/SSI by suspending rather than terminating benefits during incarceration; help people who lack benefits apply for same prior to release
- Make housing for persons with mental illness and criminal justice involvement a priority; remove constraints that exclude persons formerly incarcerated from housing or services
- Expand access to treatment; provide comprehensive and evidence-based services; integrate treatment of mental illness and substance use disorders
- Expand supportive services to sustain recovery efforts, such as supported housing, education and training, supportive employment, and peer advocacy
- Ensure constitutionally adequate services in jails and prisons for physical and mental health; individualize transition plans to support individuals in the community
- Ensure all systems and services are culturally competent, gender specific, and trauma informed – with specific interventions for women, men, and veterans



Action Steps for Service-Level Change at Each Intercept

- ***911:*** Train dispatchers to identify calls involving persons with mental illness and refer to designated, trained respondents
- ***Police:*** Train officers to respond to calls where mental illness may be a factor
- ***Documentation:*** Document police contacts with persons with mental illness
- ***Emergency/Crisis Response*** Provide police-friendly drop off at local hospital, crisis unit, or triage center
- ***Follow Up:*** Provide service linkages and follow-up services to individuals who are not hospitalized and those leaving the hospital
- ***Evaluation*** Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement

- ***Screening:*** Screen for mental illness at earliest opportunity; initiate process that identifies those eligible for diversion or needing treatment in jail; use validated, simple instrument or matching management information systems; screen at jail or at court by prosecution, defense, judge/court staff or service providers
- ***Pre-trial Diversion:*** Maximize opportunities for pretrial release and assist defendants with mental illness in complying with conditions of pretrial diversion
- ***Service Linkage:*** Link to comprehensive services, including care coordination, access to medication, integrated dual disorder treatment (IDDT) as appropriate, prompt access to benefits, health care, and housing; IDDT is an essential evidence-based practice (EBP)

- ***Screening*** Inform diversion opportunities and need for treatment in jail with screening information from Intercept 2
- ***Court Coordination:*** Maximize potential for diversion in a mental health court or non-specialty court
- ***Service Linkage:*** Link to comprehensive services, including care coordination, access to medication, IDDT as appropriate, prompt access to benefits, health care, and housing
- ***Court Feedback:*** Monitor progress with scheduled appearances (typically directly by court); promote communication and information sharing between non-specialty courts and service providers by establishing clear policies and procedures
- ***Jail-Based Services:*** Provide services consistent with community and public health standards, including appropriate psychiatric medications; coordinate care with community providers

- ***Assess*** clinical and social needs and public safety risks; boundary spanner position (e.g., discharge coordinator, transition planner) can coordinate institutional with community mental health and community supervision agencies
- ***Plan*** for treatment and services that address needs; GAINS Reentry Checklist (available from http://www.gainscenter.samhsa.gov/html/resources/reentry.asp) documents treatment plan and communicates it to community providers and supervision agencies – domains include prompt access to medication, mental health and health services, benefits, and housing
- ***Identify*** required community and correctional programs responsible for post-release services; best practices include reach-in engagement and specialized case management teams
- ***Coordinate*** transition plans to avoid gaps in care with community-based services

- ***Screening:*** Screen all individuals under community supervision for mental illness and co-occurring substance use disorders; link to necessary services
- ***Maintain a Community of Care:*** Connect individuals to employment, including supportive employment; facilitate engagement in IDDT and supportive health services; link to housing; facilitate collaboration between community corrections and service providers; establish policies and procedures that promote communication and information sharing
- ***Implement a Supervision Strategy:*** Concentrate supervision immediately after release; adjust strategies as needs change; implement specialized caseloads and cross-systems training
- ***Graduated Responses & Modification of Conditions of Supervision:*** Ensure a range of options for community corrections officers to reinforce positive behavior and effectively address violations or noncompliance with conditions of release

