Locked Up & Forgotten

The Federal Government's Failure to Fund Tribal Correctional Healthcare

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In Consultation With the Arizona Tribal Correctional Healthcare Coalition

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Arizona Tribal Correctional Healthcare Coalition

In October 2015, the Tuba City Regional Health Care Corporation began to reach out to the tribes and tribal organizations in Arizona, where tribes operate five of the seven correctional facilities previously operated by the Bureau of Indian Affairs. These tribes bear the costs of healthcare for their inmates for which there are no delegated resources. To address this issue, these tribes created the Arizona Tribal Correctional Healthcare Coalition, an ad hoc organization comprised of tribal hospital administration and medical staff, tribal correctional administration and staff, state government representatives, inter-tribal staff, and federal partners.

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PART I
TRIBAL CORRECTIONAL HEALTHCARE OVERVIEW

What Is The Problem?

The problem is that the federal government does not fund healthcare in tribal jails, despite its trust responsibility to do so. State and local jurisdictions are able to pay for inmate healthcare by leveeing property taxes. Tribes do not have this same ability because federal law prohibits tribes from imposing property taxes on the federal trust land that comprises Indian reservations. It is therefore the responsibility of the federal government to provide healthcare and public safety to American Indian and Alaska Native (AI/AN) communities.

The federal government pays for the healthcare provided at Federal Bureau of Prisons (FBOP) facilities because they are federal facilities. Despite its trust responsibility to do so, the federal government does not provide healthcare at Bureau of Indian Affairs (BIA) tribal jails which are also federal facilities. However, federal funds are used to construct tribal jails to incarcerate federal trustees on federal trust lands pursuant to federal correctional guidelines.

The federal government's failure to provide healthcare to individuals incarcerated in tribal jails is unconstitutional because the U.S. Supreme Court has determined that systemic failure to provide healthcare to inmates violates their Eighth Amendment protection against cruel and unusual punishment.[1]

The absence of medical staff in tribal jails means that correctional officers must transfer inmates to their local Indian Health Service (IHS) or tribal 638 healthcare provider for all medical services (i.e. emergency, primary, dental, mental and behavioral health).

Federal Trust Responsibility

The federal trust responsibility is a legal obligation set out under case law, statute, and treaty under which the United States, "has charged itself with moral obligations of the highest responsibility and trust. Its conduct, as disclosed in the acts of those who represent it in dealing with the Indians, should therefore be judged by the most exacting fiduciary standards."* This trust doctrine was first codified in the Snyder Act of 1921, "for the benefit, care, and assistance of the Indians ,,, for the following purposes: education, health, property, [and] the administration of Indian affairs."** The trust doctrine is a legally enforceable fiduciary obligation on the part of the United States to protect tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to American Indians and Alaska Natives.

* Seminole Nation v. United States, 316 U.S. 286, 296-97 (1941).

** Public Law 67-85.

[1] Estelle, et. v. Gamble, 429 U.S. 97 (1976), Brown, et al v. Plata 131 A.Ct. 1910 (2011).

Federal Trust Land

A federal Indian reservation is an area of land reserved for a tribe or tribes under treaty or other agreement with the United States, executive order, or federal statute or administrative action as permanent tribal homelands, and where the federal government holds title to the land in trust by the United States government on behalf of the tribe. There are approximately 326 federal Indian reservations (i.e., reservations, pueblos, rancherias, missions, villages, communities, etc.).

638 Agreements

Under the Indian Self-Determination and Education Assistance Act of 1975 and its amendments, Indian tribes and tribal organizations may enter into agreements with the federal government to manage programs that impact their members, resources and governments. These agreements are referred to as either "638 contracts" or "self-governance compacts."

These agreements are referred to as "638 compacts and contracts" because they were first authorized under Public Law 93-638.

Neither IHS nor tribal healthcare providers receive payment for outpatient services they provide to inmates because IHS does not have a correctional healthcare budget and Medicaid excludes inmate healthcare from such reimbursement. Tribal jails similarly receive no funding to pay their significant costs of transporting inmates to tribal hospitals and maintaining custody until such inmates are returned to jail.

