Belmont Law Review

Volume 6 Article 2

2019

At the Intersection of Health and Justice: How the Health of American Indians and Alaska Natives Is Disproportionately Affected by Disparities in the Criminal Justice System

Bette Jacobs
Georgetown University - School of Nursing & Health Studies

Mehgan Gallagher
O'Neill Institute for National and Global Health Law; New York Law School

Nicole Heydt
Prometheus Federal Services

AT THE INTERSECTION OF HEALTH AND JUSTICE: HOW THE HEALTH OF AMERICAN INDIANS AND ALASKA NATIVES IS DISPROPORTIONATELY AFFECTED BY DISPARITIES IN THE CRIMINAL JUSTICE SYSTEM

DR. BETTE JACOBS[*], MEHGAN GALLAGHER[*], AND NICOLE HEYDT[*]

GEORGETOWN UNIVERSITY

ABSTRACT

American Indian and Alaska Natives (AI/AN) are a neglected population in the United States. Their health and welfare needs are often swept aside and, because of historical treaty agreements with the United States government, they suffer disparities in the justice system and, consequently, poor health. A deep look into everyday life for an AI/AN tells a story of poverty and relatively low life expectancy, proportionately high incidences of disease, high rates of incarceration, and prolific alcohol and substance abuse. AI/ANs are incarcerated at a higher rate proportionately than their white counterparts. They experience harsher sentences, due in part to jurisdictional laws, and they are the racial group most likely to be killed by law enforcement. This paper highlights concerns about how disparities in the justice system impact the health of AI/ANs.

[*] Bette Jacobs, PhD, Professor & Distinguished Scholar, Georgetown University School of Nursing & Health Studies - 3700 Reservoir Rd., NW, Washington, DC 20007 - bette.jacobs@georgetown.edu.
[*] Mehgan Gallagher, Esq., Law Fellow, O'Neill Institute for National and Global Health Law, Georgetown University Law Center - 600 New Jersey Ave., NW, Washington, DC 20001 - mg1498@georgetown.edu.
[*] Nicole Heydt, Consultant, Prometheus Federal Services - 805 15th St. NW, Suite 910, Washington, DC 20005 - nbh4@georgetown.edu.

INTRODUCTION

AI/AN health indicators demonstrate dramatically high rates of mortality, morbidity, and burden of disease.[1] AI/AN life expectancy is 5.5 years less than the average American.[2] Homicide and suicide pose serious threats.[3] Other violent and nonviolent crimes are just as troubling for families and communities. Many factors contribute to high incidences of death and disease among AI/ANs, including poverty, limited access to services, and generally low educational achievement.[4] In addition to AI/ANs suffering from lower health generally than the rest of the population, the interplay between federal, state, and tribal criminal jurisdiction in Indian country[5] has created an environment where AI/ANs are subject to harsher sentences and exposed to double jeopardy, increasing their likelihood of incarceration as well as the length of their average prison stays.[6]

---

1. David K. Espey et al., Leading Causes of Death and All-Cause Mortality in American Indians and Alaska Natives, 104 AM. J. PUB. HEALTH s303, s303 (2014).

2. *Disparities*, INDIAN HEALTH SERV. (Apr. 2018), https://perma.cc/H8AP-ZN97 [hereinafter *Disparities*].

3. *Id.*

4. *Id.*

5. Throughout the paper the authors use the term "Indian country," a commonly used and accepted phrase to denote land within an AI/AN reservation or land that is federal trust land. *See Indian Country Criminal Jurisdiction: What is Indian Country?*, https://perma.cc/Z22H-DRLM (last updated June 14, 2018).

6. Jake Flanagin, *Native Americans are the Unseen Victims of a Broken U.S. Justice System*, QUARTZ (Apr. 27, 2015), https://perma.cc/5SJD-K4VX (citing Dan Frosch, *Committee is Evaluating Whether Those Living on Reservations Face Disproportionately Harsher Penalties Than Other Citizens*, WALL ST. J. (Apr. 21, 2015, 5:30 AM),

The purpose of this paper is to examine how disparities in the criminal justice system disproportionately impact the health of AI/ANs, and how health—particularly mental health—can affect the likelihood of incarceration. The authors visited Pine Ridge Reservation in South Dakota, home of the Oglala Lakota Sioux tribe, to speak with representatives from Indian Health Services (IHS), the Pine Ridge Court Administrator from the Community Justice Center, and local educators. The authors interviewed an attorney for the Indian Law Practice Group at Montana Legal Services Association about the obstacles and hurdles of working with AI/ANs in the criminal justice system. In addition, the authors spoke to the CEO of the Montana Healthcare Foundation, an organization that works directly with tribal directors in Montana to improve the health of AI/ANs.

I. BACKGROUND

There has been a long history of mistreatment of AI/ANs by the United States government, which has had long lasting impacts.[7] "The gradual process of the United States' domination of Native nations led to profound social disruptions that still plague Native communities in the forms of poverty, substance and alcohol abuse, disproportionately high health problems, substandard education and healthcare."[8] Proportionately the AI/AN population has higher rates of poverty, death, and disease[9] and higher incarceration rates compared to the rest of the U.S. population.[10] AI/ANs consistently die at higher rates than other Americans from causes such as "chronic liver disease and cirrhosis, diabetes mellitus, unintentional injury, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases."[11] The suicide rates for AI/ANs have been reported as 3.5 times higher than other minority groups.[12] The long history of

---

https://www.wsj.com/articles/federal-panel-reviewing-native-american-sentencing-1429608601).

