Care of Justice-Involved Populations

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Conflict of Interest

- I have no relevant financial relationships to disclose.

Presentation Objectives

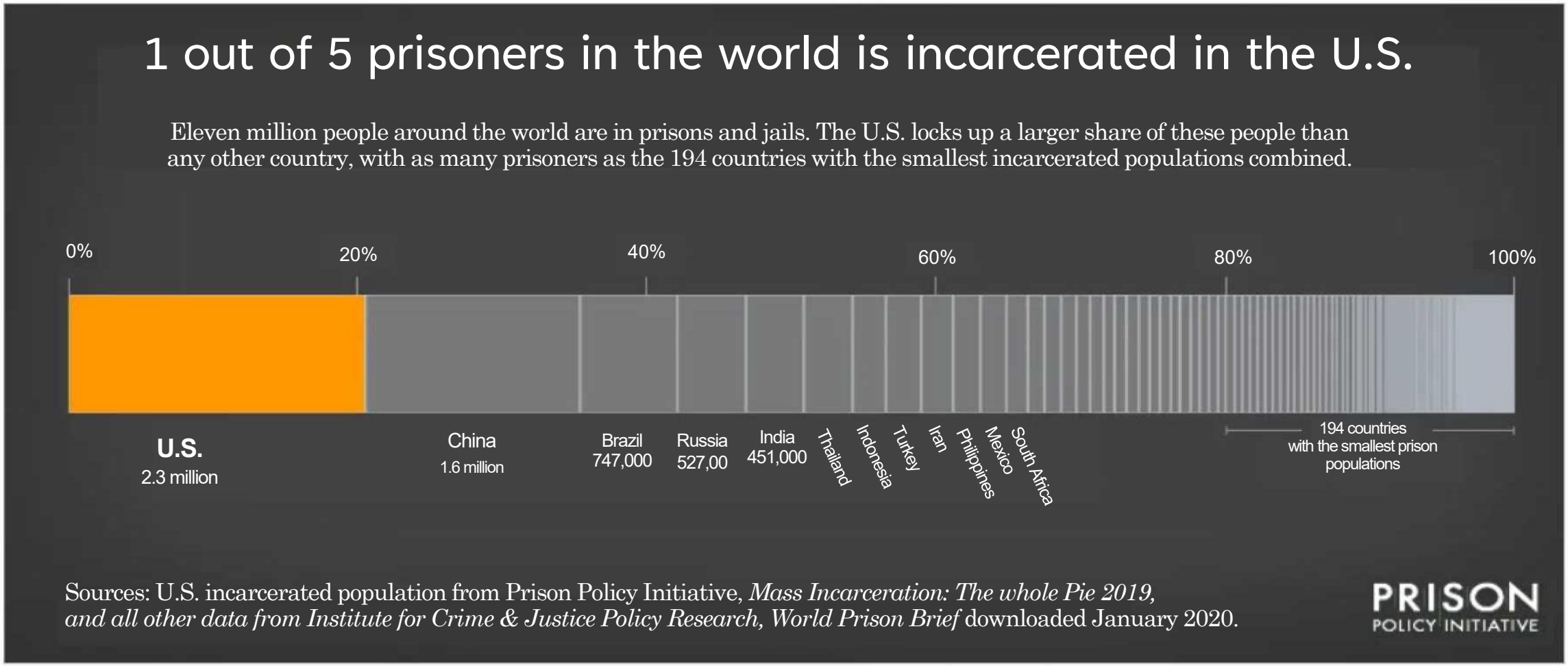
- Define terms related to justice-involved populations
- Describe demographics of justice-involved populations
- Identify common medical and psychiatric comorbidities in justice-involved populations
- Apply concepts presented to provide high quality primary care in justice involved populations.

Definitions

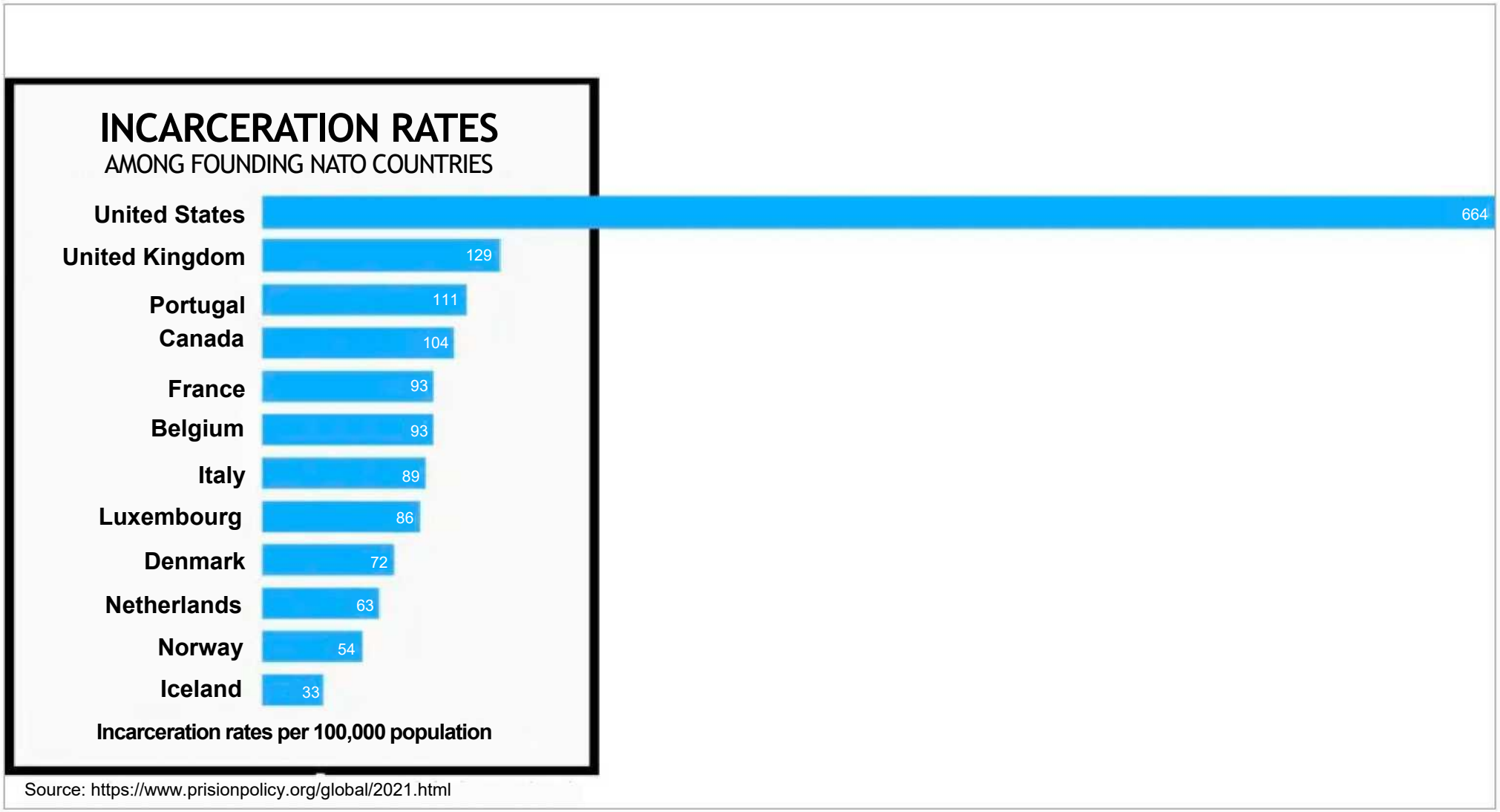
- Justice-Involved Person: Non-specific term for a person who is/has been involved with the justice system through incarceration, probation, attendance at court-ordered classes, etc.
- Incarcerated: nonspecific term which refers to a person confined to a jail, prison, or other institution
- Inmate: a person confined in a correctional facility (preferred term: incarcerated person)[1]
- Jails: a local facility under municipal or county jurisdictions that houses persons awaiting trial, sentencing, or transfer to another facility and some individuals who have been sentenced to less than a year in custody
- Prison: A federal or state facility that generally houses persons who have been sentenced to greater than one year in custody.

1. https://www.ncchc.org/filebin/Positions/Use-of-Humanizing-Language-in-Correctional-Health-Care-2021.pdf1.

The U.S. Incarcerates More People than ANY Other Country

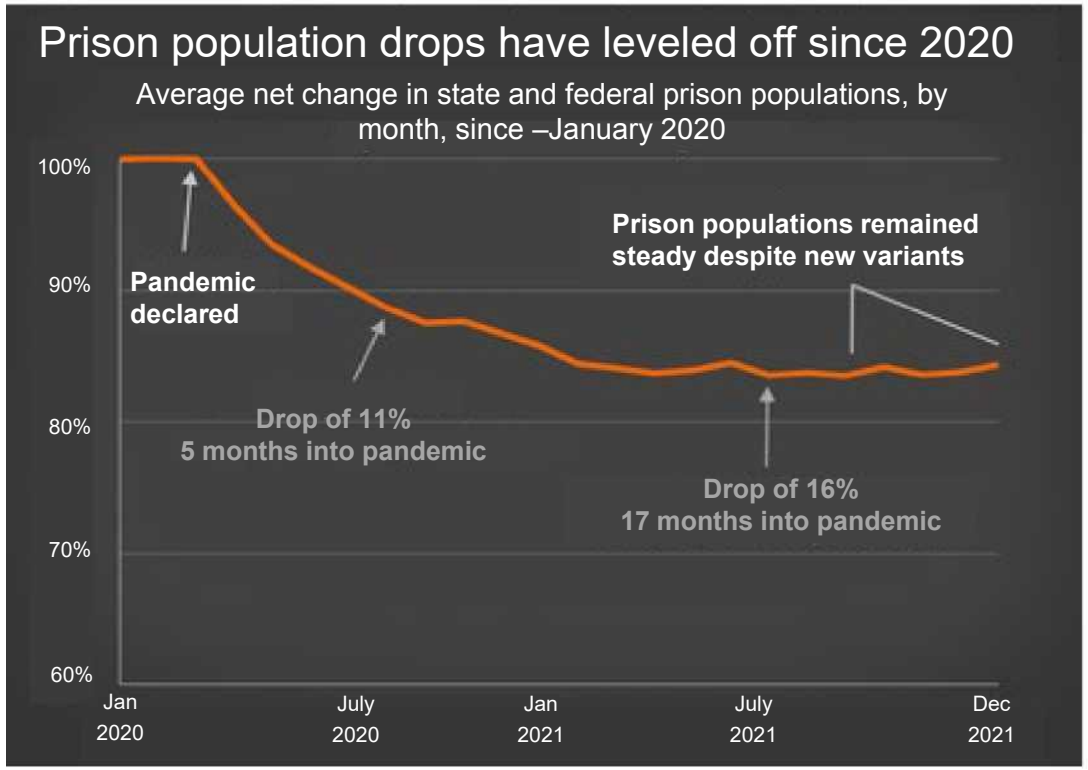


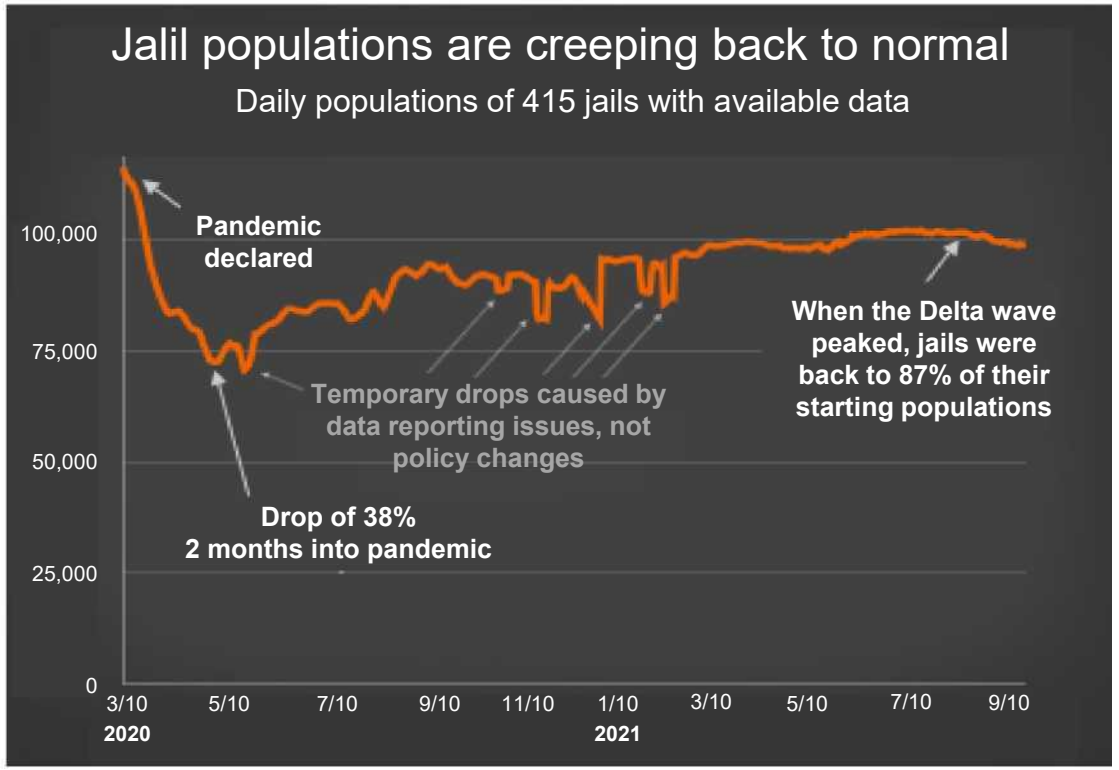
US Incarceration Rates Eclipse the Rates of other NATO Countries