This federal government failure to budget and pay for tribal correctional healthcare exacerbates the already challenging problem of AI/AN health disparities. AI/AN's experience lower health status and higher mortality rates than all other Americans due to inadequate education, disproportionate poverty and discriminatory delivery of health services.[2] Ironically, these same factors can lead to criminal activity.

Access to healthcare is the prerequisite for an inmate's successful return to their community. Until the federal government funds healthcare in tribal jails, reducing recidivism in Indian Country is unlikely. The U.S. Department of Justice's (DOJ) inter-agency ReEntry Initiative will effectively exclude Indian Country unless and until the federal government funds tribal correctional healthcare.

DOJ's ReEntry Initiative is premised upon five principles, including that each inmate should be provided education, employment training life skills, substance abuse, mental health, and other programs that target their criminogenic needs and maximize their likelihood of success upon release. Criminogenic needs are "characteristics, traits, problems or issues of an individual that directly relate to the individual's likelihood to commit another crime, such as low levels of educational and employment performance, or substance abuse."[3]

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[2] Disparities, Indian Health Service Factsheet. https://www.ihs.gov/newsroom/index.cfm/factsheets/disparities/

[3] Roadmap to ReEntry, https://www.justice.gov/reentry/roadmap-reentry

Who Does This Problem Harm?

The absence of healthcare inside tribal jails jeopardizes inmates and staff alike, in addition to their friends and families back home. Infectious diseases, such as tuberculosis and Hepatitis C, can quickly spread from inmates to staff to the rest of their tribal community. Sexually transmitted diseases (STDs), such as HIV/AIDS, syphilis and chlamydia, are disproportionately prevalent among inmates in general, but are particularly concerning in tribal jails were STDs are not screened.[4]

The absence of healthcare inside tribal jails jeopardizes correctional officers and their facilities. Tribal correctional officers must dispense inmate medication because there are no medical staff in tribal jails to do so. As a result, BIA and tribal jails are potentially one dosage away from incurring liability for an inmate's death.

Flynn v. Doyle

In 2009, inmates of the Taycheedah Correctional Institution in Fond du Lac, Wisconsin won a class action lawsuit against the state because the state did not require medical personnel administer medications to prisoners, which resulted "in patients routinely receiving wrong medications, medications that should have been discontinued, wrong dosages of medications, and medications that cause adverse interactions with other medications." Instead the state permitted correctional officers without medical training to do so. The court ordered that Wisconsin begin using licensed practical nurses or medical personnel with equivalent training to distribute and administer prescriptions.

Flynn v. Doyle, 630 F. Supp 2d 987 (D. Wis. 2009) 989.

What Is The Solution?

The solution to providing tribal correctional healthcare is surprisingly simple:

1. BIA should partner with the U.S. Public Health Service through a Memorandum of Agreement to get Commission Corps Officers assigned to tribal jails just as they are already assigned to FBOP facilities;
2. BIA should include a correctional healthcare line item in its annual budget to fund Commission Corps Officers in tribal jails; and Congress should appropriate funds for Commission Corps Officers to be assigned to tribal jails; and
3. Congress should amend Medicaid to allow reimbursement for outpatient services that IHS and 638 tribal healthcare facilities provide to individuals who are enrolled members of federally recognized Indian tribes and are incarcerated in tribal jails.

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[4] Study Reveals High Rates of Sexually Transmitted Diseases at Maricopa County, Arizona Jails, Prison Legal News, July 15, 2012. https://www.prisonlegalnews.org/news/2012/jul/15/study-reveals-high-rates-of-sexually-transmitted-diseases-at-maricopa-county-arizona-jails/

PART 2
INSIDE TRIBAL CORRECTIONS

What Is The Federal Government's Role?