7. Dina Gilio-Whitaker, *Injustices of the Past and Present in Indian Country: Ways the Past Sill Works Against Native Americans*, THOUGHTCO., https://perma.cc/UFG6-NXDZ (last updated Oct. 9, 2017).

8. *Id.*

9. Rebecca Newlin Hutchinson & Sonya Shin, *Systematic Review of Health Disparities for Cardiovascular Diseases and Associated Factors Among American Indian and Alaska Native Populations*, 9 PLOS ONE 1, 2, 6 (2014).

10. PRISON POLICY INITIATIVE, UNITED STATES INCARCERATION RATES BY RACE/ETHNICITY, 2010 (2010), https://perma.cc/K62S-DMFW (citing U.S. CENSUS 2010, SUMMARY FILE 1).

11. *Disparities*, *supra* note 2.

12. Rachel A. Leavitt et al., *Suicides Among American Indian/Alaska Natives—National Violent Death Reporting System, 18 States, 2003–2014*, 76 MORBIDITY & MORTALITY WKLY. REP. 237, 237 (2018) ("[I]n 2015, AI/AN suicide rates in the 18 states participating in the National Violent Death Reporting System (NVDRS) were 21.5 per 100,000, more than 3.5 times higher than those among racial/ethnic groups with the lowest rates.") (citing *About Underlying Cause of Death, 1999-2016*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://perma.cc/GV8C-8D5F (last visited July 14, 2018)).

mistreatment and discrimination toward AI/ANs has created an environment where it is difficult for the population to flourish.

In this paper, the authors expand the current understanding of how disparities in the criminal justice system disproportionately impact the health of AI/ANs by examining how a number of factors and determinants of health are interrelated to influence health outcomes among the population. Understanding how all of these factors influence each other to impact health among AI/ANs has been largely unexplored. The results provide support for the idea that historical land and sovereignty laws and policies designed by the U.S. government, along with disparities in the criminal justice system, have led to negative mental and physical health consequences, including high incidences of death and disease among AI/ANs.

II. HISTORY OF AI/AN HEALTH CARE

The notion to provide health services for federally recognized tribes was established through the government-to-government relationship between tribes and the federal government in 1787. This agreement, based on Article I, Section 8 of the U.S. Constitution, has grown over the years through various laws, treaties, Supreme Court decisions, and Executive Orders.[13]

A. Indian Health Service (IHS)

The IHS was established in 1955 under the U.S. Public Health Service to provide health care to AI/ANs under the Transfer Act.[14] At the time the IHS was established, AI/AN health was extremely dire, with high rates of disease, particularly among populations living in rural poverty. Tuberculosis was prevalent among Native populations, and the infant mortality rate was four times the national average.[15] Since its inception, the IHS has helped to dramatically improve health conditions among AI/ANs; however, disparities still exist, and AI/ANs still suffer some of the worst health conditions among any population in the country.[16]

The goal of the IHS is to raise the health status of AI/ANs to "the highest level."[17] In order to carry out its responsibilities, the IHS operates a health service delivery system which was designed to provide a variety of health care services including preventive, curative, rehabilitative, and

13. *About IHS*, INDIAN HEALTH SERV., https://perma.cc/R9JB-KKWK (last visited July 15, 2018) [hereinafter *About IHS*].

14. INDIAN HEALTH SERV., TRENDS IN INDIAN HEALTH: 2014 EDITION 1 (2014) [hereinafter TRENDS 2014].

15. David S. Jones, *The Persistence of American Indian Health Disparities*, 96 AM. J. PUB. HEALTH 2122, 2122 (2006).

16. *Id.*

17. *About IHS*, supra note 13.

environmental services.[18] Primary care services are available to AI/ANs through IHS free of charge. Some—although very limited—specialty services are also available free of charge through contracts with private providers.[19] In this way, health services are delivered directly through IHS facilities, purchased by IHS through contractual arrangements with private sector providers, and delivered through Urban Indian Health Programs and tribally-operated programs.[20]

The IHS operates through local administrative units referred to as service units. Similar to the way a city or county health department in a state health department operates, a service unit serves as the primary level of health organization within a geographic area served by the IHS program.[21] The IHS provides health care in the form of primary and public health services for Natives through a system of providers covering 12 geographic service areas.[22] IHS hospitals are not available in all areas, and the services that IHS provides vary widely among tribes.[23] A recent survey showed a total of 662 IHS and tribally-operated facilities located mostly on or near reservations. Of those, 82% were operated by tribes.[24] The IHS currently operates 28 hospitals, 61 health centers, three school health centers, and 34 health stations.[25]

Eligibility for IHS services is established by counting AI/ANs who reside in geographic areas that are "on or near" reservations.[26] Approximately 58% of all AI/ANs residing in the U.S. are estimated to be eligible.[27] The 2010 census reported approximately 5.2 million U.S. residents who are full or part AI/AN, but the IHS service areas covered a population of 2.1 million AI/ANs in 2014.[28]

The IHS has been highly criticized—and rightly so—for its lack of sufficient funding and low quality of care, among other things.[29] The funding restrictions of IHS limit the provision of care available for the AI/AN

---

18. TRENDS 2014, *supra* note 14, at 1.

19. Mim Dixon, *Access to Care for American Indians and Alaska Natives*, *in* PROMISES TO KEEP: PUBLIC HEALTH POLICY FOR AMERICAN INDIANS AND ALASKA NATIVES IN THE 21ST CENTURY 61, 67-68 (Mim Dixon & Yvette Roubideaux eds., 2001).