Source: https://www.prisionpolicy.org/global/2021.html

Pandemic-Related Population Changes





https://www.prisonpolicy.org/reports/pie2022.html#covid

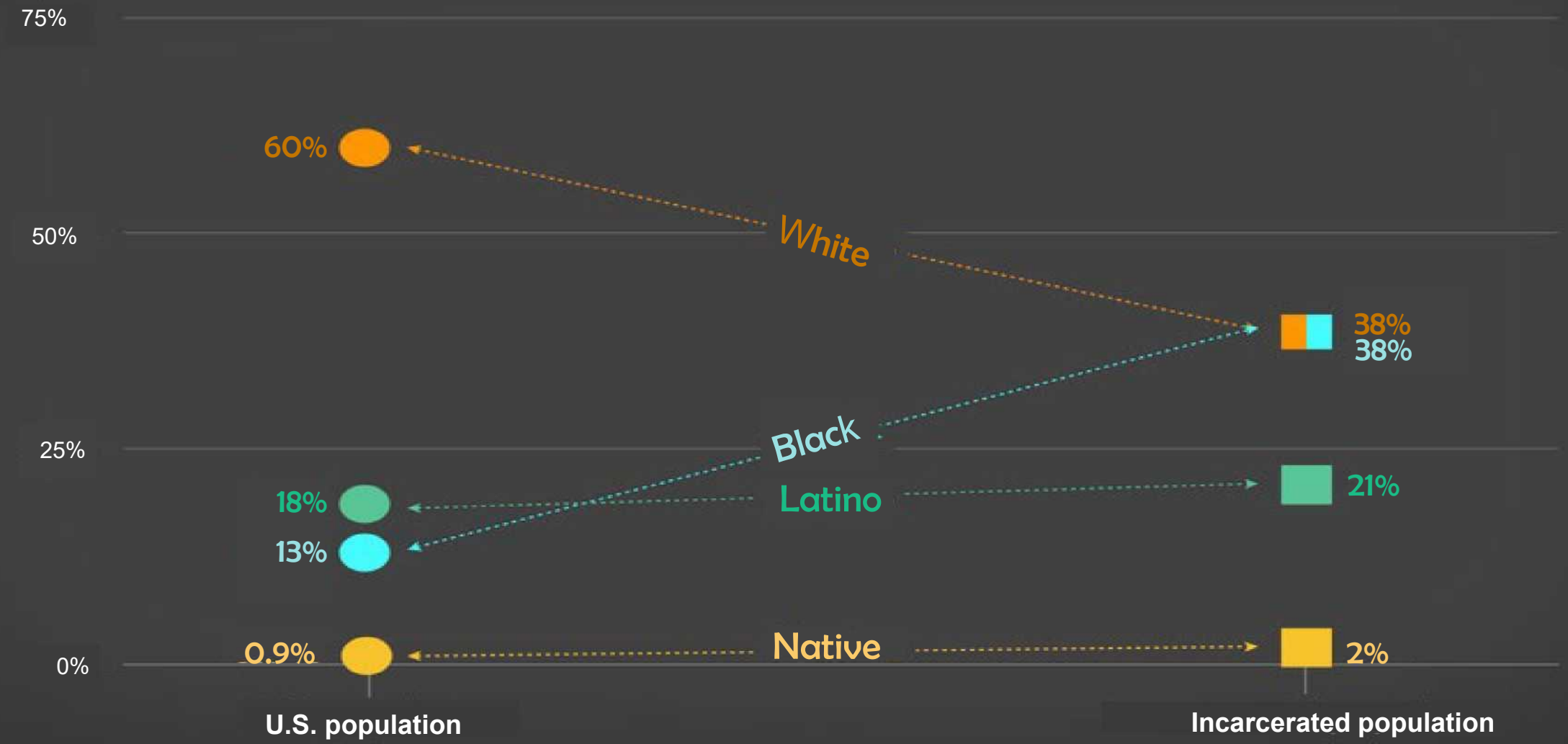
Demographic Trends In Incarcerated Populations

- 93% of all incarcerated persons are males, 7% are females
- Persons older than 55 make up 11% of the incarcerated population
- 10% of all jail, state and federal inmates are military veterans
- 12-16% of all incarcerated persons have a history of unstable housing
- Racial and ethnic minorities make up much of the US incarcerated population

Davis DM, Bello JK, Rottnek F. Care of Incarcerated Patients. Am Fam Physician. 2018 Nov 15;98(10):577-583

Racial and ethnic disparities in correctional facilities

White people are underrepresented in prisons and jails while Black, Native, and Latino people are overrepresented.



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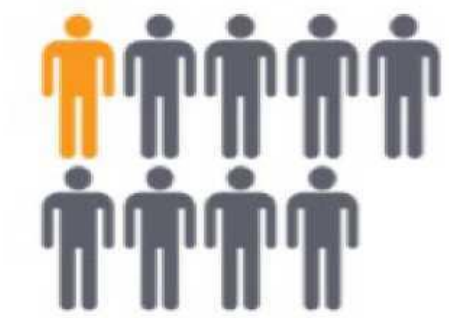
Source: U.S. Census Bureau, American Community Survey 2019, Tables B02001 and DP05
For category definition and selection details, see www.prisonpolicy.org/reports/pie2022.html#methodology

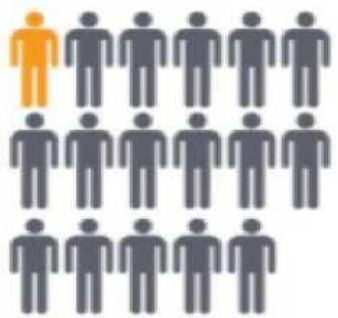
Lifetime Likelihood of Imprisonment of U.S. Residents Born in 2001

All Men



1 in 9

White Men

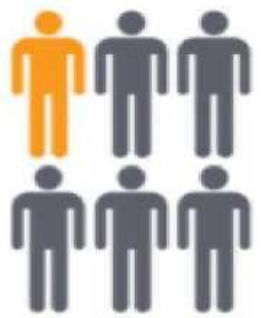


1 in 17

Black Men

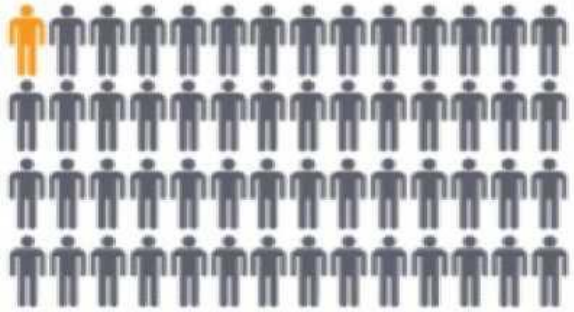
1 in 3

Latino Men



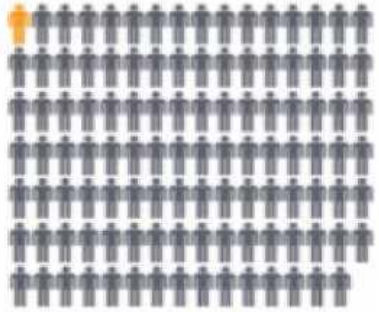
1 in 6

All Women



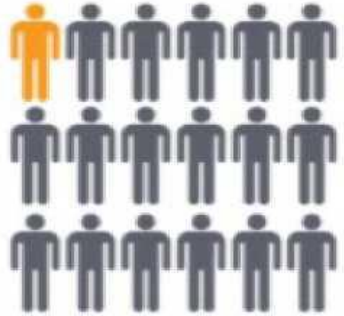
1 in 56

White Women



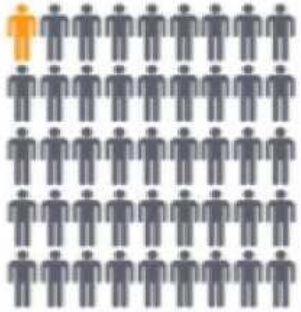
1 in 111

Black Women



1 in 18

Latina Women



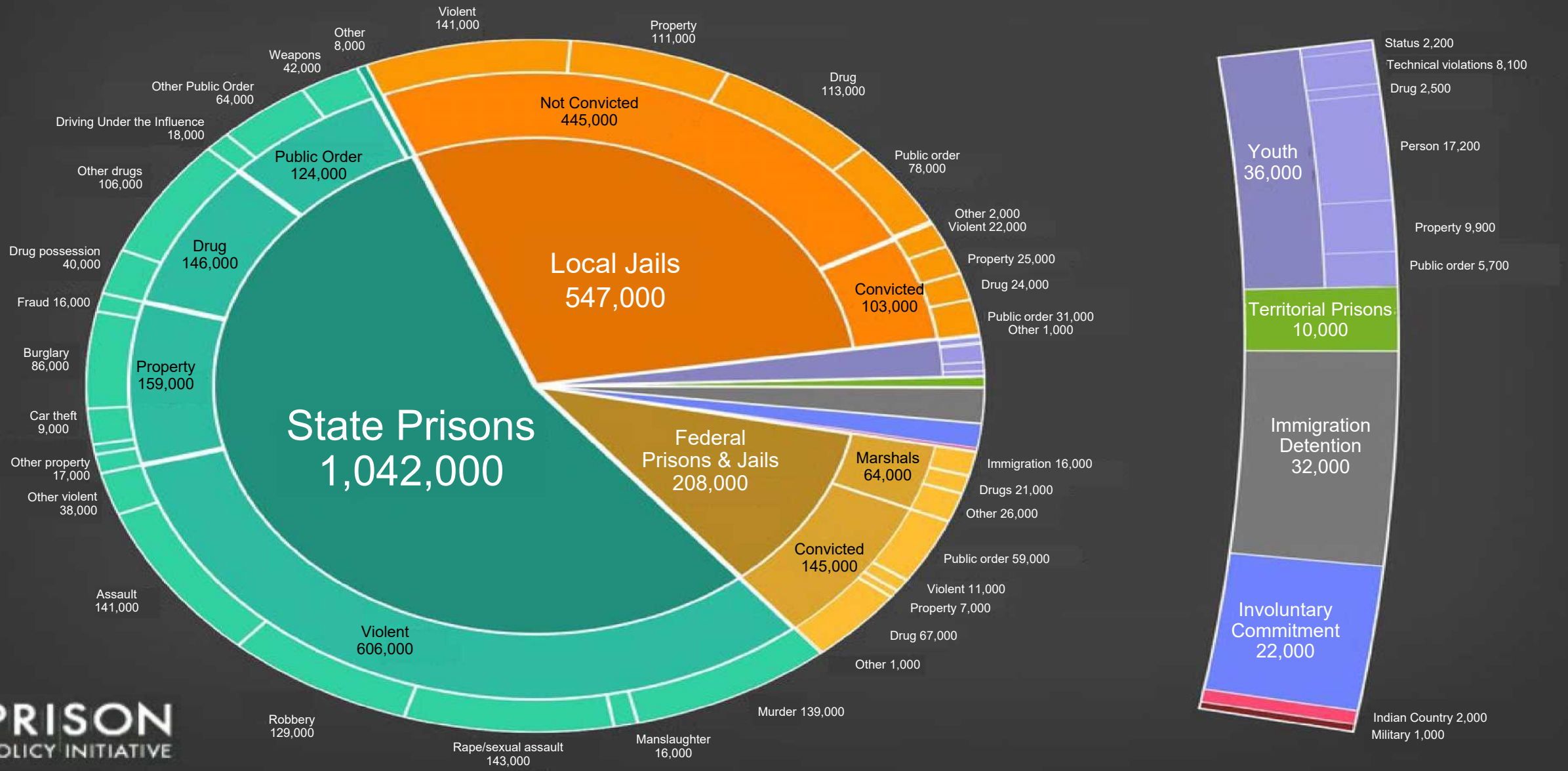
1 in 45

Source: Bonczar, T. (2003). *Prevalence of Imprisonment in the U.S. Population*, 1974-2001. Washington, DC: Bureau of Justice Statics.

THE SENTENCING PROJECT

How many people are locked up in the United States?

The U.S. locks up more people per capita then any other nation, at the staggering rate of 573 per 100,000 residents. But to end mass incarceration, we first consider *where* and *why* 1.9 million people are confined nationwide.

