

Perceptions and opinions about the comparability of health care in the community versus that in correctional facilities vary, often changing by one's experience with the topic. In 2004, the Centers for Disease Control undertook focus-group research to better understand perceptions of the barriers to providing health and mental health services in correctional facilities and in the community. This research could help both corrections and public health providers develop stronger collaborative approaches to enhance the health of the community in general.

Five focus groups, each with nine participants, were held in Atlanta, Chicago, Houston and San Rafael, Calif. The groups included participants who formerly had been incarcerated, the families and friends of incarcerated individuals, law enforcement officials and employees of correctional facilities.

The research reported here focused on the opinions and perceptions of the participants as they related to three topics: 1) health and social services in the community, 2) the same health and social services in the outside community compared with those inside correctional facilities, and 3) the level of care that should be provided in correctional facilities.

From responses to a facilitator-led standardized set of questions, four themes emerged: 1) the benefits of providing health and mental health services to incarcerated populations, 2) the barriers currently facing individuals who are seeking care while living in a correctional setting, 3) the barriers facing correctional staff assisting and responding to inmate health care requests, and 4) barriers faced by the offender when returned to the community.

In the study, all of the previously incarcerated participants and those who had a family member or friend behind bars were minorities (87 percent black, 13 percent Hispanic). The race/ethnicity of the correctional facility staff and law enforcement officials was equally distributed between whites and non-whites. Each was paid \$50 (\$30 for participation, \$20 for transportation) for their involvement.

Former inmates and the families of current inmates were asked about their opinions and experience with departments of health and social services in prisons and in the community. Correctional system personnel and law enforcement officials were asked about their perceptions of the care provided both in corrections and the community, and

# THE PERCEPTION OF HEALTH AND MENTAL HEALTH SERVICES: BENEFITS AND BARRIERS

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probed about their personal experience seeking care for offenders inside and for themselves and family members on the outside.

## Barriers to Providing Health And Mental Health Services

For former inmates and families of those currently incarcerated, difficulty in accessing health and mental health services in the correctional system or community meant that their health was at risk. The access to and lack of provision of health and mental health services to inmates was considered problematic by many participants personally and, in their view, eventually led to problems for the community. The participants who were corrections personnel and law enforcement officials expressed similar concerns about the struggle many individuals in resource-poor communities have accessing health and mental health services. It was their perception that the difficulty inmates had in accessing care also put the community's health and safety at risk.

**Barriers in the Community.** In each of the focus groups, respondents agreed that the two main obstacles to accessing health and mental health services in the community are lack of insurance and money, and the inequities present in poor communities. Those with health insurance complained that they did not have access to health care providers outside their plan, while those without health insurance complained that they were not treated the same as paying clients. Other key issues identified were lack of choices, long waits and a perception of disrespect for the patients.

A former inmate typified the difficulty experienced in seeking care in the community during a recent illness: “[At] one of the state hospitals here, I was turned around because I had insurance and they wouldn’t accept it. So I had to go somewhere where they will accept the insurance. Then I went over to [the clinic], which is another part of [the county]. I was turned down there because I had Medicaid. I didn’t have the proper insurance; I didn’t have the HMO that I needed.”

Another former inmate perceived that he was not given care because of his lack of insurance. “They felt that I had no insurance so there wasn’t anything wrong. They treated me like I was gum under their shoe or something.”

Most respondents believed that poverty and lack of understanding of the health care system prevented releasees from getting care in the community. For another former inmate, poverty, unemployment, lack of housing and education most influenced an individual’s plight in the community. He said, “Prison life is a result of a lot of conditions from the outside, mostly with economics that’s not empowering other people ... a lot of folk don’t have health care, a lot of folk don’t have clothes, a lot of clinics are getting closed so people don’t go seek out those things.”

**Barriers Behind the Walls.** Lack of education and lower socio-economic status were not

the barriers most identified by respondents on the inside. Those who were previously incarcerated or had family or loved ones serving time perceived that the difficulty in seeking care inside jails and prisons was due to unresponsive correctional and law enforcement officers.

For a former inmate who served time in a local jail, the problem was the deputies and sheriffs. “The problem wasn’t that bad once I got to a doctor and he saw how sick I was ... but it was just getting to the doctor.”

The wait to see a health care provider took from hours to days, according to one former inmate who served time in a state prison. “In prison, medical treatment is one of the poorest things you can have there. And, in order to get down there if you are sick ... you could really be sick ... it’s going to take two or three hours. It may take a day or two.”

Inmates also recognized procedural barriers to care — the process of filling out a request form and then waiting for care. Most agreed the current methods were inefficient.

“Basically, if you plan to get to [medical treatment], you have to fill out this form, and wait until they get back at you. It could be two weeks sometimes, and you have to deal,” one former inmate said.

Another former state inmate explained their process in this way: “If you fall out, then they immediately come and transport you to [medical care], but if you put in a slip, it’s just kind of like at some point they will shoot you a docket, which is like a little pass to go to the infirmary.”