20. TRENDS 2014, *supra* note 14, at 1.

21. *Id.* at 2.

22. INDIAN HEALTH SERV., FISCAL YEAR 2016: JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES 54 (2015).

23. Mim Dixon, *The Unique Role of Tribes in the Delivery of Health Services*, *in* PROMISES TO KEEP: PUBLIC HEALTH POLICY FOR AMERICAN INDIANS AND ALASKA NATIVES IN THE 21ST CENTURY 31, 41 (Mim Dixon & Yvette Roubideaux eds., 2001) [hereinafter Dixon, *Unique Role*].

24. *IHS Profile*, INDIAN HEALTH SERV. (May 2018), https://perma.cc/T6XH-LQAL.

25. TRENDS 2014, *supra* note 14, at 4.

26. *Id.* at 8.

27. *Id.*

28. *Id.* at 4.

29. ARTIGA ET AL., HENRY J. KAISER FAM. FOUND., HEALTH COVERAGE AND CARE FOR AMERICAN INDIANS AND ALASKA NATIVES 2 (2013).

population.[30] Because IHS is a discretionary program, the funding is limited, and it must be appropriated annually by Congress. Each year, the approved funds are distributed among IHS facilities all over the country. Services must be rationed or prioritized, in the case where service demands exceed available funds.[31]

An example of the funding and how it is allocated is demonstrated by examining the 2013 budget. The total amount appropriated to IHS in fiscal year 2013 was $4.3 billion. Of that total, $3.1 billion went toward health care services, and the rest was apportioned toward supporting preventive health and other services.[32] Approximately $1.8 million of the $3.1 million allocated for direct care services went to tribally-operated facilities, and the remaining $1.3 million went toward facilities directly operated by IHS.[33]

III. THE STATE OF AI/AN HEALTH

Today, AI/ANs still suffer from poor health but in different ways. Starvation is not an issue in AI/AN communities as it was in the past. Instead, obesity, another form of malnutrition is a concern among the population, and it is the cause of many chronic diseases. Infant mortality and childhood mortality rates have greatly reduced; however, "more AI/AN people are developing cancer, diabetes, heart disease, and stroke."[34]

Of all the marginalized populations in the United Sates, AI/ANs represent one of the populations most affected by health disparities.[35] Data shows that AI/ANs suffer from higher rates of death and disease than their counterparts.[36] This is true for heart disease, unintentional injuries, diabetes, stroke,[37] and chronic alcoholism.[38] A number of factors help to explain this unfortunate reality, including disproportionate poverty, inadequate educational opportunities, inadequate housing, high unemployment levels, cultural differences, and discrimination in the delivery of health services.[39]

---

30. *Id.* at 6.

31. *See* INDIAN HEALTH SERV., FISCAL YEAR 2014: JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES (2013).

32. *Id.* at 14.

33. ARTIGA ET AL., *supra* note 29, at 7.

34. Espey, *supra* note 1, at s303.

35. Hutchinson & Shin, *supra* note 9, at 2.

36. INDIAN HEALTH SERV., TRENDS IN INDIAN HEALTH, 2002-2003 EDITION 4 (2009) [hereinafter TRENDS, 2002-2003]; *see also* Clark H. Denny et al., *Surveillance for Health Behaviors of American Indians and Alaska Natives: Findings from the Behavioral Risk Factor Surveillance System, 1997-2000*, 52 MORBIDITY & MORTALITY WKLY. REP. 1 (2003).

37. *Profile: American Indian/Alaska Native*, OFF. OF MINORITY HEALTH, https://perma.cc/97HD-7PMS (last modified Mar. 28, 2018) [hereinafter *Profile: AI/AN*].

38. Jones, *supra* note 15, at 2122.

39. *Disparities*, *supra* note 2.

A. Tobacco

AI/ANs have particularly high rates of mortality caused by tobacco-related illnesses. AI/AN men are 20% more likely to be cigarette smokers than white men.[40] Compared to other minority populations in the U.S., the prevalence of smoking among youth—ages 12 to 17—and adults is higher among AI/ANs.[41] Heart disease and lung cancer rates have decreased for both males and females among non-Hispanic whites over the years; however, the rates have plateaued among non-Hispanic AI/AN males and are increasing among non-Hispanic AI/AN females.[42] One explanation is the fact that smoking is a traditional activity deeply imbedded in Native culture and identity.