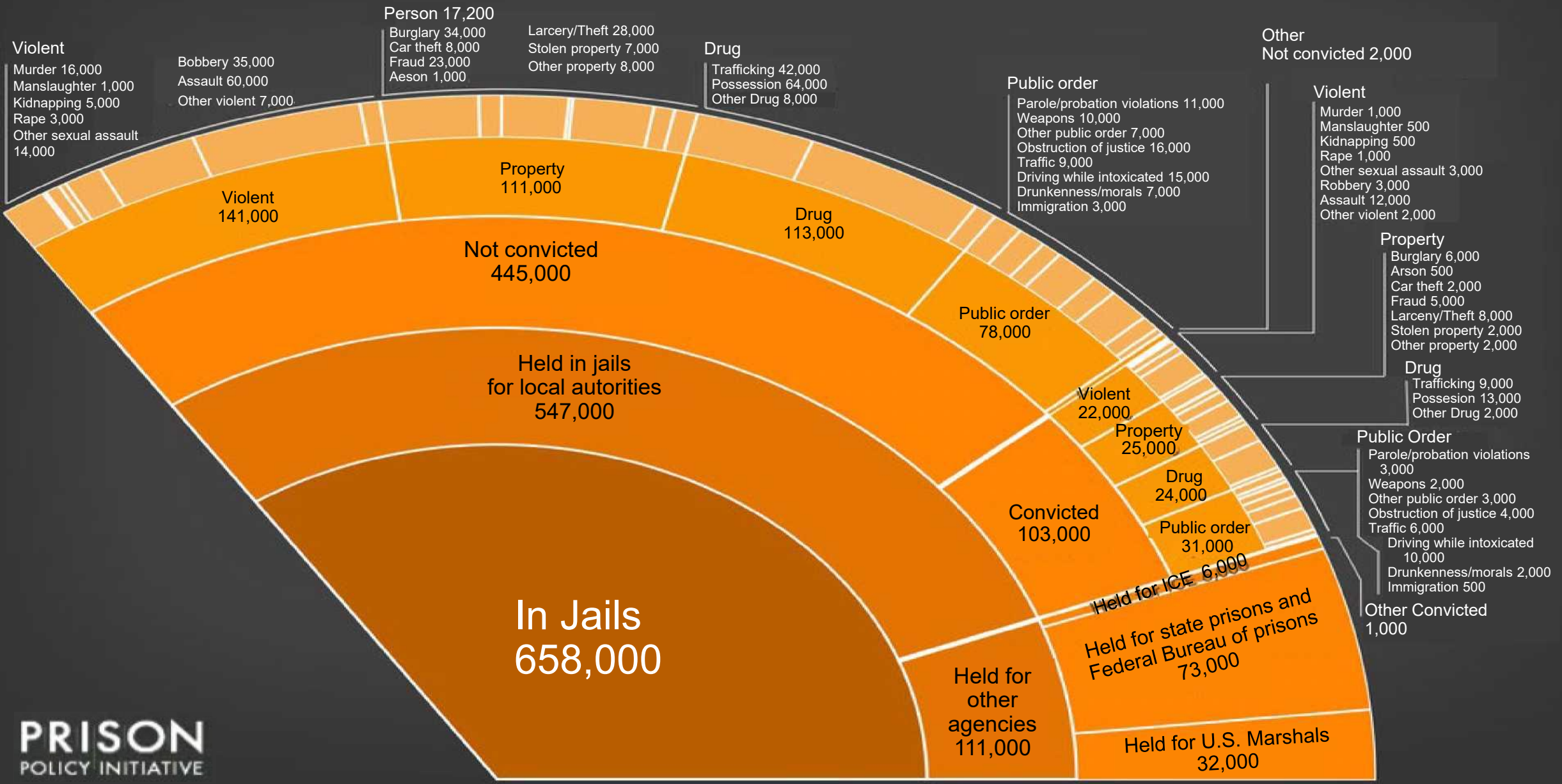


PRISON POLICY INITIATIVE

Sources and data notes: See https://www.prisonpolicy.org/reports/pie2022.html

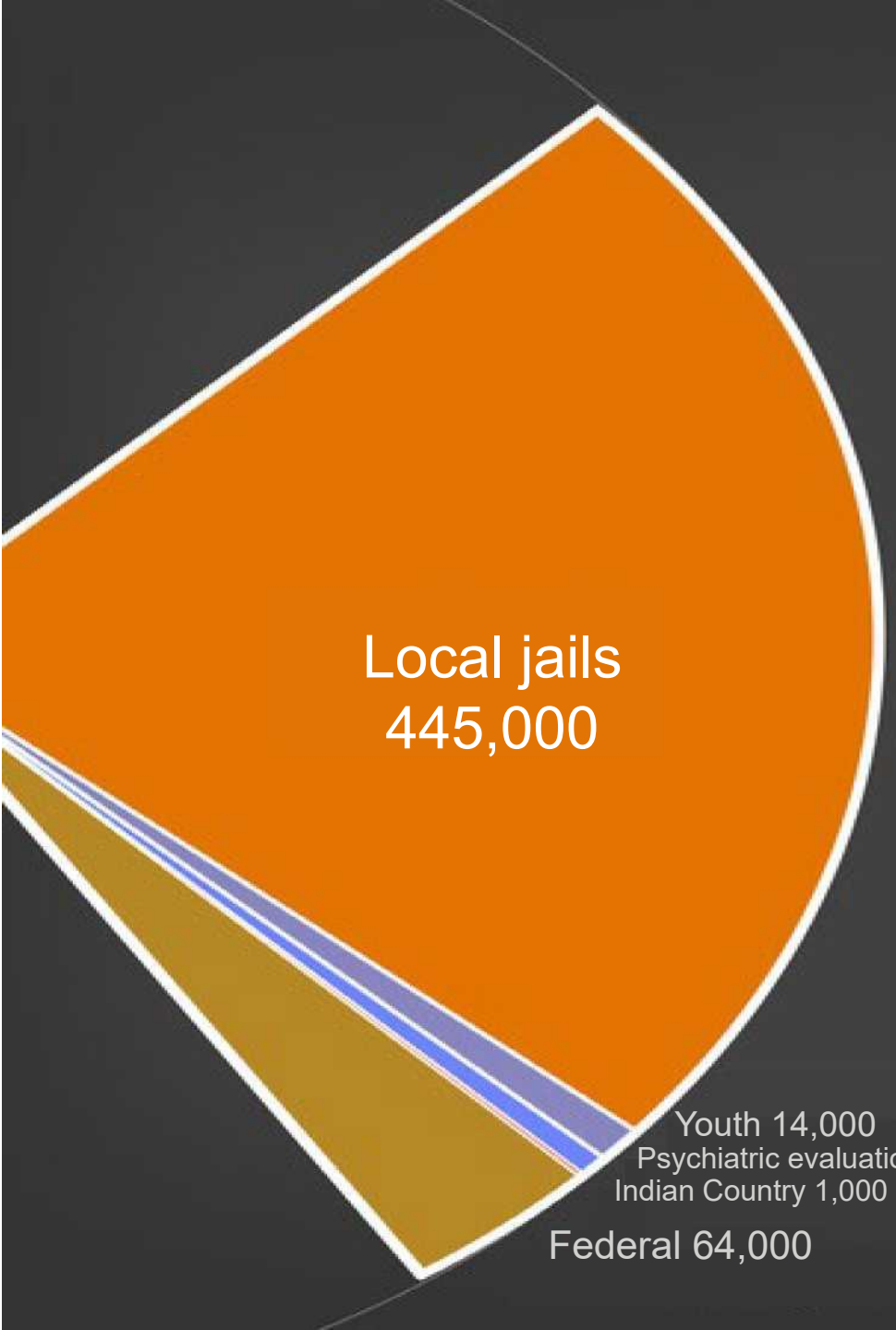
1 in 3 people behind bars is in a jail. Most have yet to be tried in court.

Over 80% of those in jail under local authority have not been convicted and are presumed innocent. If you include the 111,000 people held in jails that rent out space to other agencies, 67% of all people in jails are unconvicted. Either way, jail incarceration rates are driven largely by local bail practices.



PRISON POLICY INITIATIVE

Pretrial Detention



Most people in jail are not convicted, but are locked up awaiting trial.

Why?

Many are detained in local jails because they cannot afford to pay the bail amount set to secure their release.

The median hail amount for felonies is $10,000, which represents 8 months' income for a typical person detained because they can't pay bail.

Jails are not the only places detaining people pretrial. The federal government and other authorities detain another 88,000 people.

https://www.prisonpolicy.org/reports/pie2022.html#bigpicture

Why are so many people detained in jails before trial? They're not wealthy enough to afford money bail.

Median annual pre-incarceration incomes (in 2015 dollars for people ages 23-39 in local jails who were unable to post a bail bond, compared to incomes of same-age non-incarcerated people, by gender

For detailed, data notes, see *Detaining the Poor* at www.prisonpolicy.org/reports/incomejails.html

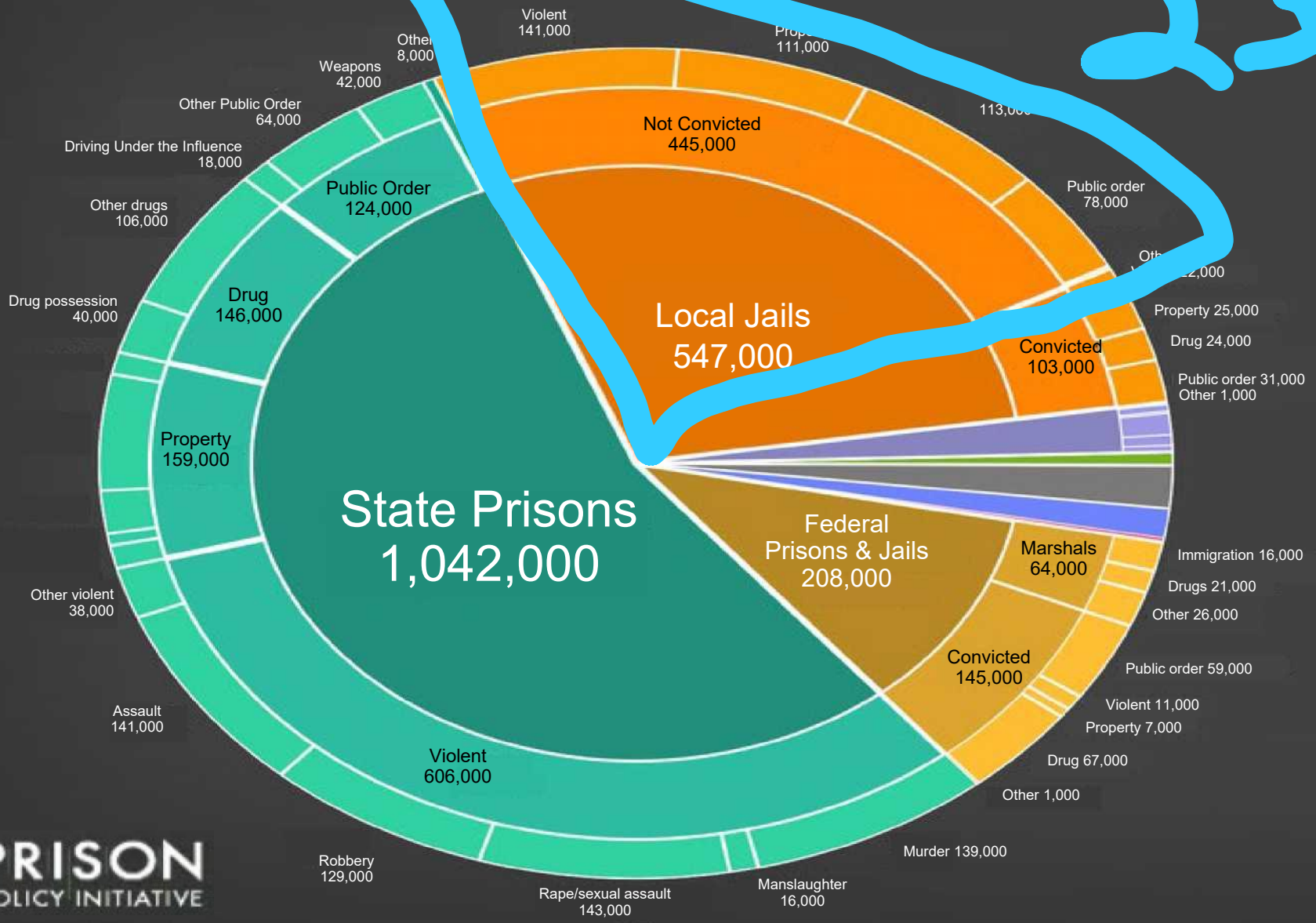
PRISON POLICY INITIATIVE

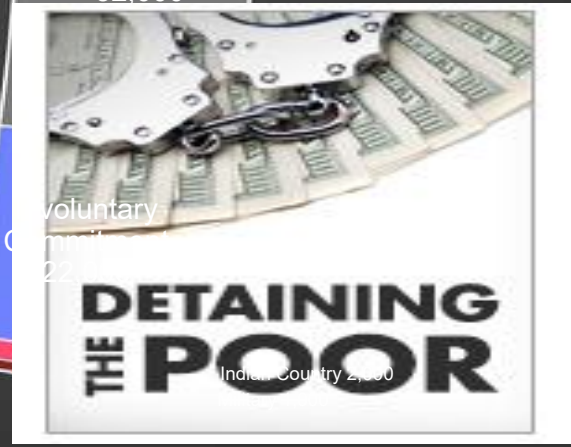
Racial Disparities in US Pre-Trial Detention Rates

There are racial disparities in local jails and pretrial detention:

How many people are locked up in the United States?

The U.S. le[illegible] per capita then any other nation, at [illegible] of 573 pe[illegible]00,000 residents.
But to en[illegible]mass incarceration[illegible]irst consider *where* and *why* 1.9 m[illegible]on peop[illegible]re conf[illegible]ed nationwide.





PRISON POLICY INITIATIVE

Sources and data notes: See https://www.prisonpolicy.org/reports/pie2022.html

Local Jails: the real scandal is the churn

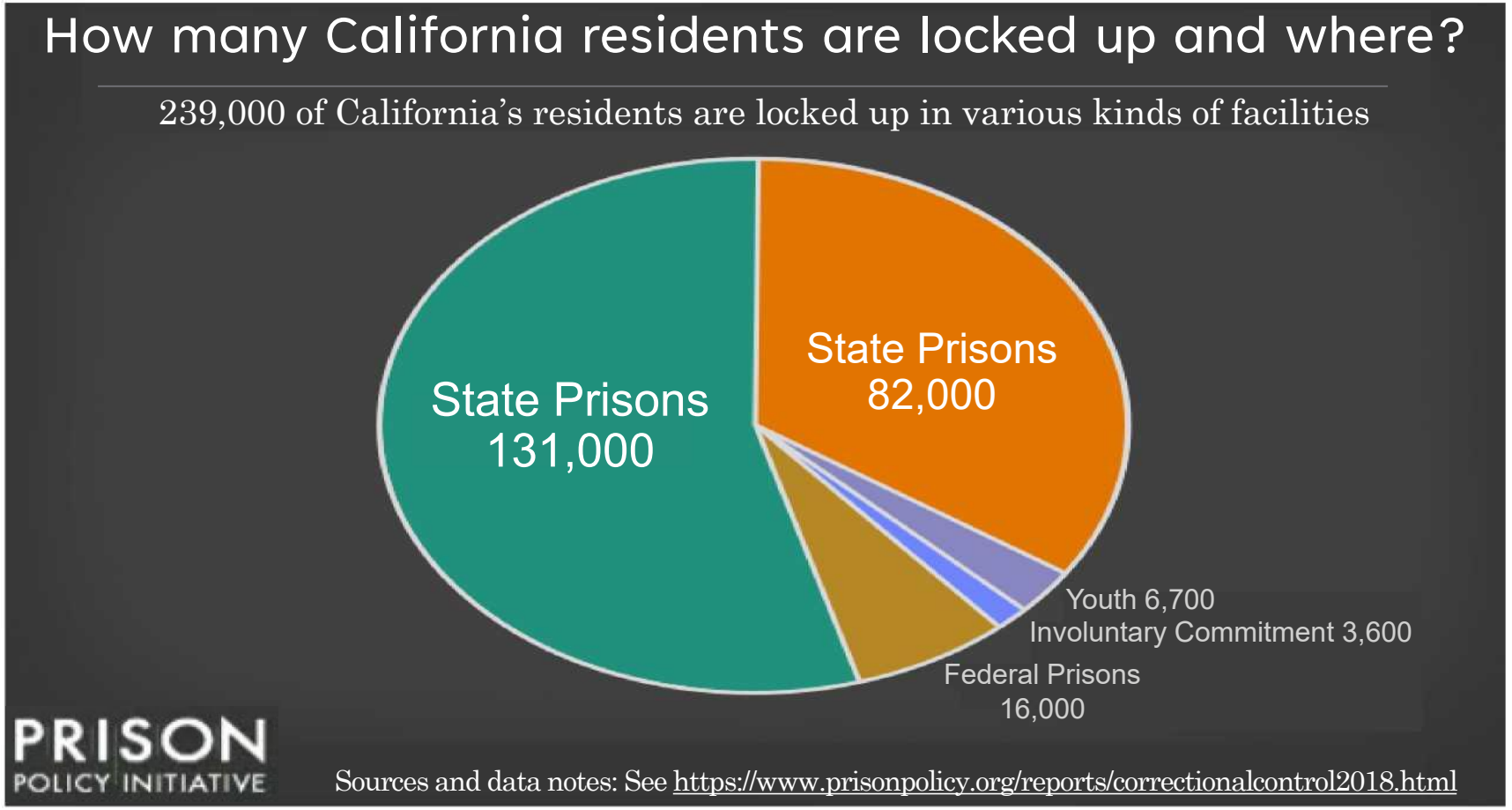
When talking about the societal impact of jails, the average daily population, of 547,000 is far less important than the staggering number — over 10 million — admitted to jails in a typical year.