BIA has oversight of all 79 jails in Indian Country and the 2,380 inmates that are currently incarcerated in them.[5] BIA either directly operates these jails or contracts with tribes to operate them. Many of these jails have not been upgraded since they were originally built between the 1940s and 1970s.[6]

In 2011, the Department of Interior Office of the Inspector General found that many tribal jails had "egregious physical conditions ... including ... unsecure fencing, doors, and windows; absence of practiced safety and security measures; leaky roofs; rusted sinks, toilets, and showers ...".[7] The Inspector General also found a prisoner overcrowding crisis in Indian Country, where one out of five tribal jails operate at 150 percent of capacity on their most crowded days.[8]

Tribes have few options to improve these facilities themselves because, unlike state and local jurisdictions, tribes cannot levee property taxes to generate the revenues needed for jail construction or operation.

Jails vs. Hospitals

The federal Government's failure to fund tribal correctional healthcare sometimes thrusts tribal detention and medical staff into adversarial situations:

A tribal corrections director reports that two of his inmates were denied treatment at the local tribal hospital. Both inmates had broken bones. Medical staff instructed the correctional officers to transport the inmates to the nearest metropolitan hospital for care.

Tribal corrections staff transported a 13 year old with a fractured wrist from juvenile detention to the hospital. Medical staff allegedly refused the child treatment because he was not an enrolled member of the hospital's Indian Health Service Area. Correctional officers had to transport him to his home service area many miles away in order for him to receive healthcare.

Tribal corrections staff have transported inmates to tribal judges to seek emergency release from jail so that criminal defendants can receive healthcare at their local tribal hospital.

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[5] Jails in Indian Country, 2014, Todd D. Minton, Office of Justice Programs Bureau of Justice Statistics, October 2015, NCJ 248974). http://www.bjs.gov/content/pub/pdf/jic14.pdf

[6] Neither Safe Nor Secure: An Assessment of Indian Detention Facilities, US Department of the Interior, Office of Inspector General, No. 2004-I-0056, Sept. 2004), https://www.hsdl.org/?view&did=688492

[7] Bureau of Indian Affairs Detention Facilities, Office of Inspector General, Department of the Interior, Report No. WE-EV-BIA-0005 Feb. 2010), 1.

[8] A Roadmap for Making Native America Safer - Report to the President & Congress of the United States, Indian Law and Order Commission, November 2013, 123.

Why Is Tribal Correctional Healthcare An Emergent Issue Today?

Historically, tribes have neither the capacity nor the criminal jurisdiction to incarcerate large populations of inmates for extended periods of time. The Inspector General's 2011 report revealed tribal jails are overcrowded, antiquated facilities that lack the physical capacity to hold individuals for much longer than a few days. Federal law also limited tribal incarceration to no more than one year.

Decisions in Washington D.C., however, have recently changed conditions on the ground. In 2010, the Tribal Law and Order Act (TLOA) became law, giving tribal courts new felony sentencing authority of three years per offense, which are stackable up to nine years.

Since 2007, DOJ has also begun investing in the construction of modern tribal jails that can house at least 100 inmates for extended periods of time. In 2010 alone, DOJ awarded 20 such grants using American Recovery and Reinvestment Act funds. Unfortunately, DOJ is constructing much needed, beautifully designed tribal jails without any regard to the staffing and services available for them.

One Child In Lock-Up

Jody was a typical 15 year old, but all that changed when she was gang raped. Jody did not report the crime because she could not name any of the perpetrators. However, news of the incident spread on social media. As a result, Jody was bullied at school. A young man's harassment made her snap. Jody hit him with a broken bottle.

Jody was arrested and sent to juvenile detention. where correctional officers transported her to the tribal hospital because she was suicidal. A hospital exam revealed the vaginal tearing Jody sustained and the gonorrhea she acquired from the rape. Medical staff also discovered that Jody had not had a dental or physical exam in over 12 years, needed glasses, and was out-of-date on her vaccinations. Her medical evaluation recommended psychiatric hospitalization.

Jody was instead returned to juvenile detention. There is no in-patient psychiatric facility on her reservation and the state mental hospital would not take her. Jody was not eligible for psychiatric hospitalization because she lost her Medicaid coverage when she was incarcerated.