Smoking leads to many health issues including cancer, stroke, and cardiovascular disease (CVD).[43] The impact of smoking is particularly worrisome among AI/ANs because "[i]t is generally recognized the cardiovascular health indices among AI/AN[s] are worse than any other ethnic group in the United States."[44]

B. Alcohol

The issue of alcohol abuse has long plagued the AI/AN community. Prior to the settlement of Europeans in America, Natives had little to no interaction with alcohol. Some tribes produced beer, but it was only used for ceremonial purposes.[45] When European colonists introduced distilled forms of alcohol that were stronger, tribes did not simultaneously develop coping mechanisms including legal, social, and moral guidelines to regulate the use of alcohol. The colonists commonly engaged in extreme intoxication, which influenced the way Natives saw and would later use alcohol.[46] There are several possible explanations for the alcohol abuse that occurs today among Native populations. Some studies show that Natives have an increasing genetic component to the susceptibility to alcoholism.[47] Another explanation is the bleak socio-economic picture for many Natives as unemployment rates are high, school completion rates are low, and many basic support systems are underdeveloped. The gradual and ongoing loss of Native culture is

40. *Heart Disease and American Indians/Alaska Natives*, OFF. OF MINORITY HEALTH, https://perma.cc/WZ4F-S7WG (last modified Sept. 15, 2017).

41. Hutchinson & Shin, *supra* note 9, at 2.

42. Mary C. White et al., *Disparities in Cancer Mortality and Incidence Among American Indians and Alaska Natives in the United States*, 104 AM. J. PUB. HEALTH S377, S382 (2014).

43. *Smoking & Tobacco Use*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://perma.cc/LE9R-ADHE (last updated May 15, 2017).

44. Hutchinson & Shin, *supra* note 9, at 2.

45. Fred Beauvais, *American Indians and Alcohol*, 22 ALCOHOL HEALTH & RES. WORLD 253, 253 (1998).

46. *Id.*

47. *Id.* at 256.

another possible explanation that Natives say accounts for many of their social problems, including high rates of alcoholism.[48] It should, however, be noted that while alcohol abuse is an important topic which has left physical and emotional tolls impacting the health and welfare of AI/ANs, Native communities have also been burdened by the unfortunate stereotype surrounding alcohol abuse within their culture, painting a picture that all AI/ANs are afflicted with alcohol problems.[49] This takes away from AI/ANs who do not abuse alcohol and otherwise live productive lives.[50]

Alcohol use, and especially abuse, is a concern among AI/ANs. Alcohol is attributed to approximately 88,000 deaths annually in the U.S., making it the third leading preventable cause of death in the country.[51] Alcohol is a contributing factor to many deaths including unintentional injuries and car crashes. Data shows that alcohol-impaired driving fatalities accounted for 9,967 deaths throughout the U.S. in 2014, accounting for 31% of overall driving fatilities.[52] Additionally, alcohol abuse causes many health issues and can lead to chronic liver disease, which is a leading cause of death among AI/ANs.[53]

C. Noncommunicable Diseases (NCDs)

NCDs, also referred to as chronic diseases, cannot be passed from person to person. Generally, NCDs are long lasting and have a slow progression.[54] The World Health Organization (WHO) classifies NCDs into four main types: cardiovascular diseases, including heart attacks and stroke; cancers; chronic respiratory diseases, including pulmonary disease and asthma; and diabetes.[55] NCDs account for 63% of deaths worldwide, according to a WHO report.[56]

NCDs are a growing concern all over the world, and particularly among minorities. "In the United States, NCDs are prevalent among

---

48. *Id.*

49. *See generally id.*

50. *Id.* at 253 (citing Fred Beauvais, *Indian Adolescence: Opportunity and Challenge*, *in* ADOLESCENT DIVERSITY IN ETHNIC, ECON., AND CULTURAL CONTEXTS 110-140 (Raymond Montemayor, Gerald R. Adams & Thomas P. Gullotta eds., 2000)).

51. *Alcohol Facts and Statistics,* NAT'L INST. ON ALCOHOL ABUSE AND ALCOHOLISM, https://perma.cc/F8DM-ZCAB (last updated June 2017); *see also Alcohol and Public Health: Alcohol-Related Disease Impact (ARDI)*, CTRS. FOR DISEASE CONTROL & PREVENTION https://perma.cc/97JC-3KFX (last visited July 16, 2018).

52. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS 2014 DATA: ALCOHOL-IMPAIRED DRIVING 1 (2015).

53. *Chronic Liver Disease and American Indians/Alaska Natives*, OFF. OF MINORITY HEALTH, https://perma.cc/T6QZ-9T5A (last modified Sept. 15, 2017).

54. *Noncommunicable Diseases*, World Health Org. (2018), https://perma.cc/54LU-CHWW.