Source: adapted from CMHS National GAINS Center 2009

JAIL VERSUS PRISON

Jails primarily house people who are not yet convicted of a crime and those with sentences of one year or less. Incarcerations typically average two months (and can be as little as 24 to 48 hours). Once a person is convicted, he or she is sent to a state or federal prison where the median length of incarceration is 2.5 years. The approach to health care changes depending on where within the system an inmate is. Though jails have more of a community setting, prisons allow for better continuity of care because inmates are there for longer periods and release dates are known, which allows for better prerelease planning. However, because of barriers to working within prisons, jail-focused initiatives may be a more logical place for health funders to intervene, even though the lack of set release dates makes it much harder to do discharge planning or provide continuity of care. Barriers to working within prisons include: geographic challenges, the bureaucratic complexity and politics associated with prison contracts, the difference in health care needs of those in jails (who tend to be younger) and those in prisons (who tend to be older), and issues associated with public perceptions of prisoners as hardened criminals.

Excerpted from: View Associates, *Philanthropic Opportunities in Correctional Health Care* (New York, NY: The Jacob and Valeria Langeloth Foundation, 2006).

Medicare reimbursements might improve the likelihood of inmates receiving quality correctional health care. Convincing states to suspend rather than terminate benefits during incarceration would definitely improve continuity of care since many ex-offenders have no way to pay for their doctors' appointments or medicine until they are reenrolled in Medicaid or Medicare weeks or months after release (Commission on Safety and Abuse in America's Prisons 2006; View Associates 2006).

> ***It is important to remember [that] mental illness is not in and of itself a crime.***
>
> ***– Chris Koyanagi, Judge David L. Bazelon Center for Mental Health***

The scarcity of skilled, committed, and compassionate medical and mental health providers poses another barrier to quality, accessible correctional health care. One promising solution is for prisons and jails to partner with public health agencies and community health professionals, which increases the number of qualified providers and improves chances that people will continue to receive disease treatment and preventive care when they return home (Commission on Safety and Abuse in America's Prisons 2006). Counties across the country are beginning to build this link between corrections and communities, developing a new model of correctional health care that includes several key elements:

- recognition of incarcerated people and ex-offenders as displaced members of a community,
- strong partnerships among a wide range of stakeholders,
- discharge planning begun well in advance of release and continued planning during the post-release phase,
- personal contact between inmates and community organizations that builds rapport before release and has ongoing involvement,
- strong case management and outreach,
- colocation of health practitioners and case managers, and
- operational support for cross-discipline work (View Associates 2006).

The emphasis on discharge planning and ongoing relationships between released inmates and community organizations is an attempt to address the growing concern that people leaving prison find themselves permanently marginalized. The number of people released from prison has increased by 350 percent over the last 20 years (View Associates 2006). These people are released with limited job prospects, complex health needs, pressing family responsibilities, and little community supervision.

Ordinarily, people in need of basic resources, opportunities, and services turn to the public sector for aid. In this case, however, government policies can be more of a hindrance than a help. Public policies restrict ex-offenders' ability to vote, apply for jobs, secure housing, and apply for public assistance. In effect, these policies continue retribution after a person's release from prison or jail and produce a group of people who are forever categorized as ineligible for public support (Moritsugu 2007; Pogorzelski et al. 2005).

So what can help people successfully integrate into the community? Studies have shown that having a job and having health insurance after release reduce recidivism, drug use, and crime (Freundenberg et al. 2005). Programs across the country are developing and testing interventions that make coming home from jail an occurrence that rebuilds rather than disturbs individuals, families, and communities. So far, the characteristics of innovative reentry models seem to be:

- a strong mission to prepare inmates for successful reentry,
- demonstrated leadership by both correctional and health care agencies in support of the program,
- a holistic perspective to successful reentry,
- a long-term commitment spanning at least 5 to 10 years,
- commitment to reentry and transitional health as manifested in program operating budgets,
- intensive reentry planning and focus in the last three to six months before release,
- individual accountability by each inmate for his or her success upon returning home, and
- geographic proximity of facilities to the communities to which former inmates will return (View Associates 2006).