What does more than 10 million jail admissions look like?

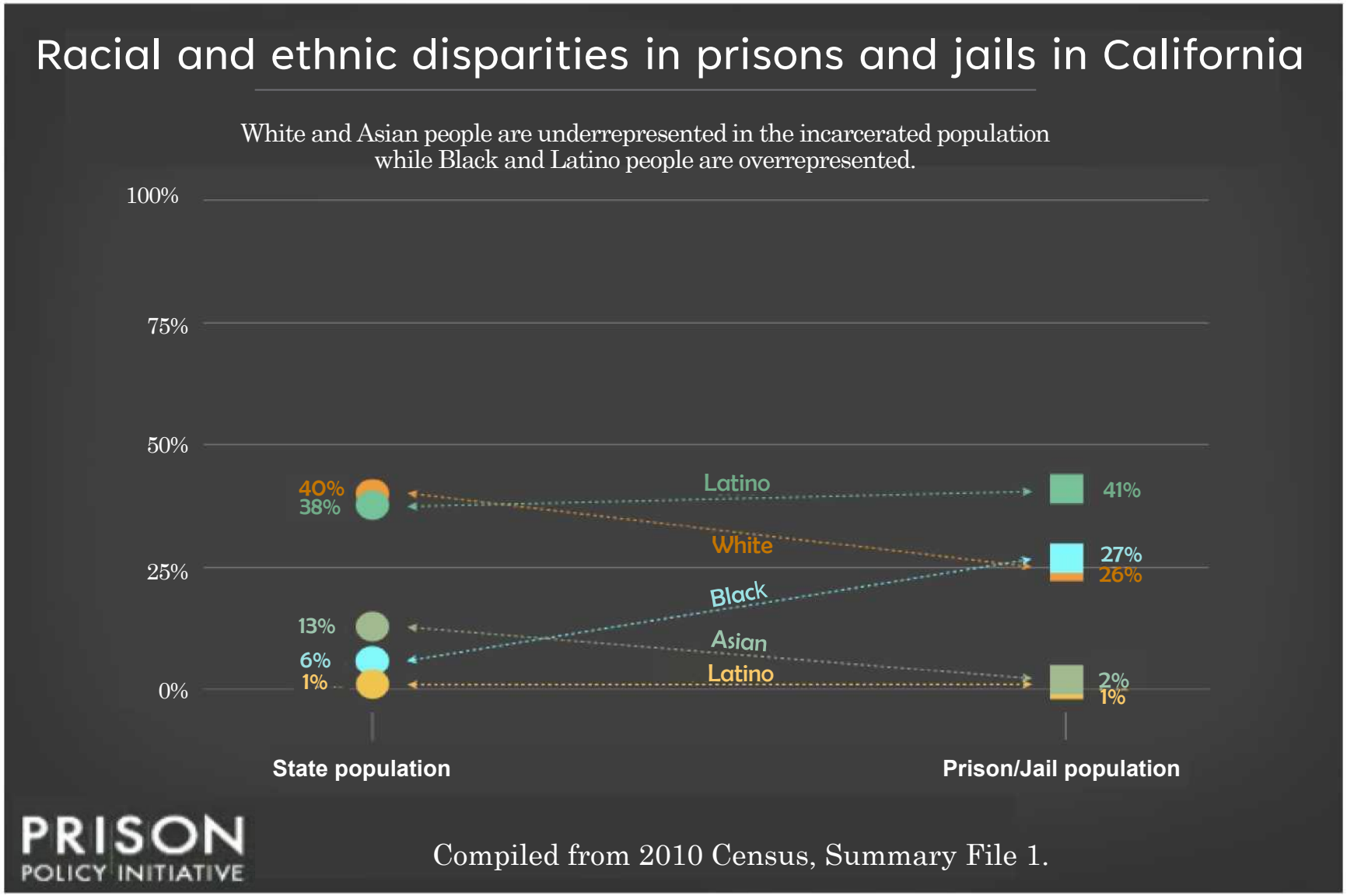
It's enough people to fill a line of prison buses bumper-to-bumper from New York City to San Francisco.

https://www.prisonpolicy.org/reports/pie2022.html#bigpicture

CA's Incarcerated Population

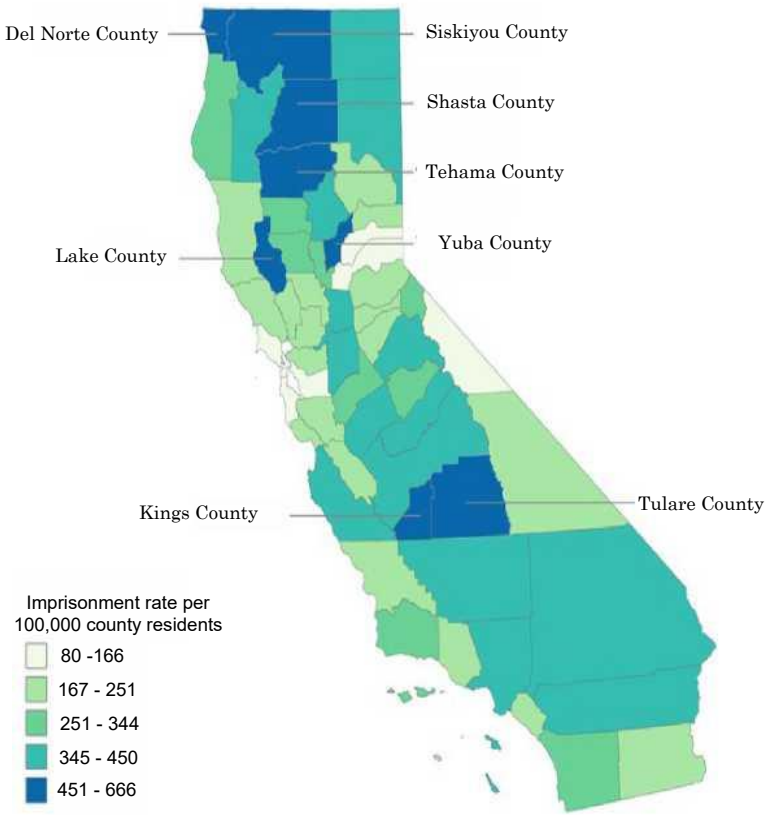


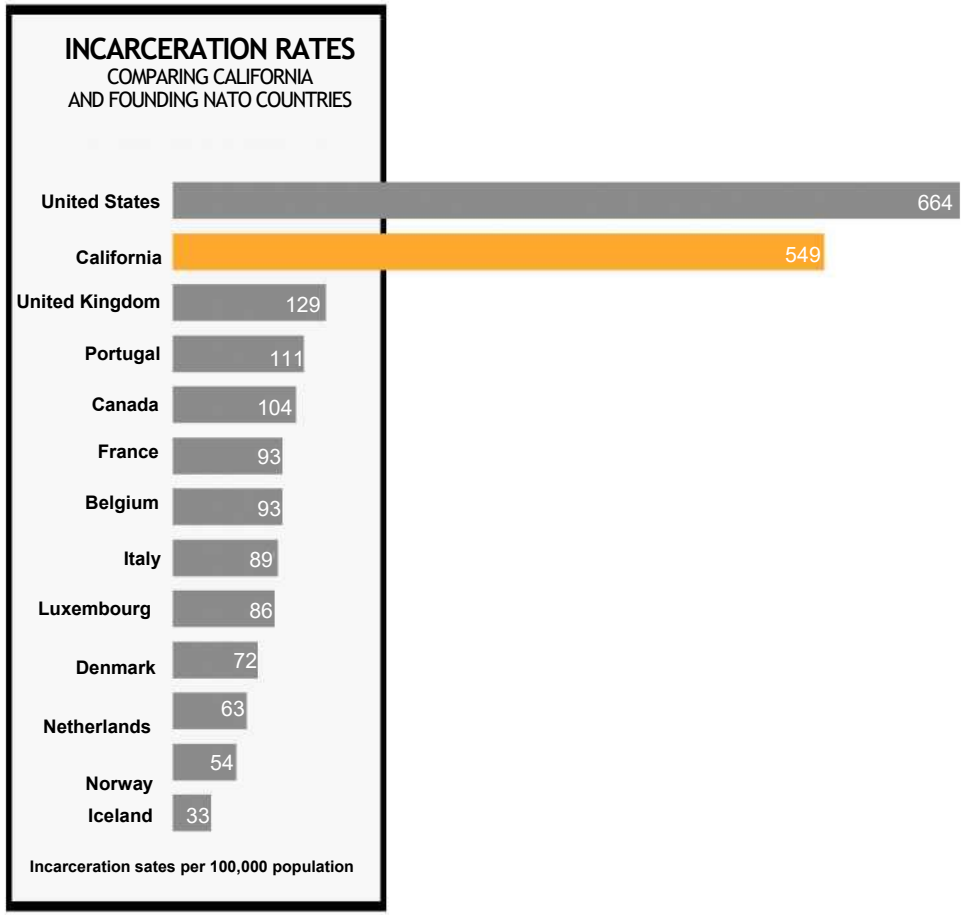
Mirrors National Trends



Rates of Imprisonment Vary Throughout the State of CA

High county imprisonment rates are clustered in a handful of northern and central California counties





Source: https://www.prisonpolicy.org/global/2021.html

Mass incarceration directly impacts millions of people

But just how many, and in what ways?

Most face "collateral consequences" even after their sentence ends
such as voting, housing, education, employment, and other restrictions

Compiled by the Prison Policy Initiative from 2016 and 2017 Bureau of Justice Statics data; Shannon, et al. *(2017) The Growth, Scope, and Spatial Distribution of People With Felony Records in the United States, 1948-2010; and* FWD.us (2018) *Every Second: The Impact of the Incarceration Crisis on America´s Families*

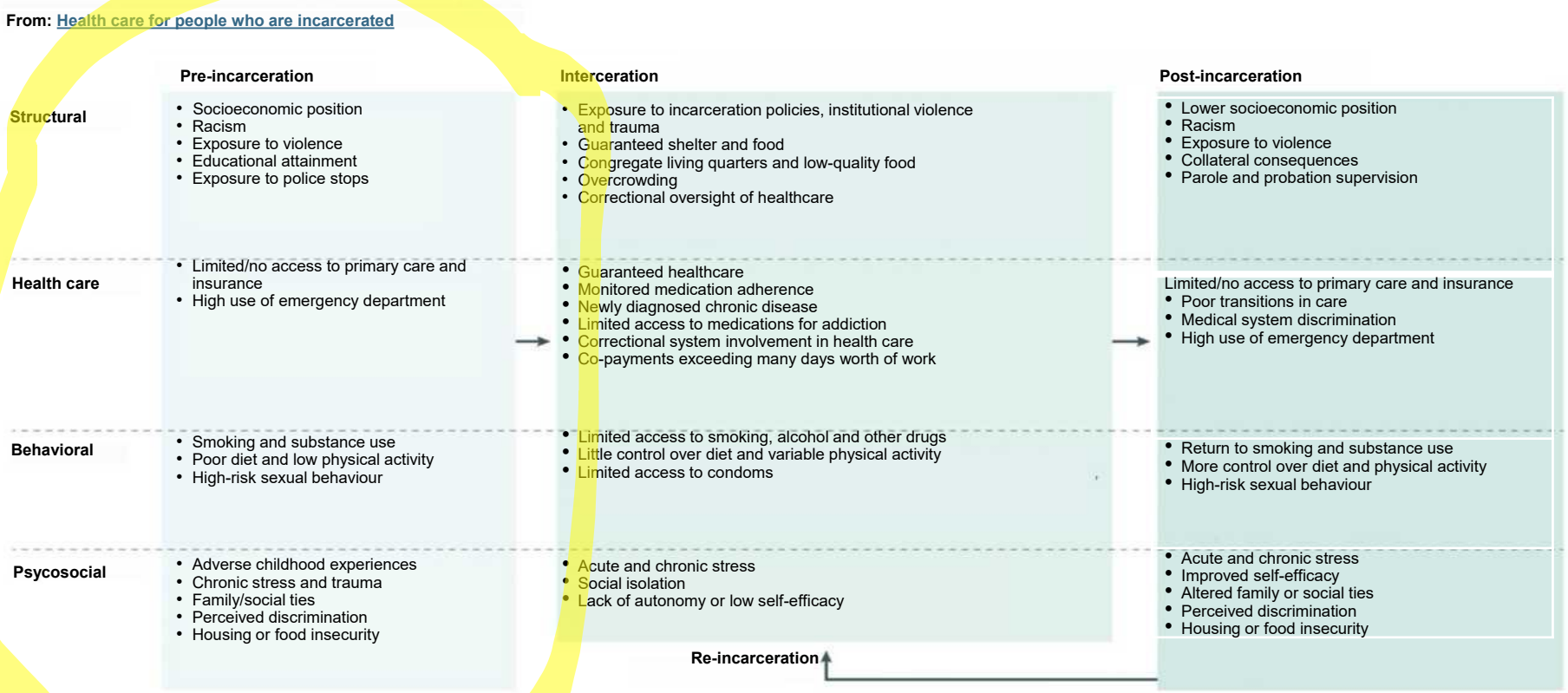
PRISON POLICY INITIATIVE

To Review:

- The U.S. incarcerates more people than any other country in the world AND more people per capita than any other country in the world
- 80% of persons incarcerated in U.S. jails have NOT been convicted of a crime
- Incarcerated persons in the US are primarily male, young, racial/ethnic minorities, and low income.
- New Fact: **95% of persons incarcerated in jails or prisons will ultimately be released back into their community, where they have increased medical needs in comparison to non-incarcerated populations.**