55. *Id.*

56. DAVID E. BLOOM ET AL., WORLD ECON. FORUM, THE GLOBAL ECONOMIC BURDEN OF NON-COMMUNICABLE DISEASES 6 (2011).

minority populations and have generally been associated with health behaviors associated with lower income, such as lack of exercise and consumption of less healthy food."[57] This is particularly worrisome for AI/ANs. It is generally recognized that AI/ANs suffer disproportionately higher rates of health problems and potentially greater mortality rates than any other ethnic group in the United States.[58]

NCDs derive from a combination of both modifiable and non-modifiable risk factors. While non-modifiable risk factors are characteristics that cannot be altered by an individual or the environment, such as sex, age, and genetic make-up, modifiable risk factors refer to characteristics that can be changed by individuals or societies to improve health outcomes,[59] including physical inactivity, poor diet, tobacco use, and harmful alcohol use.[60]

i. Cardiovascular Diseases (CVDs)

Many of the same risk factors of cancer also hold true for CVDs. According to WHO, CVDs include "disorders of the heart and blood vessels and include coronary heart disease, cerebrovascular disease, rheumatic heart disease and other conditions."[61] Heart attacks and strokes account for four out of five CVD deaths.[62] Being overweight as well as having increased blood pressure, glucose, and lipids are symptoms for increased risk of CVD.[63]

One factor contributing to the high prevalence of CVDs among AI/ANs is diet. Over the span of a few decades, the nutritional status of AI/ANs has changed from a case of under-nourishment to poor nutrition caused by excessive intake of food that is high in calories and low in nutritional content.[64]

ii. Diabetes

WHO classifies diabetes as a "chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar), which leads over time to serious damage to the heart, blood vessels, eyes, kidneys,

57. Hutchinson & Shin, *supra* note 9, at 2.

58. *Id.* at 6-7.

59. BLOOM ET AL., *supra* note 56, at 9.

60. WORLD HEALTH ORG., GLOBAL STATUS REPORT ON NONCOMMUNICABLE DISEASES 2010, at vii (Ala Alwan ed., 2011) [hereinafter WHO, GLOBAL STATUS REPORT].

61. *Cardiovascular Disease*, WORLD HEALTH ORG. (2018), https://perma.cc/SA22-6YPN.

62. *Id.*

63. *Id.*

64. Carol Ballew et al., *Intake of Nutrients and Food Sources of Nutrients Among the Navajo: Findings from the Navajo Health and Nutrition Survey*, 127 J. NUTRITION 2085S, 2087S-2092S (1997); *see also*, *generally*, Charlene Compher, *The Nutrition Transition in American Indians*, 17 J. TRANSCULTURAL NURSING 217 (2006).

and nerves."[65] Type 2 diabetes is the most common type and is usually found in adults.[66] Generally, it occurs when the body either does not produce enough insulin on its own or when the body becomes resistant to insulin.[67] Alternatively, type 1 diabetes occurs when the pancreas produces little or no insulin on its own. This type is sometimes referred to as juvenile diabetes or insulin-dependent diabetes.[68] Within the past three decades, incidences of type 2 diabetes have increased dramatically in countries spanning all income levels.[69]

The burden of diabetes is particularly troubling within the AI/AN community.[70] AI/ANs are more than twice as likely to have diabetes as their non-Hispanic counterparts.[71] Obesity, physical inactivity, poor diet, and smoking—all of which are common within AI/AN communities—are contributing factors to diabetes.[72] One study found that consumption of processed meats, and Spam (a processed canned cooked meat product) in particular, is associated with an increased risk of developing diabetes.[73] The same survey found that consumption of unprocessed red meat was not associated with diabetes development among AI/ANs.[74] AI/AN diets are traditionally rich in red meats, but their traditional diets include unprocessed red meat.[75] It should be noted that although studies have shown increased intakes of both processed and unprocessed red meat can increase the likelihood of diabetes, consumption of processed red meat is associated more strongly with incidences of diabetes.[76] Processed meat includes products

---

65. *Diabetes*, WORLD HEALTH ORG. (2018), https://perma.cc/K3QB-4887 [hereinafter *Diabetes*].

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. Centers for Disease Control and Prevention, *Diagnosed Diabetes Among American Indians and Alaska Natives Aged <35 years—United States, 1994-2004*, 55 MORBIDITY & MORTALITY WKLY. REP. 1201, 1201 (2006); Centers for Disease Control and Prevention, *Diabetes Prevalence Among American Indians and Alaska Natives and the Overall Population—United States, 1994-2002*, 52 MORBIDITY & MORTALITY WKLY. REP. 702, 702 (2003) [hereinafter CDC, *Diabetes Overall*].

71. Cobb et al., *Health Behaviors and Risk Factors Among American Indians and Alaska Natives, 2000-2010*, 104 AM. J. PUB. HEALTH S481, S485 (2014).

72. *See generally* Amanda M. Fretts et al., *Physical Activity and Incident Diabetes in American Indians: The Strong Heart Study*, 170 AM. J. EPIDEMIOLOGY 632 (2009) [hereinafter Fretts et al., *Physical Activity*]; *see also*, *generally*, Amanda M. Fretts et al., *Associations of Processed Meat and Unprocessed Red Meat Intake with Incident Diabetes: The Strong Heart Family Study*, 95 AM. J. CLINICAL NUTRITION 752 (2012) [hereinafter Fretts et al., *Red Meat*].

73. Fretts et al., *Red Meat*, *supra* note 72, at 755.

74. *Id.* at 756.

75. *Id.* at 754.