PART 3
INSIDE TRIBAL HEALTHCARE

What Is The Federal Government's Role?

In 2010, Congress permanently reauthorized IHS, codifying into law the Declaration of National Indian Heath Policy as "the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians, to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[9]

Unfortunately, Congressional intent is greater than appropriations. IHS is among the most persistently and profoundly underfunded agencies in the federal government. A 1998 Report to Congress revealed the federal government spends 46% less per capita on healthcare for AI/ANs than it spends on healthcare for Members of Congress, their staff, and federal agency employees.[10]

It would cost about $3 billion per year to fully fund IHS, or less than half of 1% of the Department of Health and Human Service's (HHS) annual $800 billion budget.[11] It would cost just $11.3 million annually to fund a IHS correctional healthcare budget. The federal government's failure to do so exacerbates AI/AN health disparities and even further underfunds IHS.

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[9] S. 1790 Title 1, Section 103, H. R. 3590 Title X, Part III, Section 10221, Public Law 111-148. Codified at 25 U,S,C 1602.

[10] LNF Workgroup Report. Level of Need Funded; A Study to Measure the Costs of a Mainstream Package of Health Services for Indian People. Rockville, MD: Indian Health Service; 1999: 2. Citied in American Indian Health Policy: Historical Trends and Contemporary Issues, Donald Warne, MD, MPH and Linda Bane Frizzell, Phd., American Journal of Public Health: June 2014, Vol. 104(Suppl 3) S263-S267. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035886/

The Level of Need Funded (LNF) Workgroup was established by Congressional directive in 1998 so that IHS would work with tribes to determine an equitable methodology for funding federal Indian health programs.

[11] Ibid.

Transport Costs

In April 2016 one Arizona tribal jail had:

- 24 routine medical transports to the local tribal healthcare facility which cost $360 in staff expenses.
- 27 emergency room transports to the local tribal healthcare facility which cost $2,025 in staff expenses, not counting fuel or overtime, and
- 1 mental health transport to the local tribal healthcare facility which cost $360 in staff expenses, not counting fuel or overtime.
- Routine medical transport requires 1 officer for 1 hour. Cost is $15 per trip, not counting fuel cost.
- Emergency room transport requires 1 officer for 2 to 5 hours. Cost is $30 to $75 per trip, not counting fuel or overtime, if visit extends into next shift when officer waits with inmate until a bed is located.
- Mental health or suicide ideation transport requires 2 officers for 8 to 12 hours. Cost is $240 to $360 per trip, not counting fuel or overtime, if visit extends into next shift and officers have to wait with inmate until seen.
- Routine medical transport to off reservation metropolitan healthcare facility is 240 miles roundtrip. Staffing requires 2 officers for 5 to 8 hours. Cost is $150 to $240 per trip, not counting fuel or overtime.

IHS has oversight of all tribal healthcare facilities, both facilities that IHS operates directly and 638 facilities IHS contracts with tribes to operate. Because the funding allocated to IHS provide less than half the funding needed to operate each year, IHS and 638 tribal healthcare facilities increasingly rely upon Medicaid reimbursement to cover their annual operating costs.

In 2014, the national percentage of AI/AN adults living at or below the federal poverty level was 25.4%, the highest rate of all others in the United States.[12] In states with dense AI/AN populations, such as Arizona, the poverty level of AI/AN families is estimated to be 31.8%.[13] In states like Arizona that have expanded Medicaid to cover qualified childless adults, most tribal inmates are enrolled in, or are eligible, for Medicaid.

Why Can't Medicaid Help Pay For Tribal Correctional Healthcare?

Federal law prohibits Medicaid reimbursement for the cost of providing outpatient healthcare to all inmates everywhere, not just tribal inmates. The rationale for this Medicaid inmate exclusion is that Congress already appropriates annual funds to pay for the healthcare costs of federal prisoners and that state and local jurisdictions are responsible for the costs of providing healthcare to their inmates and can levy property taxes to pay for it. Unfortunately, federal law prohibits tribes from doing the same as states and local jurisdictions because tribes cannot levy property taxes on federal trust land.