Factors Associated With Health in Individuals Who are Incarcerated

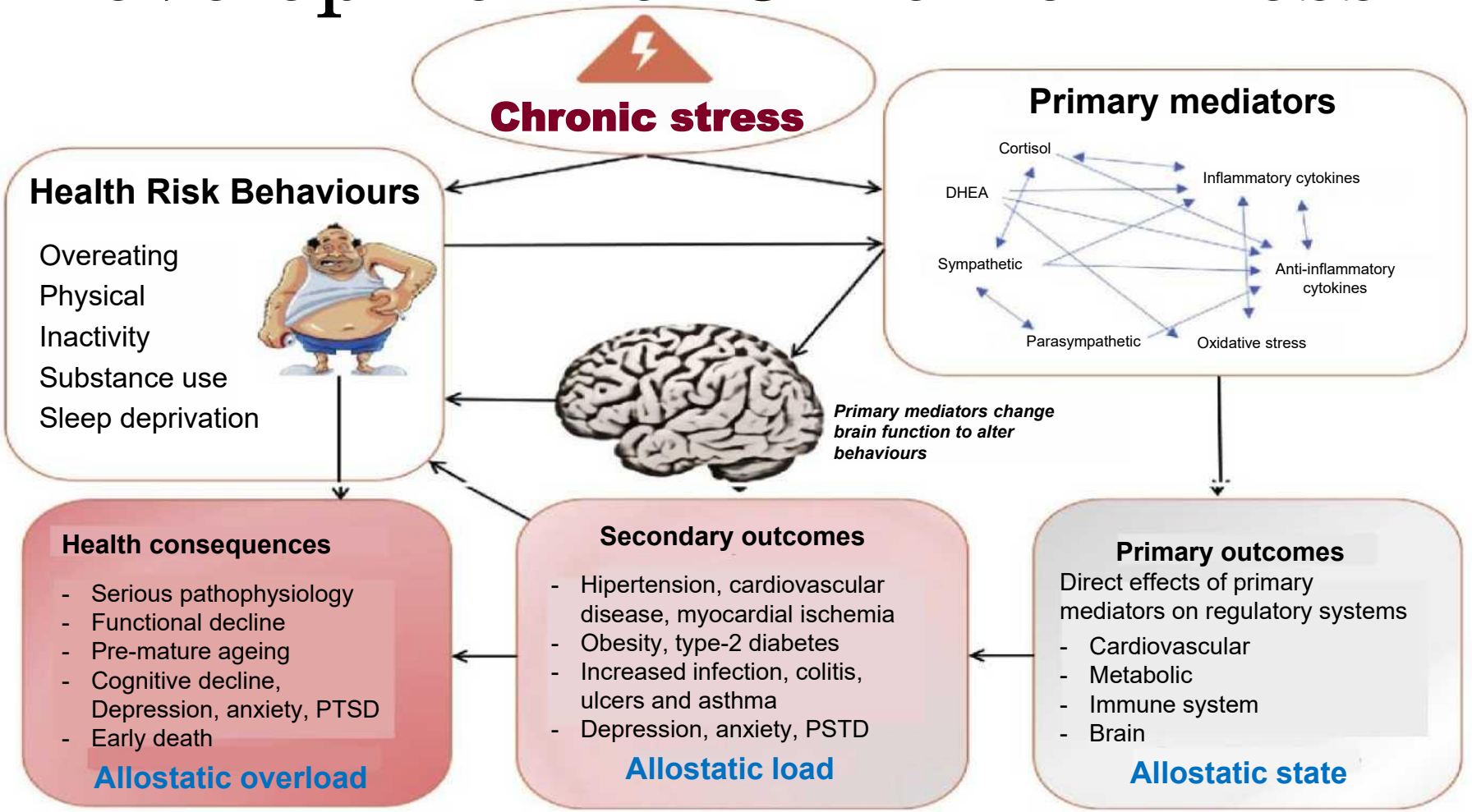
From: Health care for people who are incarcerated



Structural, behavioural and social factors, in addition to health-care factors, are associated with health in incarcerated individuals.

Source: https://www.nature.com/articles/s41572-021-00288-9/figures/1

Allostatic Load: A Model for Development of Chronic Illness



Source: Suvarna B, Suvarna A, Phillips R, Juster RP, McDermott B, Sarnyai Z. Health risk behaviours and allostatic load: A systematic review. *Neurosci Biobehav Rev*. 2020;108:694-711. doi:10.1016/j.neubiorev.2019.12.020

“Incarceration is both a correlate and a cause of poor health outcomes”

-Guiterrez

Right to Health Care

- Incarcerated persons in the U.S are the only persons guaranteed access to health care services (per the 1976 US Supreme Court decision Estelle v. Gamble).
- The type and quality of health care services for incarcerated persons differs widely across the US.
- This care is EXPENSIVE

Davis DM, Bello JK, Rottnek F. Care of Incarcerated Patients. Am Fam Physician. 2018 Nov 15;98(10):577-583.

Medical Care at the St. Louis County Jail (BWJC)

Largest jail facility in MO

American Correctional Association (ACA) Accredited

24/7/365 Nursing/EMT/EMTP Staff

24/7/365 APP staffing

Full time Medical Director

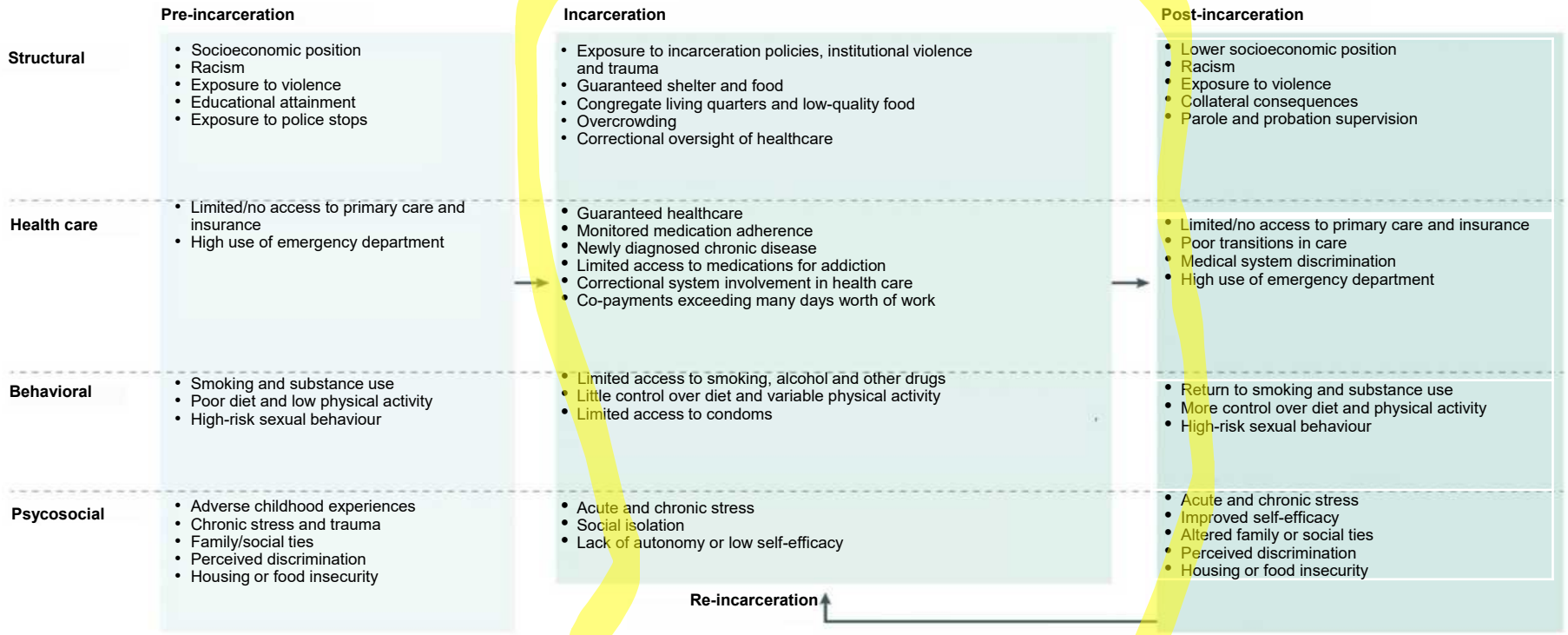
Psychiatry and Dental Services

Medical and Psychiatric Infirmaries

Urgent and Routine Clinical Services

Factors Associated With Health in Individuals Who are Incarcerated

From: Health care for people who are incarcerated



Structural, behavioural and social factors, in addition to health-care factors, are associated with health in incarcerated individuals.

Source: https://www.nature.com/articles/s41572-021-00288-9/figures/1

Medical Care in Jails Around the US

- Wildly variable based on size of facility, budget, and staffing
- Limited number of health staff and providers willing to work in correctional facilities
- Care can be limited by security concerns/transport issues/justice services staffing
- Telehealth consultations require complex negotiations to move equipment around a facility
- Even the best intentions can meet hard realities of day to day operations…..

Health Problems Specific to Incarcerated Populations

- Incarcerated individuals and recently incarcerated individuals have a higher burden chronic diseases, communicable diseases, mental health diagnoses, and substance use disorders than the general population.
- Incarcerated populations are more likely than members of the general population to lack access to regular medical care when they are not incarcerated.

Davis DM, Bello JK, Rottnek F. Care of Incarcerated Patients. Am Fam Physician. 2018 Nov 15;98(10):577-583.

Common Medical Conditions

TABLE 1

Common Medical conditions in Jail inmates and State and Federal Prisioners

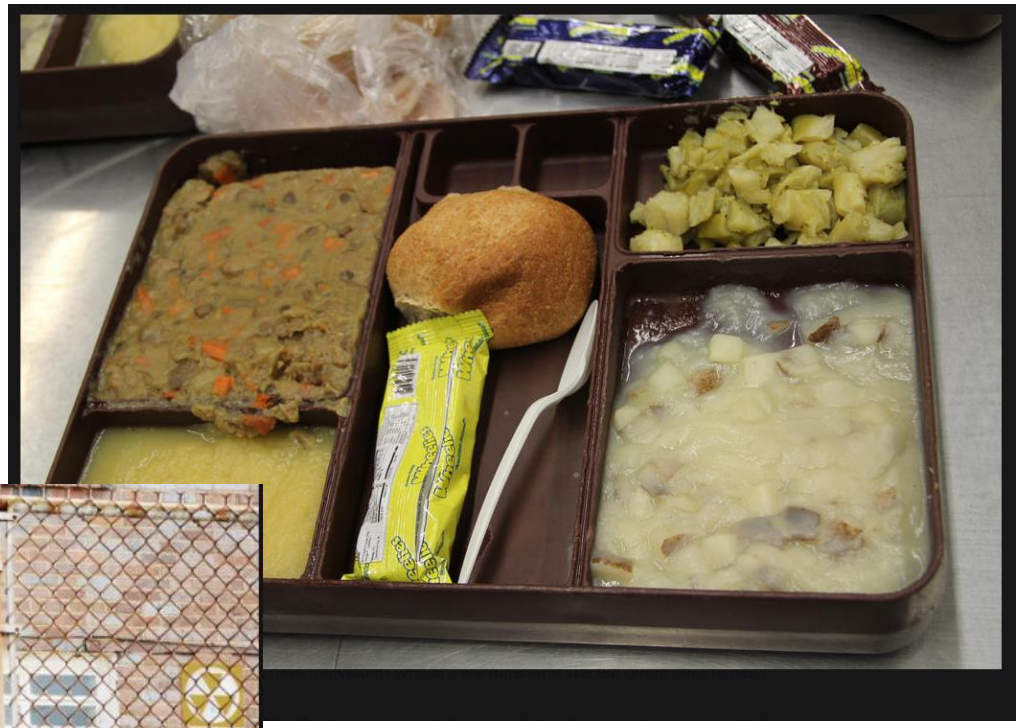
Condition	Jail inmates (%)	State and federal prisioners (%)
Drug dependence or morbid obesity[13]	63.3	58.5
Overweight, obesity, or morbid obesity[14]	62	74
History of mental health disorder[15]	44.3	36.9
Hipertension[14]	26.3	30.2
Asthma[14]	20.1	14.9
History of infectious disease[14]	14.3	21
Arthritis or rheumatism[14]	12.9	15
Heart conditions[14]	10.4	9.8
Diabetes mellitus or high blood glucose levels[14]	7.2	9

Information from references 13 through 15.

Mo DOC reports 89% of new inmates qualify as having a SUD

Davis DM, Bello JK, Rottnek F. Care of Incarcerated Patients. Am Fam Physician. 2018 Nov 15;98(10):577-583.

Conditions in Jails and Prisons Can Cause or Exacerbate Chronic Health Issues



Obesity
Hypertension
DM II
PTSD…..

Massoglia M, Pridemore WA. Incarceration and Health. *Annu Rev Sociol*. 2015;41:291-310.

Infectious Diseases

- The rate of HIV infection is 4x greater in state and federal prison populations than the general population.
- The annual incidence of tuberculosis in jail and federal populations was 8x greater than the general population.
- Higher prevalence of Hepatitis C and chronic HBV
- High prevalence of STIs including syphilis

Davis DM, Bello JK, Rottnek F. Care of Incarcerated Patients. Am Fam Physician. 2018 Nov 15;98(10):577-583. PMID: 30365288.
https://www.cdc.gov/std/treatment-guidelines/correctional.htm

STIs – 2021 CDC Guidelines for Persons in Correctional Facilities

- Universal opt-out screening for chlamydia and gonorrhea in women ≤ 35 and men < 30 years
- Opt-out screening for trichomoniasis for females aged ≤ 35
- Opt-out screening for syphilis based on local and institutional prevalence
- All persons housed in juvenile and adult correctional facilities should be offered opt out screening for HIV
- All persons housed in juvenile and adult correctional facilities should be screened at entry for viral hepatitis, including HAV, HBV, and HCV.
- Women and transgender men should be screened for cervical cancer per community screening guidelines.

https://www.cdc.gov/std/treatment-guidelines/correctional.htm

USPSTF A&B Recommendations

Status	Type	Year	Topic	Age Group	Grade	Category
Published	Screening	2021	Chlamydia and Gonorrhea: Screening	Adolescent, Adult, Senior	B, I	Infectious Diseases
Published	Screening	2020	Hepatitis B Virus Infection in Adolescents and Adults: Screening	Adolescent, Adult, Senior	B	Infectious Diseases
Published	Screening	2020	Hepatitis C Virus Infection in Adolescents and Adults: Screening	Adolescent, Adult, Senior	B	Infectious Diseases
Published	Screening	2019	Human Immunodeficiency Virus (HIV) Infection: Screening	Adolescent, Adult, Senior	A	Infectious Diseases
Published	Screening	2016	Latent Tuberculosis Infection: Screening	Adult, Senior	B	Infectious Diseases
Syphilis Infection in Nonpregnant Adolescents and Adults: Screening: asymptomatic, nonpregnant adolescents and adults who are at increased risk for syphilis infection			The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.		A	September 2022 *

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?searchterm=

Hepatitis C

- CDC estimates prevalence in correctional settings between 16.1% and 23%[1]
- Prevalence study at BWJC was 16.4% in 2014 – OR was highest in those who used injection drugs, and prevalence in females was 3X that of males[2]
- Following a class-action lawsuit, MO DOC is now required to screen inmates for Hepatitis C and treat the "highest priority patients" with DAA –spending a minimum of $7 million on treatment each year[3]
- All sentenced BOP inmates with HCV infection are eligible for "consideration of treatment"[4]
- MAVRIT will be a game changer in community treatment.