Describing the process for accessing mental health, a former inmate said of the request slip, “It says something like check off if you’re sneezing, coughing, and one of the things on there they give out is ‘thinking of hurting myself or someone else.’ So like someone is going to check ‘I’m thinking about hurting myself or someone else,’ I’m just going to wait a week or two to be seen. You know like that’s pretty ridiculous.”

Family members of those incarcerated expressed difficulty with both the care and access to care received for their ill family member inside correctional facilities. A mother of a former jail-incarcerated man talked about her experiences while her son was critically ill. “My son was 19. He died three years ago from complications of AIDS due to ... neglect. He didn’t get the proper treatment that he was supposed to have gotten. They never took him to the doctor. He started out with a simple cold ... they did treat the cold. And they let him go. He just laid there and eventually got worse and worse and it turned into pneumonia ... it took him to the grave. They wouldn’t even let me see my son. I told them that my son is sick and I need to see him and they’re telling me that he’s in lockup and he’s not to have any visitors. In the meanwhile, my son was ... dying with no treatment at all.” In the end, formerly incarcerated or family members of

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incarcerated individuals tended to view correctional health care as nonresponsive to crisis events.

Alternatively, correctional officials and law enforcement officers perceived providing health services as a process: medical emergencies garnered immediate response, while routine medical concerns required the submission of a form before services could be provided.

A jail-based correctional officer described how medical care was apportioned at his facility. “[If they] say I’m having a heart attack, that’s going to be immediate. Or say we had one guy come up and say ‘hey this bullet came out of me.’ [If] he handed the bullet to the officer, if you get something like that, [it] is immediate because we’re not playing around with that. But there are request forms.”

A state prison correctional health care provider underscored the comments of former inmates about correctional health care services. “You know we’re really good at catastrophic treatment. We’re good at things like liver transplants when somebody has to go to the hospital or something like that. But what we’re not good at ... is someone could wait a long time to get cough syrup.”

## Benefits to Providing Health And Mental Health Services

Public safety is a primary reason for incarceration of convicted offenders. Public safety — keeping communities healthy — also was identified as a key benefit to providing health and mental health services to inmates by participants in both sets of focus groups.

Specifically, respondents saw public safety as the underlying rationale for the availability of physical and mental health services and substance abuse treatment for inmates and those recently released. Many felt that neglecting the health of incarcerated men and women by not addressing infectious diseases and mental health problems meant neglecting the health and safety of the community. Because inmates eventually return with their health problems to the community, ultimately the neglect could negatively affect the health and safety of a community as untreated disease and mental illness are reintroduced.

A county law enforcement officer summed it by saying “they’re only inmates today, they were citizens yesterday.” These law enforcement officers realize that the vast majority of inmates will be returning to the community.

The participants who worked in corrections made a connection between mental health problems and criminal behavior. A prison correctional officer said, “Your traumatic brain injury, your organic brain syndrome ... those folks cause problems in the community. Law enforcement solves problems and we get [them]. Whether that’s right or wrong, it’s not like law enforcement brings them to us because they were singing too loud in church. They earned their way in.”

Another law enforcement officer concluded: “We put people in prison for having mental illness. That’s just what we do.”

## Conclusions

Participants who were previously incarcerated and family members of current inmates spoke of an inability to

navigate the health system in the community because of the lack of insurance or inexperience accessing care. They identified the difficulty of accessing care in correctional facilities as the system itself or the correctional staff, a point of view supported by some of the correctional facility staff participating in these focus groups. Many of the former inmates, families of inmates and law enforcement staff said that better health services for those incarcerated could reduce the risk of diseases to communities.

Among the correctional officials and law enforcement officers, many discussed barriers to providing correctional health services. And many of these participants perceived public safety as a key benefit to providing medical services in correctional systems.

The focus group participants’ responses on what could be done to improve the health of corrections and community populations were largely similar. Some of the responses, especially from the formerly incarcerated inmates, indicated that strategies are needed to promote health and mental health services in correctional systems.

## The Need for Collaborative Approaches

There was agreement among focus group participants on both barriers to service and the need for such services that benefit the community. There is a tendency among the public to think that law enforcement and corrections personnel and the inmates they manage see the world in opposing ways. Our admittedly small sample size suggests there is a much greater similarity than difference. This is especially true in discussion of the benefits to the community associated with correctional health care. We believe this common vision may provide a bridge on which to build strong public health and corrections links.

Initiating and sustaining partnerships between corrections, public health and organizations providing community health services would be key to addressing the barriers discussed by the focus group participants. Inmates who are released from jails and prisons need to have access to the same services that they received while incarcerated. For example, an inmate diagnosed with diabetes upon entering prison, and then stabilized on appropriate medications, needs access to those same medications and monitoring to stay healthy. Other than some systems for supporting those infected with HIV, such continuity of care systems are largely missing in the community. Additional prevention services would ensure that former inmates and the community would stay healthy.

Collaborative approaches between public health and corrections could enhance the probability that those exiting jails and prisons would become familiar with health services in the community and have enough understanding of the health system to protect their own health. Ultimately, this benefit could translate into the improvement of the health of communities, especially medically-underserved communities.

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