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[12] U.S. 2014 Census (estimate), American Fact Finder. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_S0201&prodType=table

[13] 2013 American Indian Population and Labor Force Report, Bureau of Indian Affairs, Jan. 16, 2014. 55.

Why Is Medicaid Now An Emergent Issue In Tribal Correctional Healthcare?

New tribal jails now house larger populations of inmates for longer periods of time than the old jails they replace. This creates a dense new sub-population of high need patients because incarceration is often the first chance to diagnose and treat them. Inmates are often medically more complex and expensive to treat because their transient and criminal lifestyles lead to chronic disease and traumatic injury. Medicaid's "inmate exclusion" therefore jeopardizes the financial sustainability of tribal healthcare facilities, forcing IHS and 638 tribal healthcare facilities to absorb, on average, $1.5 million in annual uncompensated cost when a new tribal jail opens in their service area.

PART 4
INSIDE TRIBAL INMATES

Why Are They Sick?

Tribal corrections directors estimate that at least 95% of their inmates are incarcerated for alcohol and drug related charges, an observation consistent with alcohol and drug use in tribal communities. Across most age groups AI/ANs, are about twice as likely as all other races/ethnicities to have substance dependence.[14] Tragically, alcohol mortality rates are 514% higher among AI/AN populations than in the general public.[15]

Substance Use Treatment

Ages	AI/ANs need treatment	other races/ ethnicities need treatment
12 to 17	16.1%	7.9%
18 to 25	29.8%	21.7%
26 to 44	22.7%	11.5%
45 +	9.6%	4.7%

NSDUH Report Nov. 12: Need for and Receipt of Substance Use Treatment Among AI/ANs, Table 1. http://www.samhsa.gov/data/sites/default/files/NSDUH120/NSDUH120/SR120-treatment-need-AIAN.htm

According to the World Health Organization, disease and injuries caused by alcohol consumption are greater health burdens than alcoholism itself.[16]

The Unique Challenge of the Elderly Inmate

Mary is 72-year old great-grandmother in tribal detention for assault. The jail is chronically understaffed and has no medical staff. Mary's chronic diseases require a full-time correctional officer be assigned just to her to take care of her healthcare needs.

The correctional officer must administer 14 medications Mary takes throughout each day and transport her to her daily medical appointments: dialysis three time a week, counseling and psychiatry for depression, and diabetes treatment.

While at the tribal hospital for one of her weekly treatments, Mary had a heart attack. After being hospitalized for one week, Mary was returned to jail. Her family did not allow her to be released to their care because the assault for which Mary is charged is the third time she has seriously injured a family member while intoxicated.

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[14] Results from the 2013 National Surveys on Drug Use Health: Summary of National Findings, Substance Abuse and Mental Health Services, Center for Behavioral Health Statistics and Quality, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD, 2014, 88.

[15] Indian Health Disparities, IHS Facts Sheets, Jan. 2011, 1. https://turtletalk.files.wordpress.com/2012/11/exh_35_ihs-fact-sheet.pdf

[16] Global Status Report on Alcohol and Health 2014, World Health Organization, Management of Substance Abuse, 50.

A Tribal Emergency Department Nurse's View of Tribal Correctional Health

"Our Emergency Department (ED) has seen and medically cleared 1,032 patients coming from the tribal Police and the Detention Center between May 2015 and April 2016. Its impact is significant, ranging anywhere from increasing Length of Stay for other patients, increased risk of violence towards staff and/or other patients and staff burn-out/compassion fatigue and liability.

The prisoners we get from the Detention Center frequently suffer from alcohol withdrawal or from suicidal ideation, and often have acute illnesses or illness secondary to being off their prescriptions. For those having suicidal ideations, we could board them in the ED for days pending an inpatient psychiatric bed or an Involuntary Commitment order from the court.

It's not uncommon to board them in the ED up to or greater than 72 hours. These patients require one-to-one observation 24/7 and utilize a considerable amount of staff resources. If staff are unavailable, it increases risk for patient injury and liability."