1.https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm
2. Wenger PJ, Rottnek F, Parker T, Crippin JS. Assessment of hepatitis C risk factors and infection prevalence in a jail population. Am J Public Health. 2014 Sep;104(9):1722-7.
3. https://www.kcur.org/health/2020-08-21/missouri-department-of-corrections-agrees-to-expand-hep-c-treatment-for-inmates
4. https://www.bop.gov/resources/pdfs/hcv_guidance.20210513.pdf

History of Traumatic Injuries

- Prevalence of reported head injuries/TBI in correctional settings: 25-87%
- Prevalence of reported TBI in the general population: 8.5%
- Potential long-term symptoms: attention deficits, memory deficits, impulsive/uninhibited behavior, difficulty controlling emotions, depression, anxiety, SUD
- “Invisible Disability”

https://www.cdc.gov/traumaticbraininjury/pdf/prisoner_tbi_prof-a.pdf

History of Traumatic Injuries

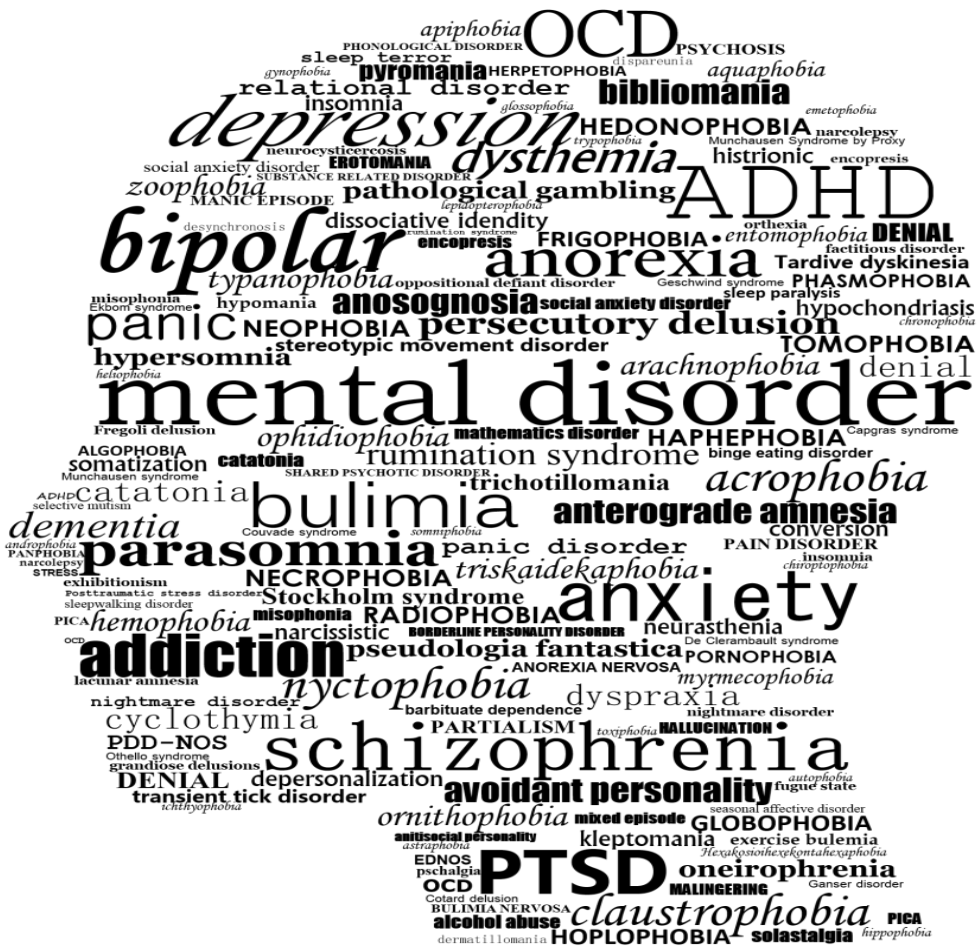
- Little data on prevalence of prior non-fatal GSW or interpersonal violence related injuries in US inmate populations
- Cook County Jail study from 1995 reported that 51% of their detainees had been hospitalized in the past for violence related injuries, and 26% had survived prior GSW. 61% reported that they had been previously threatened with knife or gun.
- Long term consequences: emotional trauma/PTSD, chronic pain, movement/gait disorders, late complications of prior surgeries

May JP, Ferguson MG, Ferguson R, Cronin K. Prior nonfatal firearm injuries in detainees of a large urban jail. *J Health Care Poor Underserved*. 1995;6(2):162-176. doi:10.1353/hpu.2010.0640

Special Needs of Female Patients

- Patients should be evaluated for need for cervical cancer screening/breast cancer screening
- Screen for STI based on national guidelines/patient risk factors
- Discuss family planning needs
- Be mindful that female patients involved with the justice system have higher rates of history of domestic violence, sexual trauma, and psychiatric illness as well as substance use disorders than the general population.

Untreated/Undertreated Psychiatric Illness



https://justiceaction.org.au/vicroyalcommission/

BMC Health Serv Res. 2022 Jul 29;22(1):966. doi: 10.1186/s12913-022-08306-6

The relationship between community public health, behavioral health service accessibility, and mass incarceration

Niloofar Ramezani [1], Alex J Breno[2], Benjamin J Mackey[2], Jill Viglione[3], Alison Evans Cuellar[4], Jennifer E Johnson[5], Faye S Taxman[2]

Results: Fewer per capita psychiatrists (z-score = -2.16; p = .031), lower percent of drug treatment paid by Medicaid (-3.66; p < .001), higher per capita healthcare costs [5.71; p < .001), higher number of physically unhealthy days in a month (8.6; p < .001), lower high school graduation rate (-4.05; p < .001), smaller county size (-2.56, p = .008; -2.71, p = .007; medium and large versus small counties, respectively), and more police officers per capita (8.74; p < .001) were associated with higher per capita jail population. Controlling for other factors, violent crime rate did not predict incarceration rate.

Conclusions: Counties with smaller populations, larger percentages of individuals that did not graduate high school, that have more health-related issues, and provide fewer community treatment services are more likely to have higher jail population per capita. Increasing access to services, including mental health providers, and improving the affordability of drug treatment and healthcare may help reduce incarceration rates.

Ramezani N, Breno AJ, Mackey BJ, et al. The relationship between community public health, behavioral health service accessibility, and mass incarceration. *BMC Health Serv Res*. 2022;22(1):966. Published 2022 Jul 29. doi:10.1186/s12913-022-08306-6

Multicenter Study > Psychiatr Serv. 2007 Jun;58(6):794-801. doi: 10.1176/ps.2007.58.6.794.

The role of Medicaid enrollment and outpatient service use in jail recidivism among persons with, severe mental illness

Joseph P Morrissey[1], Gary S Cuddeback, Alison Evans Cuellar, Henry J Steadman

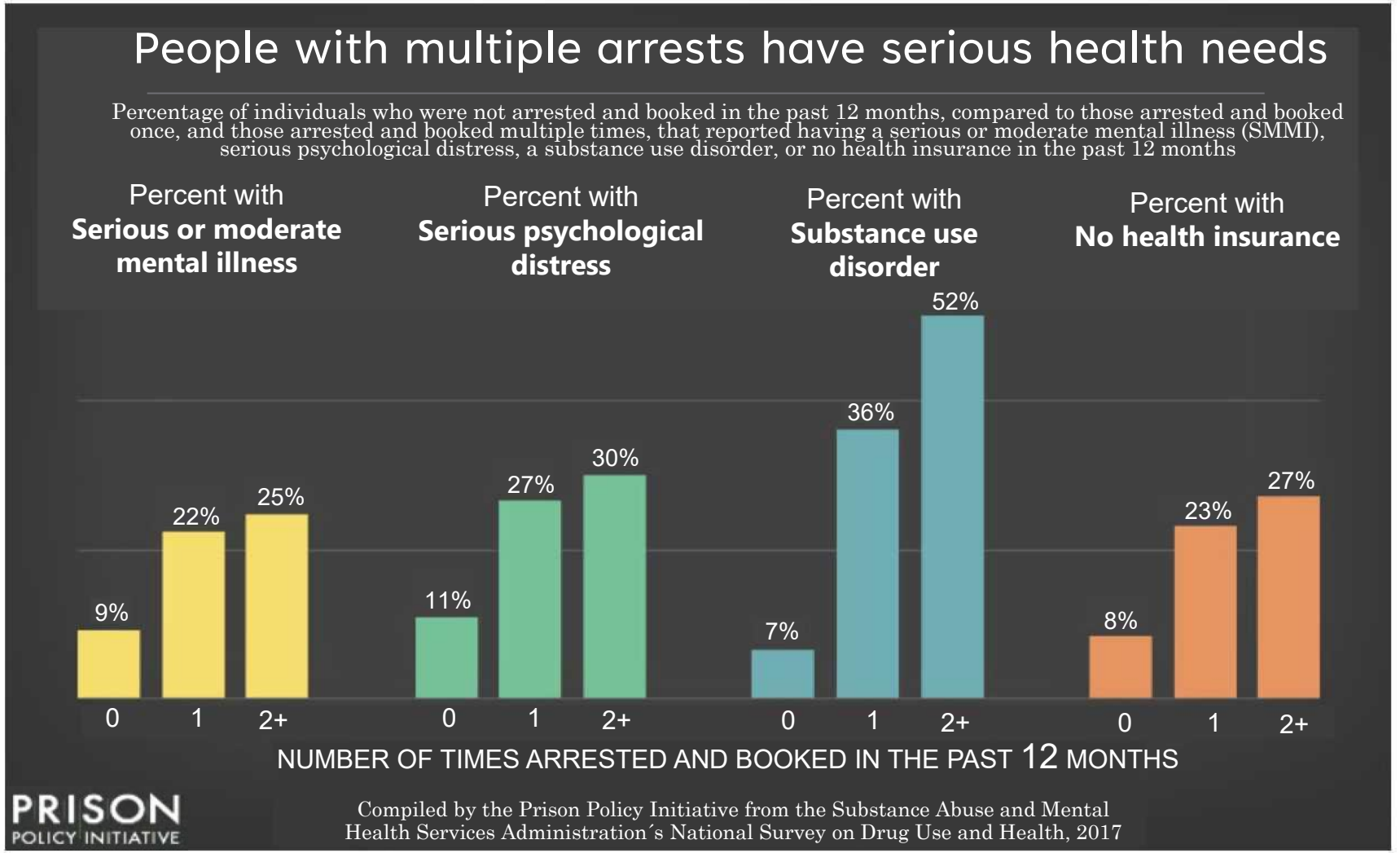
Objective: This study sought to determine whether having Medicaid benefits and receiving behavioral health services are associated with a reduction in recidivism for jail detainees with severe mental illness.

Results: In both counties, having Medicaid at release was associated with a 16% reduction in the average number of subsequent detentions ($p<.001$ and $p<.01$, respectively). After the analysis controlled for demographic and clinical variables, more days on Medicaid were associated with a reduced number of subsequent detentions in King County ($p<.001$) and more days in the community before subsequent arrest in both counties ($p<.01$ and $p<.05$, respectively). No association was found between Medicaid status and the seriousness of the subsequent offense in either county.

Conclusions: Although Medicaid benefits and behavioral health services were associated with fewer rearrests and more time in the community, the observed differences were relatively small, Further research is needed to determine how greater reductions in Jail recidivism can be achieved for this target population.

Morrissey JP, Cuddeback GS, Cuellar AE, Steadman HJ. The role of Medicaid enrollment and outpatient service use in jail recidivism among persons with severe mental illness. *Psychiatr Serv*. 2007;58(6):794-801. doi:10.1176/ps.2007.58.6.794

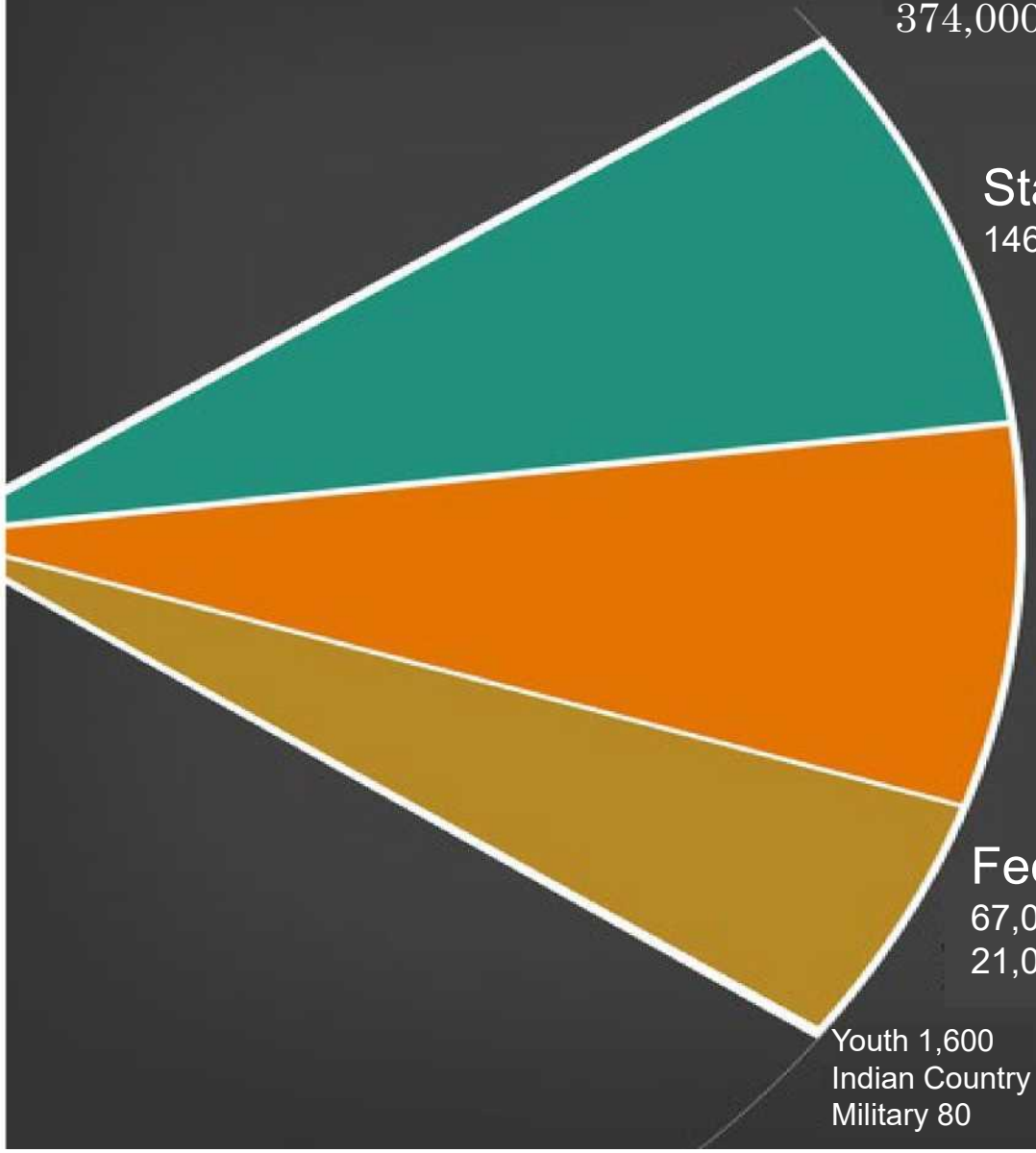
Individuals With Multiple Arrests Are More Likely To Have Psychiatric Illnesses and/or SUD



People who were jailed were more likely tan those who weren´t jailed to have serious mental and physical health needs, and to lack health insurance. These needs were even more prevalent among those arrested more than once per year. For the raw data used to construct this graph, see Appendix Table 1.