At the federal level, the Second Chance Act is legislation developed to help ex-offenders who are returning to their communities. Signed into law in April 2008, the Second Chance Act permits federal grants to government agencies and nonprofit organizations to be used for employment assistance, substance abuse treatment, housing, family programming, mentoring, victims support, and other services that can help reduce recidivism. One section of the act authorizes grants to state and local governments and Indian tribes for reentry demonstration projects. Funding under this section is available to help state and local agencies implement programs and strategies to reduce recidivism and ensure the safe and successful reentry of individuals released from prisons and jails. In fiscal year 2009, $15 million was available for reentry demonstration projects under the act. Another section of the act authorizes the U.S. Department of Justice to make grants to nonprofit organizations and Indian tribes for the purpose of providing mentoring and transitional services essential to reintegrating individuals released from prisons or jails into the community. In fiscal year 2009, $10 million was available for mentoring programs under the act (Reentry Policy Council 2009).

FOUNDATION GRANTS AND INITIATIVES

Grantmakers across the country are supporting a range of innovative programs and policy change efforts that address the health of adults in the criminal justice system by addressing substance use disorders and severe mental illnesses, linking correctional and community health, reintegrating returning prisoners, lending support to families of the incarcerated, and advocating for policy change.

➤ ***Addressing Substance Use Disorders and Severe Mental Illnesses in the Criminal Justice System*** – Since its creation in 1997, The Health Foundation of Greater Cincinnati has invested almost $30 million

in projects that address substance use disorders and severe mental illnesses. Of this, the foundation has invested $9 million in projects specifically addressing how people with these conditions interact with the criminal justice system. Between 1999 and 2007, the foundation made 74 grants in its Substance Use Disorders and Severe Mental Illnesses in the Criminal Justice System initiative to organizations, including local mental health and substance use disorder treatment providers, state departments of corrections, local funding boards, churches, and residential substance use disorder treatment centers (The Health Foundation of Greater Cincinnati 2009).

From grantee reports submitted to the foundation, staff and trustees have begun to see what effects their investments are having in the community. They have also started to reflect on what makes it easier for the initiative's grantees to succeed:

- planning grants,
- technical assistance,
- strong leadership and collaboration from all systems,
- a focus on sustainability from the beginning,
- cross-system training,
- boundary spanners to bring the systems together, and
- exposure to national activities.

Additionally, they have been reflecting on what makes it more difficult for grantees to succeed:

- poor relationships, mistrust, and no joint ownership of the problem;
- data collection challenges; and
- scarce resources.

In late 2007 the foundation's board of directors approved three additional years of funding in the initiative, through 2010. The foundation staff is designing a six-year prospective study of grants awarded between 2008–2010, which will provide valuable information on how the initiative is affecting the lives of the people it was designed to serve. The foundation will publish the findings of the study as they become available.

➤ ***Linking Correctional and Community Health*** – In 1996 the Hampden County Jail and House of Corrections began to contract for medical services with four nonprofit neighborhood health centers in greater Springfield, Massachusetts. The contract began what became an innovative model: when an inmate was diagnosed, his home zip code was matched with the community health center closest to his home and he was assigned to a dually based physician and case manager. Health center medical staff provided treatment for jail inmates and continued that treatment at the health center upon the inmate's release. In essence, the correctional center became the entry point into the health care system (COCHS 2009a).

In 2006 the Robert Wood Johnson Foundation (RWJF) took notice of the Hampden County program and created Community Oriented Correctional Health Services (COCHS) to assist jurisdictions that want to connect their local correctional facilities and their community-based health services. COCHS, which also receives programmatic support from The Jacob and Valeria Langeloth Foundation and The California Endowment, is currently working with two sites, one located in Ocala, Florida, and the other in Washington, DC (COCHS 2009a).

The COCHS model provides continuity of care for a vulnerable population, with benefits for correctional facilities and health centers. For jails, the approach:

- provides an alternative correctional health care option to proprietary health care providers;

- allows taxpayer dollars to stay in the community;
- provides a service similar in cost to current correctional health care systems;
- provides a health care system that meets community standards;
- focuses on long-term disease prevention and cost reductions; and
- has the potential to lower pharmacy costs through the 340(b) program, which provides discounted prescription drugs to certain federally qualified health centers and disproportionate share hospitals (COCHS 2009b).