The following are the main diseases and injuries impacted by alcohol consumption:[17]

- Cancer;
- Cardiovascular disease;
- Diabetes;
- Fetal Alcohol Spectrum Disorder;
- Infectious disease;
- Liver and pancreas disease;
- Neuropsychiatric disease; and
- Unintentional and intentional injury.

An inmate in a tribal "drunk tank" is likely to be an individual with a chronic disease.

AI/ANs have greater difficulty accessing mental health and substance abuse treatment, despite experiencing psychological distress more frequently than the general population.[18] Their most significant mental health concerns are depression, substance disorders, suicide ideation and anxiety, including Post Traumatic Stress Disorder (PTSD).[19] Given the legion of educational, economic, bureaucratic, political and practical barriers prevalent in most tribal communities, it is not surprising that AI/AN's experience

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[17] Ibid.

[18] Health, United States, 2007, with Chart Book on Trends in the Health of Americans, Centers for Disease Control and Prevention, National Center for Health Statistics, (Table 61), 262.

[19] Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations, Janette Beals, PhD; Spero M. Manson, PhD; Nancy R. Whitesell, PhD; Paul Spicer, PhD; Douglas K. Novins, MD; Christina M. Mitchell, PhD, Archives of General Psychiatry, 62 (1), 99-108. http://archpsyc.jamanetwork.com/article.aspx?articleid=208186

higher rates of exposure to trauma, and therefore greater risk of developing PTSD, than does the general population.[20]

Why Are They Expensive To Treat?

Daily exercise, proper nutrition and preventive healthcare are not typical elements of the criminal lifestyle. By the time tribal inmates are first diagnosed or treated, they are often already in acute stage of injury or disease.

To illustrate this phenomenon, consider diabetes, which AI/ANs are more than twice as likely as non-Hispanic whites to experience.[21] 95% of AI/ANs with diabetes have Type 2 Diabetes. Tribal inmates who are diabetic need chronic disease management that is difficult to get in a jail that has no medical staff.

If a diabetic inmate cannot get routine care by a primary care physician then their uncontrolled diabetes could lead to a host of medical crises, including bacterial and fungal infections, foot ulcers and nerve damage, kidney disease and ketoacidosis. Such an inmate would likely require a three day inpatient admission that would cost about $40,000, which Medicaid would reimburse. Ironically, if that same diabetic inmate could access routine outpatient care four times per year (approximately $368 per visit) then the cost and suffering could be avoided. Such care would also save about $38,500 per inmate.

Why Do Some Inmates Pose A Risk To Community Health?

Unlike non-tribal corrections facilities, tribal jails do not have medical staff and so cannot perform intake tests to screen for infectious disease. The only health screening most tribal jails

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[20] Mental Health: Cure, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General. Office of the Surgeon General, Center for Mental Health Services, National Institute of Mental Health, Aug 2001. http://archpsyc.jamanetwork.com/article.aspx?articleid=208186

[21] Diabetes among American Indians and Alaska Natives. http://www.cdc.gov/media/matte/2011/11_diabetes_Native_American.pdf

Tuberculosis Outbreak

DOJ awarded a a multi-million dollar grant to a tribe to construct a much needed new jail. The tribe's old jail, which was structurally unsafe and small, typically housed inmates for just a few hours or days. This new facility was designed to incarcerate large populations for long periods of time.

Tribal hospital officials toured the new facility before it opened. They were alarmed to learn there were no plans or funds to staff its infirmary. Hospital representatives traveled to Washington D.C. and implored DOJ's Office of Justice Programs and BIA's Office of Justice Services staff to help identify funds to provide correctional healthcare to the inmates of this facility.

Absent medical staffing, tribal hospital officials warned, this beautifully designed new showplace would soon become an incubator for tuberculosis and other infectious diseases. The jail opened on time, without healthcare personnel. Within three months, it had a tuberculosis outbreak that impacted 44 total inmates and guards.

conduct when processing inmates is a self-reporting questionnaire. Unless a tribal inmate knows and admits they have a communicable disease, they will be housed in general population.