1 in 5 incarcerated people is locked up for a drug offense

374,000 are incarcerated for drug offenses on any given day



State prisons
146,000

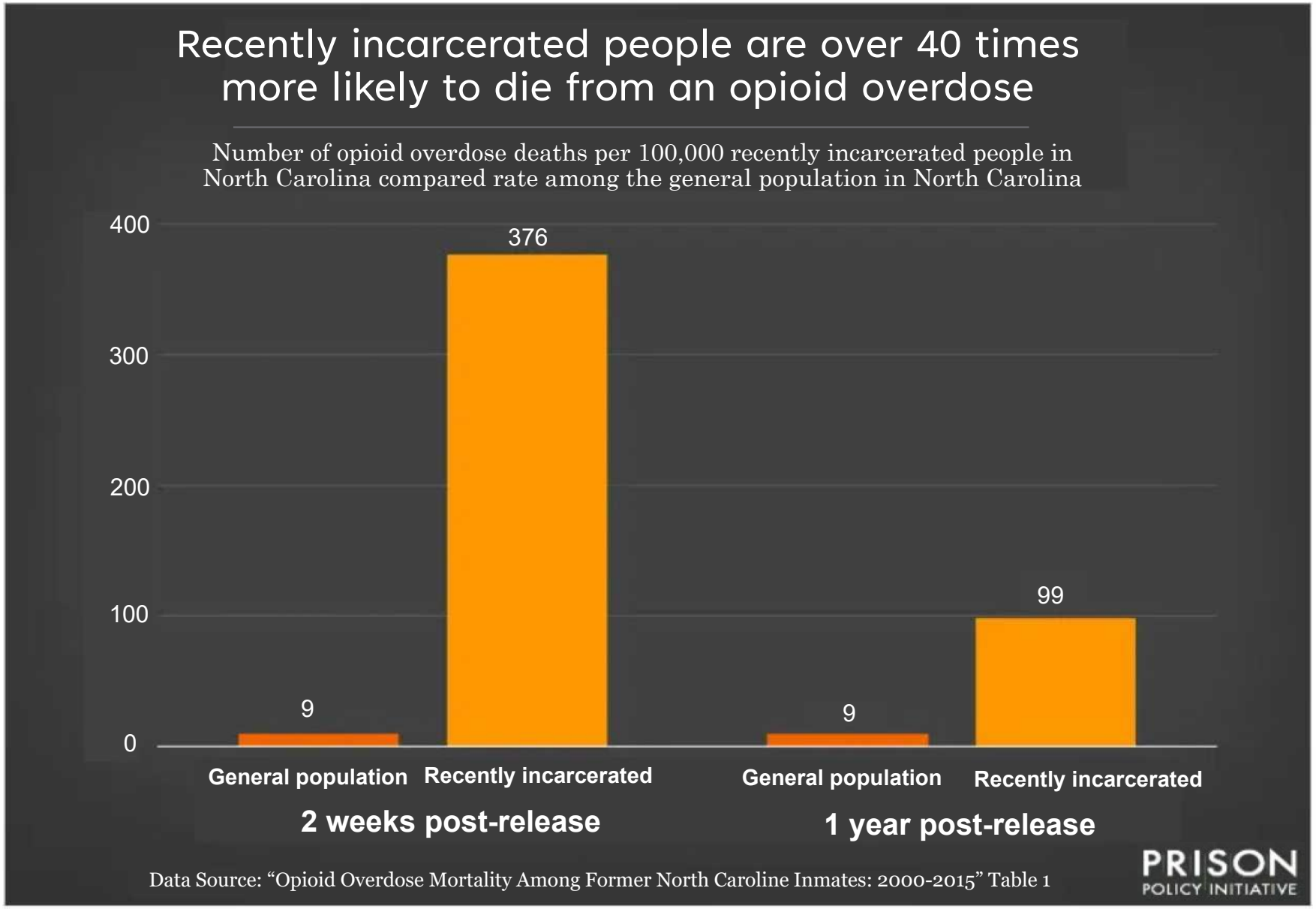
Local jails
113,000 Unconvicted
24,000 Convicted

Federal
67,000 Bureau of Prisons
21,000 U.S. Marshals

Youth 1,600
Indian Country Jails 220
Military 80

Drug overdose is the leading cause of death after release from a correctional facility.

Waddell EN, Baker R, Hartung DM, et al. Reducing overdose after release from incarceration (ROAR): study protocol for an intervention to reduce risk of fatal and non-fatal opioid overdose among women after release from prison. *Health Justice*. 2020;8(1):18.



Data Source: Opioid Overdose Mortality Among Former North Carolina Inmates: 2000-2015, Table 1. (Graph: Maddy Troilo, 2018)

Medications for Opioid Use Disorder (MOUDs)

TABLE 2

Comparison of Methadone, Buprenorphine, and Naltrexone for Opioid Use Disorder

Factors	Methadone	Buprenorphine	Naltrexone (Vivitrol)
Adverse effects	Sedation may occur Constipation Hypogonadism Prolonged QT interval Drug-drug interactions Overdose is possible at high dose or in combination with other drugs	Sedation rare Headache Nausea Constipation Insomnia/hypomania in predisposed patients	Injection site reactions Headache Depression Insomnia Increased alanine transaminase Increased creatine phosphokinase Difficult pain management Decreased tolerance and may therefore increase risk of overdose if return to use
Effectiveness	Most studied compared with buprenorphine and naltrexone Treatment retention superior to low-dose buprenorphine; equivalent to high-dose buprenorphine[15] Associated with decreases in mortality (all-cause mortality is three times higher when methadone is stopped[16]), opioid use, HIV transmission, and risky behaviors[16,17]	At doses >16 mg, treatment retention equivalent to methadone[16] and higher than naltrexone[18,19] All-cause mortality reduced by 50%[16] Much more effective than placebo at treatment retention (risk ratio = 1.82) and decreased illicit opioid — positive urine samples[15]	Least well studied compared with methadone and buprenorphine Oral form is ineffective Monthly intramuscular form has better treatment retention than non pharmacologic therapies but the lowest treatment retention of the three medication options Patients who successfully complete induction phase may have treatment retention similar to those on buprenorphine[18,19] Has not been shown to decrease all cause or drug-specific mortality[20] *
Location of Maintenance treatment	Federally certified opioid treatment program	Primary care clinic, psychiatric clinic, prenatal clinic, substance use disorder treatment program, opioid treatment program, or any outpatient setting	Primary care clinic, psychiatric clinic, substance use disorder treatment program, opioid treatment program, or any outpatient setting
Patient considerations	No withdrawal required for treatment initiation Initially must be seen daily	Mild -withdrawal required for treatment initiation, usually 8 to 48 hours of abstinence May need to be seen one to two times per week initially, can typically be spaced to monthly visits	Must completely withdraw from opioids before treatment initiation, usually 7 to 14 days of abstinence May be seen monthly for injections
Regulatory considerations[21]	Must be administered in opioid treatment program or be dispensed to inpatient hospitalized for another diagnosis	Prescriber must have a Drug Enforcement Administration waiver or be providing addiction treatment incidental to hospitalization tor another diagnosis	No restrictions on prescribing Must be stored in clinic refrigerator and administered by trained staff

Information from references 15-21

Coffa D, Snyder H. Opioid Use Disorder: Medical Treatment Options. Am Fam Physician. 2019 Oct 1;100(7):416-425.

Extended-Release Naltrexone Administered Before Release From Incarceration Decreases Opioid Use[1]

Photo Credit: https://newmexico.networkofcare.org/mh/content.aspx?cid=7539

1. Jarvis BP, Holtyn AF, Subramaniam S, Tompkins DA, Oga EA, Bigelow GE, Silverman K. Extended-release injectable naltrexone for opioid use disorder: a systematic review. Addiction. 2018 Jul;113(7):1188-1209. doi: 10.1111/add.14180. Epub 2018 Mar 24.

Narcan Reverses Opioid Overdoses

Image credit: prisonpolicy.org

The Case for Trauma Informed Care

Upstream Factors that Impact Healthcare-seeking Behaviors and Engagement for Persons With Criminal Justice System Involvement

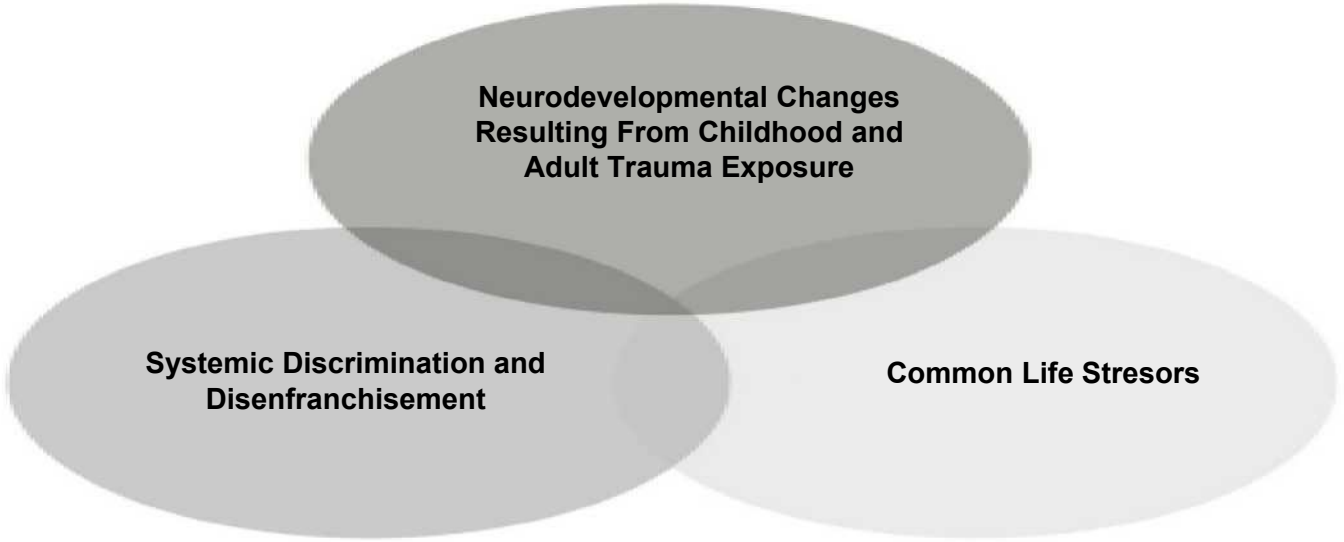


Fig. 1 Upstream factors that impact healthcare-seeking behaviors and engagement for persons with criminal justice system involvement.

Chaudhri S, Zweig KC, Hebbar P, Angell S, Vasan A. Trauma-Informed Care: a Strategy to Improve Primary Healthcare Engagement for Persons with Criminal Justice System Involvement. J Gen Intern Med. 2019 Jun;34(6):1048-1052.

Trauma Informed Care: Basic Principles

6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response | OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees a bout the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:

1. SAFETY
2. TRUSTWORTHINESS & TRANSPARENCY
3. PEER SUPPORT
4. COLLABORATION & MUTUALITY
5. EMPOWERMENT VOICE & CHOICE
6. CULTURAL, HISTORICAL & GENDER ISSUES

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by 0PHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

Examples of Trauma-Informed Programming

Table 1 Trauma-Informed Programming in Different Healthcare Domains

Healthcare domain	Examples of trauma-informed programming	Examples of trauma-informed programming for a patient with justice involvement
Care environment	Create welcoming, easy to navigate spaces that minimize visual, auditory, or other potentially re-traumatizing triggers	Assess for and minimize things that can be triggering in the clinic environment, ex. Uniformed security guards. Include reenty service organization pamphlets or posters to signal welcome and belonging
Dialog and interactions between patients, staff, and providers	Focus on positive, accepting language that facilitates patient safety, disclosure, and engagement, and create a supportive work environment for the entire care team	Recognize unfamiliarity with community healthcare systems and explain the reasoning behind common screening questions and procedures. Always obtain consent before examination. Support patients to make choices and regain a sense of control over their bodies and healthcare
Patient and provider workflows	Reduce barriers to care access (e.g., insurance coverage, physical access to the clinic), and facilitate efficient and effective patient throughput, provider workflows, and meaningful patient-provider interactions	Medicaid is suspended or revoked while incarcerated and can take time to reinstate upon release; see patients whose Medicaid may not yet be reinstated as services can be billed retroactively
Standard operating procedures	Incorporate trauma-informed principles into all aspects of clinic operations, including human resources, budgeting and financial management, and infrastructure, including incorporating trauma survivors and those with lived experience (e.g., CJS involvement) as a part of the care team	Hire peers with experience of the criminal justice system as health educators or community health workers. Budgest a small amount of funds to support recently released patients with immediate needs (a meal, clothing, bus passe, etc.), potentially increasing trust and engagement. Make walk-in appointments available to allow patients to see a clinician on their terms
Trauma screening and disclosure	While data are limited, some TIC advocates have called for upfront and universal trauma screening, including screening adults for ACEs, which can provide a better understanding of a patient´s trauma history, allow for targeted interventions, and encourage normalization and disclosure as an act of healing, [33] Weigh the pros and cons of trauma screening before deciding if it is right for your clinic	Should you decide to screen for trauma or CJS involvement, ensure that staff are trained in proper screening techniques and appropriate support is available for patients, including behavioral health and social service referral options. In the absence of screening, all staff can be trained in patient-centered communication strategies and how to appropriately respond if a patient discloses CJS involvement
Self-regulation and social resilience	Build concrete behavioral modification tools for staff, providers, and clients to manage everyday states of emotional-hyperarousal, facilitate better communication, and strengthen relationships[22],[34]	When creating tolos and guidance, study perspectives of healtcare inside correctional facilities and understand how these experiences can contribute to a patient´s emotional State and engagement in care when back in the community