For community health centers the approach helps meet the mission of providing quality care to some of the most underserved and disenfranchised people in the community and expands the patient base.

➤ ***Reintegrating Returning Prisoners*** – The Jacob and Valeria Langeloth Foundation is interested in projects that seek to improve the health (physical, mental, substance abuse) of inmates during their time of incarceration and as they transition back to their home communities. In 2008 the foundation made three large grants focused on prisoner reentry. A $200,100 grant to The New York Academy of Medicine supports the Prison Health Reentry Initiative. A working group of state agencies, health care organizations, and community-based organizations will convene to recommend policy and programmatic changes to support health reentry planning and linkages to high-quality care. The project focuses on three related goals: 1) improving the ability of prisoners to access and navigate the health care system upon reentry by enhancing their health systems literacy, 2) insuring that eligible prisoners are enrolled in Medicaid upon release, and 3) developing a model pilot program to link prisoners with chronic conditions to comprehensive care upon release. As a first step toward enabling health linkages for all New York State releasees, the group is developing a blueprint for access to care for those with chronic conditions like cardiovascular disease, cancer, asthma, and diabetes (The Jacob and Valeria Langeloth Foundation 2009).

One key concern among those working to reform the justice system is the overrepresentation of people of color in the system. A $299,999, three-year Langeloth Foundation grant was made to the Arthur Ashe Institute for Urban Health (AAIUH) to assess: 1) real and perceived barriers to health care among recently released low-income minority prisoners, 2) community attitudes toward health issues facing the target population, 3) existing community resources serving health needs of ex-prisoners, and 4) best strategies for distributing information and providing health intervention activities to the target population. In conducting the program, AAIUH will call upon its experience in providing health interventions in alternative venues (for example, minority-owned beauty salons and barbershops) and using trained lay health educators from these businesses to provide ongoing post-intervention outreach and information (The Jacob and Valeria Langeloth Foundation 2009).

> ***I've become increasingly skeptical of programs as the solution to reentry issues. I don't think any set of services by itself is going to dramatically change outcomes if they aren't matched with policy change that creates a supportive environment that lets people succeed when they get out (Bunch 2008).***

Many ex-offenders are homeless upon release. A $191,000, three-year Langeloth Foundation grant to the Corporation for Supportive Housing supports an evaluation of the Frequent Users of Jail and Shelter Initiative (which places individuals into permanent housing in an attempt to break their institutional circuit between jail, shelter, emergency health, and other public systems) by Columbia University's Center for Homelessness Prevention Studies. The center is using a combination of direct structured interviews and administrative data analysis to determine the program's effects on homelessness, incarceration, and health outcomes (The Jacob and Valeria Langeloth Foundation 2009).

- ***Lending Support to Families of the Incarcerated*** – The families of people in jail and prison often face complex challenges and are even more at risk once a family member is incarcerated. Assisting these families and including them in the planning for an inmate's return often requires the involvement and coordination of a number of community organizations. In 1999 an estimated 1.5 million children had a parent in prison (Moritsugu 2007; View Associates 2006). In 2008, Grantmakers for Children, Youth, and Families (GCYF) received a major grant from The Annie E. Casey Foundation to create a learning initiative for grantmakers on children of incarcerated parents. Over the course of the year, Beyond the Bars: A Learning Initiative on Children with Incarcerated Parents provided a variety of opportunities for GCYF members to learn more about this issue and, more specifically, what roles foundations can take and are taking on behalf of this vulnerable population. With additional support from Women's Foundation of California and The California Endowment, major findings from this yearlong learning journey have been synthesized in *Beyond the Bars: Foundation Investment on Behalf of Children of the Incarcerated*.

- ***Advocating for Policy Change*** – In 1998 the W.K. Kellogg Foundation helped launch Community Voices: Health Care for the Underserved as a pilot program to create greater health care access at the local level and give the underserved a louder "voice" in the national debate on health care access. The eight Community Voices sites (Albuquerque, New Mexico; Baltimore, Maryland; Denver, Colorado; Lansing, Michigan; Miami, Florida; New York, New York; Oakland, California; Pinehurst, North Carolina) are community-based demonstration projects that function as learning laboratories that identify access problems and test policy solutions at the local level.