76. An Pan et al., *Red Meat Consumption and Risk of Type 2 Diabetes: 3 Cohorts of US Adults and an Updated Meta-Analysis*, 94 AM. J. CLINICAL NUTRITION 1088, 1088 (2011).

such as hot dogs, breakfast sausage, Spam, and lunch meat.[77] Unprocessed meat includes veal, lamb, pork roast, pork chops, deer, ribs, hamburger, roast beef, steak, and liver.[78] Processed meats contain high quantities of preservatives and additives, which include sodium nitrate, all of which could increase the risk of diabetes.[79]

Many AI/AN communities live on or near reservations and in geographically isolated areas where there is a limited supply of healthy foods available.[80] Many AI/ANs rely on food that is available at local convenience stores, including many processed meats and other processed foods.[81] To address food security issues, the United States Department of Agriculture (USDA) food assistance program "provides commodity foods to low-income [AI/ANs] who reside on reservations."[82] One of the staple products is Spam, which is available for free to AI/ANs living on reservations, or, alternatively, it can be purchased at local shops.[83] The health implications are troublesome because the most disadvantaged members of these communities may also have additional unmeasured lifestyle characteristics for diabetes, including limited access to health services and the inability to comply with medical advice.[84]

iii. Cancer

According to WHO, "[c]ancer is a generic term for a large group of diseases that can affect any part of the body."[85] A defining characteristic of cancer is the creation of abnormal cells that grow outside their usual boundaries, causing them to invade other parts of the body and eventually spread to other organs—known as metastasizing, a major cause of death from cancer.[86] Cancer accounted for 8.8 million deaths in 2015, making it a leading cause of death worldwide.[87] Lung, liver, and colorectal cancer are the most common causes of cancer deaths.[88]

Cancer is a major concern among AI/ANs. Some of the risk factors for cancer include tobacco and excessive alcohol use, diets that are high in fat and low in nutrients, and physical inactivity. [89] Unfortunately, these are

77. Fretts et al., *Red Meat*, *supra* note 72, at 753.
78. *Id.*
79. *Id.* at 757.
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.* at 753.
84. *Id.* at 757.
85. *Cancer*, WORLD HEALTH ORG. (Feb. 1, 2018), https://perma.cc/S4AU-5TYF.
86. *Id.*
87. *Id.*
88. *Id.*
89. *Id.*

common behavior traits among AI/ANs,[90] contributing to high incidences of cancer among AI/AN populations. Many of these characteristics are found in minority and low-income populations,[91] and while these behaviors are modifiable risk factors for cancer, diseases, and other NCDs,[92] the history of such behaviors can be traced back to historical discrimination and attempts of the U.S. government to right the wrongs of the past. For example, the USDA provides certain food, such as Spam, free of charge on AI/AN reservations.[93] However, these foods are processed and have been found to cause many health disparities including stomach cancer and diabetes.[94]

D. Mental Health

Mental health is an important and often overlooked aspect of overall health. This is especially true for AI/ANs who experience a disproportionately higher rate of mental and behavioral health challenges than other populations in the United States.[95] AI/ANs also have dramatically high rates of suicide compared to other Americans.[96] Incarceration has social and economic consequences, but the experience of being incarcerated in and of itself causes stress and can directly impact mental and physical health.[97] There are also indirect impacts on physical and mental health, whereas psychological and biological pathways affect health through economic strains and deterioration in family functioning.[98] This is true especially when it occurs during critical periods of the life course.[99]

---

90. *See generally* Fretts et al., *Physical Activity*, *supra* note 72; *see also*, *generally*, Fretts et al., *Red Meat*, *supra* note 72.

91. *See* Hutchinson & Shin, *supra* note 9, at 2 and accompanying text.

92. *See* BLOOM ET AL., *supra* note 56 and accompanying text; *see also* WHO, GLOBAL STATUS REPORT, *supra* note 60 and accompanying text.

93. Fretts et al., *Red Meat*, *supra* note 72, at 753.

94. *See generally id.*; *see also* Laura Gottschalk, *Stomach Cancer and Diet: Can Certain Foods Increase Your Risk?*, NAT'L CTR. FOR HEALTH RES., https://perma.cc/53SU-QB2D (last visited July 19, 2018).

95. OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERV., ACCESS TO MENTAL HEALTH SERVICES AT INDIAN HEALTH SERVICE AND TRIBAL FACILITIES 1 (2011).

96. *Disparities*, *supra* note 2; TRENDS, 2002-2003 *supra* note 36.

97. *See generally* Michael Massoglia, *Incarceration as Exposure: The Prison, Infectious Disease, and Other Stress-Related Illnesses*, 49 J. HEALTH & SOC. BEHAV. 56 (2008); Panagiota Pervanidou & George P. Chrousos, *Metabolic Consequences of Stress During Childhood and Adolescence*, 61 METABOLISM 611 (2012); Michael E. Roettger & Jason D. Boardman, *Parental Incarceration and Gender-Based Risks for Increased Body Mass Index: Evidence from the National Longitudinal Study of Adolescent Health in the United States*, 175 AM. J. EPIDEMIOLOGY 636 (2012).