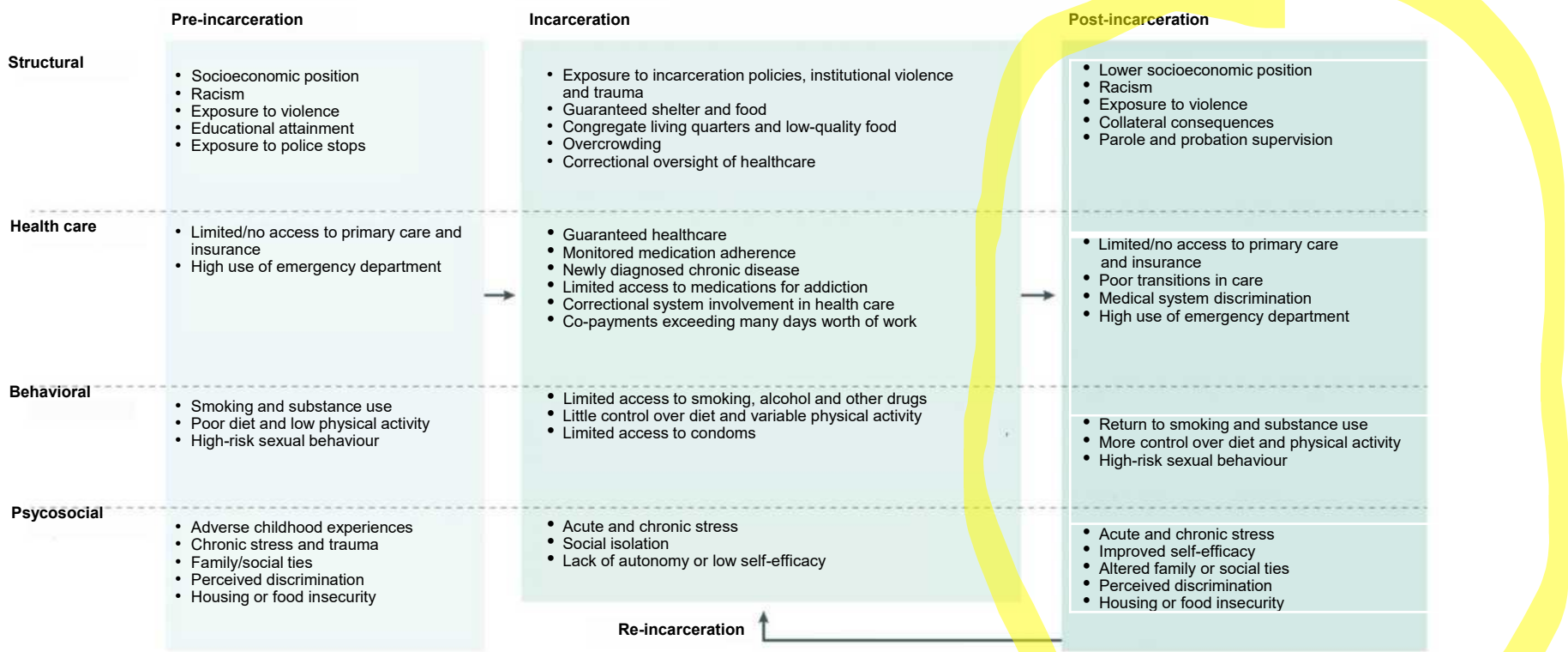
Chaudhri S, Zweig KC, Hebbar P, Angell S, Vasan A. Trauma-Informed Care: a Strategy to Improve Primary Healthcare Engagement for Persons with Criminal Justice System Involvement. J Gen Intern Med. 2019 Jun;34(6):1048-1052.

Discharge Planning From Jails ? Varies by size/location of Facility

- Minimal at BWJC, several pilots in place.
- Contra Costa County Jail (Martinez Detention Facility) has a comprehensive patient centered re-entry team which can prepare medications, provide reentry services, reinstate Medi-Cal coverage or new coverage, SUD referrals, MH services, Homeless services (personal correspondence)
- San Francisco County Jail : "5-day buprenorphine rx on discharge, Narcan on property, rx meds for psych pts, etc. Our patients with HIV have a designated RN and case manager to help them with discharge planning. We are developing a more robust discharge planning team" (personal correspondence)
- Santa Clara County: "All essential meds, including psychotropics are placed on list for RX by on-call docs the day after release. County covers 30 days, no refills. Complex patients are referred to our Reentry (transitions) clinic, and CHWs are sometimes connecting with patients pre-release. We are lacking a nurse case manager" (personal correspondence)

Factors Associated With Health in Individuals Who are Incarcerated

From: Health care for people who are incarcerated



Structural, behavioural and social factors, in addition to health-care factors, are associated with health in incarcerated individuals.

Source: https://www.nature.com/articles/s41572-021-00288-9/figures/1

Access to Post-Incarceration Care

- Before the Affordable Care Act (ACA), most adults leaving prison or jail were not eligible for Medicaid. In 2018, 33 states expanded Medicaid to all adults with incomes below 138 percent of the federal poverty level (FPL).[1]
- Missouri was not one of those states,but voted for expansion in 2021.
- Historically, previously incarcerated populations have difficulty with access to care. Specific clinics, including Transitions Clinics, have worked to bridge this gap.
- A recent program implementation at Contra Costa County Jail (Martinez) found that 62.6% of their patients needed Medi-Cal insurance and would have gone without coverage if they were released without assistance (private communication)

1. https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/state-strategies-health-care-justice-involved-role-medicaid
2. https://governor.mo.gov/press-releases/archive/state-outlines-next-steps-medicaid-expansion-after-court-ruling

Discrimination against justice involved patients

Ann Fam Med. 2018 Nov; 16(6): 549 551
doi: 10.1370/afm.2314
PMCID: PMC6231934
PMID: 30420371

Access to Primary Care for Persons Recently Released From Prison

Nahla Fahmy. MD,[1] Fiona G. Kouyoumdjian. MD, MPH, PhD,[2,3] Jonathan Berkowitz:. PhD,[1] Sharif Fahmy. MBA,[1] Carlos Magno Neves. MA,[4] Stephen W. Hwang, MD,[3] and Ruth Elwood Martin. MD, MPH[1]

Telephone callers who presented as recently released persons were significantly less likely to receive a positive outcome when compared with controls (P <.001). An appointment was offered to 42.6% of telephone callers presenting as recently released from prison, compared with 84.4% of control telephone callers (Table 2). The likelihood of obtaining an appointment was 1.98 (95% CI, 1.59-2.46) times greater for controls compared with those reporting recent release from prison, and the absolute difference was 41.8% (95% CI, 31.0-52.5). There was no significant difference in whether an appointment was offered between male and female telephone callers (P = .42).

Role of primary care

- Literature re: care of previously incarcerated focuses on specific interventions and their effectiveness, NOT on the key characteristics of strong primary care which remain access, comprehensiveness, continuity, coordination, and community orientation of care.
- At the SYSTEM level strong primary care networks are necessary to meet the needs of this complex patient population
- Medical Home Models, when available, work well with this population.

Groenewegen P, Dirkzwager A, van Dam A, Massalimova D, Sirdifield C, Smith L; EFPC working group on Prison Health. The health of detainees and the role of primary care: Position paper of the European Forum for Primary Care. Prim Health Care Res Dev. 2022 May 16;23:e29. doi: 10.1017/S1463423622000184. PMID: 35574709; PMCID: PMC9112672

Role of primary care

Role of the INDIVIDUAL primary care provider:

Provide comprehensive, individualized primary care in a non-judgmental fashion

Build trusting relationships which may improve uptake of preventative services/engagement with health care system

Minimize unnecessary ER utilization

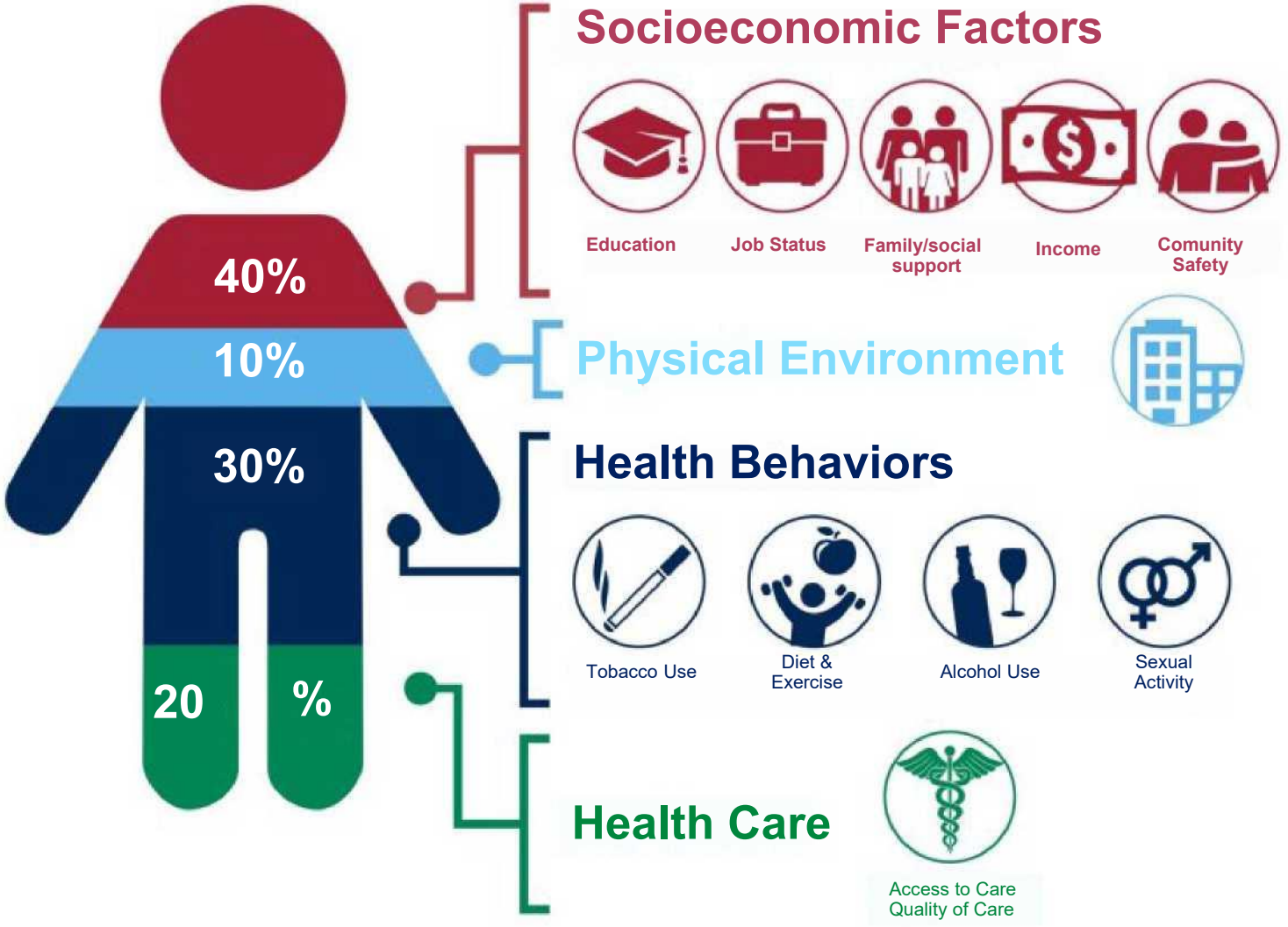
Improve long term health outcomes

Clinical Actions

- Evaluate for SUD, risk of fatal or non-fatal OD
- Provide prompt treatment or referral to MAT for patients with OUD
- Provide ANY patient with a history of substance use disorder with naloxone
- Evaluate/treat for chronic medical conditions
- Screen all formerly incarcerated patients for psychiatric comorbidities. Provide treatment or referral as indicated.
- Screen for Hepatitis B, C, HIV, and TB if patient's status is unknown or patient has ongoing risk factors. Provide hep A/B immunization if needed.
- Offer STI screening and treatment if appropriate
- Address reproductive health needs of all formerly incarcerated patients with a uterus of reproductive age.
- Provide indicated preventative care, including indicated cancer screenings
- Refer for dental care or provide information on lower-cost dental care options.
- Provide indicated vaccines, including annual influenza and primary or booster dosing of covid vaccines.

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.



SDoH Impact

20% of a person's health and well-being is related to **access to care** and **quality of services**

The **physical environment, social determinants** and **behavioral factors** drive **80%** of health outcomes

Source; institute for Clinical Systems Improvement; Going Beyond Clinical Walls; Solving Complex Problems, 2014 Graphic designed by ProMedica.

American Hospital Association™
Advancing Health in America

Review

- Recognize patients may not volunteer information about justice involvement
- Recall that persons who have experienced detention have a higher burden of psychiatric disease, substance use-related disorders, chronic diseases, communicable diseases, intellectual disabilities and stress related illness when compared to the general population. Many of these patients are COMPLEX.
- Use a trauma informed lens when possible

Positive Actions Physicians Can Take

- Learn about the unique needs of incarcerated or formerly incarcerated individuals and their families. Resources include the American College of Correctional Physicians (http://societyofcorrectionalphysicians.org/), the National Commission on Correctional Health Care (www.ncchc.org/), and the Center for Prisoner Health and Human Rights (www.prisonerhealth.org/).
- Work in the prison health system or volunteer to work with individuals in this population during or following their incarceration.
- Advocate on behalf of individuals who are incarcerated or who have been incarcerated and their families to have adequate access to all helathcare and preventive services (e.g., immunizations, PrEP, mental health services, and evidence-based substance use treatment, including medication-assisted treatment for opioid use disorders.)
- Advocate to prevent unnecessary incarceration by diverting eligible people from the justice system to substance abuse and/or mental health treatment.
- Oppose detention of those seeking asylum and against separation of parents and children in immigration detention centers, and promote policies for humane treatment of families detained as a result of seeking safe haven in the U.S.
- Partner with legislators on other policy issues related to prisoner health, such as eliminating racial disparities in the bail system, sentencing, commuting sentences of nonviolent drug offenders, and facilitating health insurance enrollment processes after release.
- Be aware of tools and resources for addressing health disparities and apply them as appropriate in their practices and communities.

Source:
https://www.aafp.org/about/policies/all/incarceration.html#after

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