Infectious diseases most commonly associated with incarceration are tuberculosis and Hepatitis C. AI/AN inmates are particularly at risk of tuberculosis. In 2010, the rate of tuberculosis among AI/ANs was seven times higher than among non-Hispanic whites. Death rates from tuberculosis for AI/ANs over 24 years old are 95% higher than that of White Americans of the same age groups.[22]

[22] Death Rates From Immunodeficiency Virus and Tuberculosis Among American Indians and Alaskan Natives in the United States, 1990-2009, Brigg Reilley, MPH, Emily Bloss, PhD, Kathy K. Byrd, MD, MPH, Jonathan Iralu, MD, Lisa Neel, MPH, and James Cheek, MD, MPH, American Journal of Public Health. June 2014; 104(Suppl 3): S453-S459. Table 2. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035874/

PART 5
CONCLUSION

Federal Tribal Correctional Health Care Policy is Neglect.

The federal government consistently overlooks the role of tribal governments whenever it enacts national public policy, and corrections is no exception. Every year, every Administration fails to include budget requests for tribal correctional healthcare. Similarly, Medicaid's "inmate exclusion" continues to punish Indian Country for their inability to tax federal lands to raise revenues needed to pay for correctional healthcare. Overlooking the medical needs of tribal inmates has become a de facto federal policy of neglect. It is a policy that both threatens the health and safety of tribal communities and deprives tribes a meaningful opportunity to participate in the federal government's high priority ReEntry Initiative.

Federal Policy Creates Local Practices that Endanger Inmates, Staff, and Community.

The federal government's failure to fund healthcare for federal trustees incarcerated in federal corrections facilities in Indian Country means that BIA and tribal jail staff:

1. Have nothing but a paper questionnaire to screen inmates for infectious diseases that could infect the rest of the jail population (including staff) and could cause contagious outbreaks in their home communities;
2. Are exposing themselves, tribes, and the federal government to civil liability by dispensing medications to inmates without any medical supervision and risking such unintended medical consequences as pain, injury, illness and even death;
3. Must transport inmates to IHS and 638 tribal healthcare facilities for all healthcare treatment, no matter how routine, and maintain a security vigil that deprives their own facility of much needed staffing resources;
4. Rely upon IHS and 638 tribal healthcare facilities to provide all the healthcare services an inmate needs, even though doing so could delay or deprive law abiding patients access to limited tribal healthcare; and
5. Will not benefit from ReEntry or other initiatives designed to innovate our nation's correctional systems.

Federal Agencies and Congress Should Authorize and Fund Healthcare for Tribal Inmates Before Somebody Dies and Somebody Sues.

Decision makers in D.C. have historically ignored tribal correctional healthcare and today most don't even know it is an issue. Tribal professionals on the front lines of health and justice - physicians, nurses, dentists, psychologists, patient advocates, healthcare administrators, jail staff and corrections directors - have thus united to not only characterize the problem but formulate its solution. Leadership is the strong medicine needed to cure this correctional healthcare crisis.

Unfortunately, these recommendations will have no effect without the active engagement of leaders in Congress, the Secretaries of Interior and HHS, the Attorney General, and all other members Federal Interagency ReEntry Council. It is essential for the health and safety of tribes that those accountable to the federal trust responsibility make tribal correctional healthcare a priority. Congress and the Administration should coordinate efforts to ensure that:

1. BIA partner with the U.S. Public Health Service through a Memorandum of Agreement to get Commission Corps Officers assigned to tribal jails just as they are already assigned to FBOP facilities;
2. BIA include a correctional healthcare line item in its annual budget to fund Commission Corps Officers in tribal jails; and Congress should appropriate funds for Commission Corps Officers to be assigned to tribal jails; and
3. Congress amend Medicaid to allow reimbursement for outpatient services that IHS and 638 tribal healthcare facilities provide to individuals who are enrolled members of federally recognized Indian tribes and are incarcerated in tribal jails.