98. *See id.*

99. *See id.*

E. Mental Health and Incarceration

Mental health disabilities can affect the likelihood of incarceration. Prisons and jails[100] often serve as dumping grounds for people with mental disabilities.[101] "Substance use disorders and psychiatric disorders are important potential risk factors that are highly prevalent in prisoners and potentially treatable."[102] Often, alcohol and drug abuse problems attribute to underlying psychological disorders.[103] As a consequence, such disorders have been linked to contributing to alcohol problems among AI/AN populations.[104] For some individuals with mental health issues that also have substance abuse disorders, the substance abuse is a means of self-medicating.[105] People with substance abuse disorders or other individuals who have committed minor offences—at least in part due to a mental disorder—are often sent to prison instead of being treated for their illness.[106] As a result, these disorders continue to go unnoticed, undiagnosed, untreated, and can even worsen in prison.[107]

F. Cause of Health Disparities

"[H]ealth statistics among AI/AN[s] are sometimes closer to those found in lower-and middle-income countries, in part reflecting disparities in socioeconomic status, including worse living conditions, lower income, and greater barriers to health services compared with non-minority populations in the United States."[108] There are debates surrounding the cause of such health disparities, but one explanation is the disparities in wealth and power

100. Throughout this paper, the authors use the term "prison" and "jail" interchangeably.

101. *Mental Health and Prisons – Information Sheet*, WORLD HEALTH ORG. & INT'L COMM. OF THE RED CROSS 1, https://perma.cc/N22X-93JS (last visited July 19, 2018) [hereinafter WHO & ICRC, *Information Sheet*].

102. Zheng Chang et al., *Substance Use Disorders, Psychiatric Disorders, and Mortality After Release from Prison: A Nationwide Longitudinal Cohort Study*, 2 LANCET PSYCHIATRY 422, 422 (2015) (citing S. Fazel et al., *Substance Abuse and Dependence in Prisoners: A Systematic Review*, 101 ADDICTION 181 (2006); S. Fazel & K. Seewald, *Severe Mental Illness in 33,588 Prisoners Worldwide: Systematic Review and Meta-Regression Analysis*, 200 BRIT. J. PSYCHIATRY 364 (2012)).

103. Yatan Pal Singh Balhara, *The Connection Between Substance Abuse & Mental Illness*, MENTALHELP.NET, https://perma.cc/AKT9-C4AE (last updated Jan. 25, 2016).

104. Beauvais, *supra* note 45, at 255 (citing PATRICIA D. MAIL & DAVID R. MCDONALD, TULAPAI TO TOKAY: A BIBLIOGRAPHY OF ALCOHOL USE AND ABUSE AMONG NATIVE AMERICANS OF NORTH AMERICA (1980); Douglas K. Novins et al., *Factors Associated with the Receipt of Alcohol Treatment Services Among American Indian Adolescents*, 35 J. AMER. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 110 (1996)).

105. Balhara, *supra* note 103.

106. WHO & ICRC, *Information Sheet*, *supra* note 101, at 1.

107. *Id.*

108. Hutchinson & Shin, *supra* note 9, at 1.

that have endured since early colonization.[109] These disparities, accompanied by a long history of cultural misunderstanding and appropriation, have created an environment where it is practically impossible for Natives to thrive, particularly those with experience in the criminal justice system.

Often health disparities can be explained by socioeconomic factors that impact minorities generally, and AI/ANs particularly.[110] "[E]ducation, income, and rates of unemployment have all been shown to be important factors in explaining disparities for other disadvantaged populations and are likely also key reasons for AI/AN health disparities."[111] Studies have found that health differences found within AI/AN populations and non-Hispanic white populations were mitigated or even eliminated after being adjusted for certain factors such as education or economic status.[112] This suggests that social determinants of health can and do play large roles in health disparities.[113]

IV. BARRIERS TO HEALTH

There are several issues that prevent AI/ANs from receiving quality medical care. These include geographic isolation, cultural barriers, poverty, inadequate housing, low educational attainment, high unemployment rates, and inaccessibility to healthy foods.[114] These barriers will be discussed in detail below.

A. Poverty

There are approximately 2 million AI/ANs in the U.S., and, with a poverty rate almost two times the national average, the population experiences higher levels of poverty than other racial groups.[115] The median household income for non-Hispanic whites is $56,565 while it is only $37,353 for AI/ANs.[116] In 2012, 26% of AI/ANs lived at the federal poverty level (FPL) while 11% of non-Hispanic whites lived at the FPL.[117] Some of the poorest people in the country live on Native reservations like Pine Ridge

109. Jones, *supra* note 15, at 2122.

110. Hutchinson & Shin, *supra* note 9, at 7.

111. *Id.*

112. Pamela Amparo et al., *Chronic Disease Risk Factors Among American Indian/Alaska Native Women of Reproductive Age*, 8 PREVENTING CHRONIC DISEASE 1, 4 (2011).

113. *Id.*

114. *Profile: AI/AN*, *supra* note 37.

115. Naomi Schaefer Riley, *One Way to Help Native Americans: Property Rights*, THE ATLANTIC (July 30, 2016) https://perma.cc/H2MH-M2Y3.

116. *Profile: AI/AN*, *supra* note 37.