  A number of Community Voices sites have taken on the issue of prisoner reentry, and the Community Voices program office at the Morehouse School of Medicine National Center for Primary Care has been at the forefront of efforts to raise the visibility of the men and women, disproportionately poor and African American, who live with the residual effects of imprisonment. In 2005, Community Voices helped develop a special theme issue of the *American Journal of Public Health*, which focused on prisons and health. In 2006, Community Voices released the report *Where are the Men?: The Impact of Incarceration and Reentry on African American Men and Their Children and Families* and, with the National Academy for State Health Policy, convened a cross-sectoral working group to develop an action agenda for connecting prisoners reentering the community to health services.

HEALTH & JUVENILE JUSTICE

In many ways, young people involved in the justice system are similar to other youth that foundation-funded programs hope to reach (Youth Transition Funders Group 2006). They often have a family background that includes abuse or neglect, unmet mental health and substance abuse needs, low family income, a limited or uneven history with the health care system, and probable eligibility for public insurance programs (National Academy for State Health Policy 2008). In fact, many young people in contact with the justice system are also in contact with several other public systems such as Medicaid, special education programs, foster care, or child protective services (Clark and Gehshan 2006).

A high percentage of young people who enter the juvenile justice system return to it after release. It is very difficult to estimate the juvenile recidivism rate due to the variation among methods used by juvenile justice systems in each state, but the Bureau of Justice Statistics has estimated that 80 percent of young people who were released from juvenile justice institutions in 1994 were rearrested (Clark and Gehshan 2006). And no experience may be more predictive of future adult difficulty than having been confined in a secure juvenile facility (Youth Transition Funders Group 2006). Being in detention, jail, or prison disconnects young people from their communities, damages their family relationships, and makes it enormously challenging for them to go back to school or find a quality job (New York City Commission for Economic Opportunity 2006).

The juvenile justice system is undergoing major reform, with the most advanced jurisdictions working to decrease institutionalization and treating youth detention as a last resort (Youth Transition Funders Group 2006). Although providing health services helps juveniles in detention centers, the challenge remains to provide services for young probationers who are not in such facilities. In the end, more youth may be missed than served (Gallagher unpublished).

There are several other obstacles to providing adequate health care to youth in the justice system. First, youth arriving in the system are often medically underserved, with inaccurate medical histories; undiagnosed medical conditions; and incomplete preventive care, such as immunizations. Second, the justice system is not designed to be a health service provider, and gaining access to and time with youth is often difficult for medical teams. Third, it is often unclear who is responsible for medical decisionmaking for young people, which becomes important when consent is required to authorize treatment. Fourth, juveniles in the system face the same challenges as adults when it comes to obtaining and retaining Medicaid coverage (Gallagher unpublished). Finally, like the adult system, the juvenile justice system often becomes the default institution for youth whose chief issues include emotional illnesses, developmental problems, and substance abuse. These youth are in desperate need of alternatives (Youth Transition Funders Group 2006).

Like adults, young people who come into contact with the justice system need to be connected (or reconnected) to community-based support services when they leave the system. The most promising reentry programs call for synchronization between several public and private agencies. Upon release, young people should be assisted in enrolling in school, entering the job market, accessing mental health and substance abuse services, and reconnecting with supportive family and mentors (Youth Transition Funders Group 2006).

A BLUEPRINT FOR JUVENILE JUSTICE REFORM

Nine Tenets for Improving Outcomes for Youth

1. Reduce institutionalization.
2. Reduce racial disparity.
3. Ensure access to quality counsel.
4. Create a range of community-based programs.
5. Recognize and serve youth with specialized needs.
6. Create smaller rehabilitative institutions.
7. Improve aftercare and reentry.
8. Maximize youth, family, and community participation.
9. Keep youth out of adult prisons.

Source: Youth Transition Funders Group, *A Blueprint for Juvenile Justice Reform* (Chicago, IL: Spring 2006).

FOUNDATION GRANTS AND INITIATIVES

Grantmakers across the country are supporting a range of innovative programs and policy change efforts that address the health of young people in the juvenile justice system by increasing diversion and developing the workforce; helping teens overcome drugs, alcohol, and crime; identifying and addressing the health needs of girls entering the justice system; and intervening during detention and probation.

- ***Increasing Diversion and Developing the Workforce*** – The John D. and Catherine T. MacArthur Foundation's $100 million Models for Change initiative is attempting to create model juvenile justice systems in four states: Illinois, Louisiana, Pennsylvania, and Washington. Each Models for Change state has a work plan that includes specific steps to bring about reform in physical and mental health. The premise of the foundation's juvenile justice work is that young people need a system that offers redemptive options and supportive services, and that such a system will improve youth outcomes, lower crime rates, and be cost effective (Models for Change 2009).

  MacArthur's grantees collaborate with national experts and each other in action networks devoted to accelerating reform on particular issues. The Mental Health and Juvenile Justice Action Network was established in 2007 to forge and implement innovative solutions to better identify and treat youth with mental health needs in the juvenile justice system. The network is an issue-focused forum for the development and exchange of ideas and strategies across states and for sharing practical information and expertise in support of reform. Ultimately, the action network is working to create a leadership community that will guide other states and shape nationwide responses.

  > ***Programs don't reclaim kids. Family and community do... Programs don't change people. Relationships do.***
  >
  > ***— Laura Burney Nissen, Portland State University***

  Teams from each of the action network states collaborate on one of two "strategic innovation" areas: 1) front-end diversion or improving ways to identify youth with mental health needs and divert them into treatment as early in the process as possible, and 2) education and training or enhancing community education and training to recruit and retain staff better equipped to work with the large numbers of youth with mental health needs involved with the juvenile justice system (Models for Change 2009).

  In addition to the four core Models for Change states, the Mental Health and Juvenile Justice Action Network includes four other states (Connecticut, Colorado, Ohio, and Texas) selected for their commitment to reform (Models for Change 2009).

- ***Helping Teens Overcome Drugs, Alcohol, and Crime*** – Launched by the Robert Wood Johnson Foundation (RWJF) with a $21 million investment in 2001, Reclaiming Futures is a national initiative that helps young people in trouble with drugs, alcohol, and crime. Communities using the Reclaiming Futures model screen and assess teens entering the juvenile justice system for drug or alcohol problems, match young people to clinical services and positive community opportunities, and provide care coordination and community support.

  Ten communities across the country developed and then pilot-tested Reclaiming Futures' integrated, community partnership model for addressing the pervasive challenges of substance abuse among juvenile offenders. Community leadership teams worked to reengineer policies and fashion new service approaches for young people in the justice system. Evaluation results suggest that the Reclaiming Futures approach is a promising method, which allows the juvenile justice system to ensure that youths receive help in a timely manner (Nissen et al. 2006).

  In addition to the 10 pilot projects, by 2010 the Reclaiming Futures model will be in 26 communities due to new investments by RWJF, the federal Office of Juvenile Justice and Delinquency Prevention, and The Kate B. Reynolds Charitable Trust.

- ***Identifying and Addressing the Health Needs of Girls Entering the Justice System*** – Girls are the fastest growing segment of the juvenile justice system nationally, yet until recently no systematic assessment tools or medical standards existed to meet the health needs of this population. To address this issue, the National Girls Health and Justice Institute created the Girls Health Screen (GHS), the first gender-responsive, computer-based health assessment tool for girls in detention. With support from The Henry J. Kaiser Family Foundation, The Jacob and Valeria Langeloth Foundation, and the Stoneleigh Center, GHS has been tested in three juvenile detention facilities. Research findings show a strong and statistically significant correlation between self-reported medical issues and those surfacing in a physical exam. Furthermore, the use of GHS identified several critical and untreated health needs. The National Girls Health and Justice Institute is currently launching the implementation phase of the project, embedding an electronic version of GHS in select detention sites across the country and working with them to develop a comprehensive electronic health passport for girls in the juvenile justice system (Acoca 2009; Dutton 2009).

- ***Intervening During Detention and Probation*** – According to California data, half of the young people incarcerated in the state's Division of Juvenile Justice will be rearrested within two years of release (Center Scene 2007). What happens to juvenile offenders during and after their incarceration is the focus of The California Endowment's four-year, $6.5 million Healthy Returns Initiative, which is working with five county probation departments to improve access to health and mental health services for adolescents in detention facilities and to ensure continuity of care upon their release. The initiative is working closely with probation departments to forge partnerships with county mental health departments, community-based health care providers, schools, and family members. Launched in 2005, the project provides four-year planning and implementation grants designed to strengthen the capacity of probation departments in Santa Clara, Santa Cruz, Ventura, Humboldt, and Los Angeles counties.

  The five counties were selected based on criteria that included the probation department's interest in and readiness to address health and behavioral health issues, and willingness of probation department leadership, juvenile court judges, and boards of supervisors to support the initiative's goals. The five counties also reflect diversity among California's rural and urban communities, and among racial, ethnic, and cultural populations that are frequently disproportionately involved in the juvenile justice system.

  Preliminary evaluation results are encouraging and include a substantial increase in the capacity of juvenile hall counselors and probation officers to recognize and address mental disorders and other health problems, increased efforts to enlist families and community-based resources in case planning and follow-up services, increased collaboration among public agencies, and pushing boundaries regarding the financing of new aftercare models (Center Scene 2007).

OPPORTUNITIES & LESSONS LEARNED

The goal of funders working at the intersection of health and justice is for their investments to pay off, not only in helping people become healthy, productive, stable citizens, but also in reducing recidivism and its accompanying costs to society. There are several opportunities and lessons learned for health funders considering this area of work.

OPPORTUNITIES FOR GRANTMAKERS

- ***Help communities understand the problem.*** Provide funding to match data from health, justice, mental health, shelter, and substance abuse systems and take an in-depth look at who the high users of services are in order to identify the people who are cycling through the system.
- ***Help convene necessary – often reluctant – stakeholders and allies.*** Pull together a cross-sectoral group of people who are willing to extend themselves in order to collaborate on a comprehensive approach, and work to build their buy-in and commitment. Make sure that consumers and their families are included in planning processes.
- ***Work to strengthen the public behavioral health system.*** As important as it is to link mental health and substance abuse interventions with the justice system, we do not want people to have to rely on the justice system alone to get screening or treatment. Support public investment in community-based mental health and substance abuse programs, which will help ensure that people avoid justice involvement unless necessary and can be referred to community programs upon release from jail or prison.
- ***Bring innovative programs to scale.*** Help translate research into practice by investing in the (often expensive) implementation of evidence-based practices and – just as importantly – reducing the funding of models that are not effective. Encourage practitioners to adopt and adapt models that work.
- ***Help manage public perceptions.*** Often, diversion programs are viewed by the public as allowing people to get off easily, and reentry programs are viewed as rewarding those who break the law. Support community conversations and public campaigns that raise public awareness about the benefits of such policies and programs.
- ***Invest in "in-reach" activities.*** Think of people in jails and prisons as displaced community members, and invest in programs that improve their health and connect them to services, their families, and community institutions.
- ***Use foundation funding to build a bridge between fragmented programs or funding streams.*** Supplement public funding by including components in programs that would otherwise be unfunded so that they can address the comprehensive needs of the population, with the goal of creating continuity of care.
- ***Support training.*** Provide funding for cross-system training for members of the health, justice, mental health, and substance abuse systems to help them understand each other's languages, cultures, goals, and priorities and to help cement their relationships.
- ***Be intentional about collaborating with government.*** In many cases, philanthropy and government are sectors that share the same interests, focus on the same target populations, and share the same goals. Find opportunities to share information about programs and policies that government agencies might support.
- ***Help document actual or potential savings from different kinds of interventions.*** Develop ideas to help states suffering from severe budget constraints get more value from their dollars by helping them identify strategies for shifting funding from incarceration and detention to prevention and community supports.

OPPORTUNITIES FOR COLLABORATION

Interested in connecting with funders with experience and expertise in the criminal and juvenile justice systems?

- The Youth Transition Funders Group (YTFG) is a network of grantmakers whose mission is to help all youth make a successful transition to adulthood by age 25. YTFG's Juvenile Justice Work Group is comprised of regional and national grantmakers working across fields of justice, education, foster care, and mental health. Members of this work group are committed to funding systems and programs that serve justice-involved youth, seizing opportunities to reduce harm, address fairness, promote public safety, and save taxpayers dollars. The goal of the work group is to make the links between fields more explicit so that more foundations can engage in this work as a logical extension of existing guidelines.

  Visit www.ytfg.org for more information.

- A group of funders has come together to create the Criminal Justice Funders Network. The group's initial project is to map philanthropic investments in the U.S. criminal justice sector and strengthen donor linkages. The project seeks to provide funders and others in the criminal justice sector with a useful snapshot of investments into the U.S. criminal justice sector by philanthropic sources. A corollary objective of the mapping project is to strengthen and expand the connectivity of criminal justice funders.

  More for more information, contact Deborah Drysdale at ddrysdale1@mac.com or Lenny Noisette at l.noisette@sorosny.org.

➤ ***Recognize that there are opportunities for noncriminal justice funders to invest in these issues.*** There are opportunities for funders with an interest in women's health, children's health, family health, behavioral health, and disease-specific issues to engage with this work.

LESSONS LEARNED BY GRANTMAKERS

➤ ***Recognize the overlapping issues plaguing people involved in the justice system.*** People suffering from mental illness, substance abuse, and trauma benefit from policies and programs that address all three.

➤ ***Insist on careful planning and evaluation.*** Consider requiring a clear planning process that involves a cross-section of stakeholders; uses a formal facilitator; and includes a needs assessment, literature review, visits to model programs, and a business plan. Be prepared to provide extensive technical assistance.

➤ ***Think differently about sustainability.*** Encourage grantees to build their programs into the infrastructure of existing systems so that they become part of everyday practice.

➤ ***Recruit partners with different strengths to play different roles.*** Effective cross-system collaboration requires powerful, respected leaders, often judges, who can drive projects; cheerleaders, who are excited, encouraging, and positive; bulldogs, who are persistent and dedicated to working with difficult populations; and boundary spanners, who can negotiate several systems and are diplomatic problem solvers.

➤ ***Think about health and justice work as a social movement, as well as an initiative.*** Help support a movement for social change by supporting policy and advocacy work, not just programmatic work. Social change often requires more disruption of the status quo than initiatives are designed to achieve (Figure 2).

➤ ***Engage in conversations about what it means to design culturally relevant programs and policies.*** Cultural competence trainings, strategies, and plans have been implemented in mental health, substance abuse, and justice-based programs for years, but have not yet resulted in a durable change in racial/ethnic disparities. This suggests that cultural competence work is only a first step in dismantling oppressive infrastructure.

FIGURE 2: JUXTAPOSING GOALS OF INITIATIVES VS. MOVEMENTS

INITIATIVE	MOVEMENT
Implementing programs	Action on social problems
Development of standards	Development of advocacy
Systems change	Social change
Professionally-driven (managed)	Grassroots-driven (managed)
Building organizations	Building networks and alliances
Coalescing to a plan	Disrupting disparities and oppression
Implementing and improving	Agitating and mobilizing
Implementation science	Political science

Source: Nissen 2009

- ***Be mindful of the common themes across all justice-involved populations, while paying attention to the distinctions.*** While many of the individuals in the justice system face similar barriers, such as behavioral health issues and lack of access to insurance coverage, they are not all the same. Pay attention to the special needs of children, adults, boys, girls, men, women, rural, and urban, and make explicit the disproportional impact of justice involvement on people and communities of color.
- ***Focus on multiple levels of intervention.*** Keep in mind that the ultimate goal should be upstream strategies that prevent entrance into the justice system. Recognize the importance of housing, education, employment, safe environments, health and mental health care, protection from trauma and abuse, and the community service infrastructure.

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