117. *Id.*

Reservation in South Dakota, which has not only been ranked the poorest reservation, but also the poorest county in the United States.[118]

There is a correlation between poverty and poor health. People with higher incomes are less likely to suffer from disease and premature death.[119] "Income is a driving force behind the striking health disparities that many minorities experience."[120] Evidence shows that when people are exposed to economic disadvantage—particularly at critical developmental stages of life—and other harmful conditions, they are more vulnerable to disease.[121] Many factors contribute to this, including access to healthy and nutritious food, access to regular and quality health care, and access to a clean and healthy living environment.[122] Income impacts mental health as well. Studies show that people from families who earn below $35,000 annually are four times more likely to report being nervous and five times more likely to report sadness "all or most of the time" compared to people from families who earn more than $100,000 a year.[123]

B. Housing

Adequate housing is an important part of overall health and wellbeing and is linked to health outcomes. Healthy housing can support occupants throughout their life stages, promote health and safety, and support mental and emotional health.[124]

An essential factor contributing to health is a healthy home;[125] however, a home also tends to be the greatest single expenditure for a family.[126] Healthy homes contribute to physical, social, and psychological

118. *Pine Ridge Indian Reservation*, RE-MEMBER, https://perma.cc/WZ6P-VPGH (last visited July 19, 2018).

119. *See* NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2011: WITH SPECIAL FEATURE ON SOCIOECONOMIC STATUS AND HEALTH (2012).

120. STEVEN H. WOOLF ET AL., URB. INST., HOW ARE INCOME AND WEALTH LINKED TO HEALTH AND LONGEVITY? 1 (2015).

121. Rachel Morello-Frosch, et al., *Understanding the Cumulative Impacts of Inequalities in Environmental Health: Implications for Policy*, 30 HEALTH AFFAIRS 879, 879 (2011) (citing Nancy E. Adler & David H. Rehkopf, *U.S. Disparities in Health: Descriptions, Causes, and Mechanisms*, 29 ANN. REV. PUB. HEALTH 235 (2008); Jane Clougherty & Laura Kubzansky, *A Framework for Examining Social Stress and Susceptibility to Air Pollution in Respiratory Health*, 117 ENVTL. HEALTH PERSP. 1351 (2009)).

122. *See id.*

123. JEANNINE S. SCHILLER ET AL., NAT'L CTR. FOR HEALTH STATISTICS, SUMMARY HEALTH STATISTICS FOR U.S. ADULTS: NATIONAL HEALTH INTERVIEW SURVEY, 2011, at 55, 61 (2012).

124. *See generally* James Krieger & Donna L. Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUB. HEALTH 758 (2002).

125. *See generally id.*

126. Jaime Raymond et al., *Inadequate and Unhealthy Housing, 2007 and 2009*, 60 MORBIDITY & MORTALITY WKLY. REP. 21, 21 (2011).

health.[127] They provide food, shelter, water, and air. Healthy homes aid in maintaining mental health by decreasing stress and isolation, and increasing the likelihood of sleep.[128] Safe and healthy homes protect inhabitants from exposure to environmental hazards ranging from weather to chemicals and allergens, and can help to prevent unintentional injuries.[129]

Alternatively, inadequate housing contributes to infectious and chronic diseases, can lead to injuries, and can even adversely impact child development.[130] Inadequate housing is defined as having moderate to severe physical problems, including a lack of running water.[131] Examples of inadequate or unhealthy housing include "the presence of any additional characteristics that might negatively affect the health of its occupants, including evidence of rodents, water leaks, peeling paint in homes built before 1978, and absence of a working smoke detector."[132]

Unfortunately, populations that have the fewest resources—including people with limited education and lower income—are disproportionately impacted by inadequate and unhealthy housing.[133] According to the American Housing Survey, the AI/AN population is 1.9 times more likely to live in inadequate housing compared to non-Hispanic white populations.[134]

C. Education

Educational attainment is an important social determinant of health.[135] Unfortunately, the educational attainment among AI/ANs is much less than that of the general American population. Forty percent of AI/AN adults have completed at least some college or higher while the same is true for 54% of the overall adult population in the U.S.[136] The percent of AI/ANs age 50 and over with less than a high school diploma is at 22%, exceeding that of the same-age general U.S. population, which sits at 16%.[137] Further,

127. *See generally* Krieger & Higgins, *supra* note 124.
128. *Id.* at 759.
129. Raymond et al., *supra* note 126, at 21.
130. Krieger & Higgins, *supra* note 124, at 758-59.
131. Raymond et al., *supra* note 126, at 21.
132. *Id.*
133. *Id.* at 24.
134. *Id.* at 21.
135. WORLD HEALTH ORG. COMM'N ON SOC. DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 32-33 (2008); *see also* Janki Shankar et al., *Education as a Social Determinant of Health: Issues Facing Indigenous and Visible Minority Students in Postsecondary Education in Western Canada*, 10 INT'L J. ENVTL. RES. & PUB. HEALTH 3908 (2013) (study finding that the health of students from low income indigenous and visible minority backgrounds was adversely impacted by the challenges they faced in postsecondary education).
136. ARTIGA ET AL., *supra* note 29, at 5 (citing analysis of 2009-2011 ACS data by the Kaiser Commission on Medicaid and the Uninsured).
137. R. TURNER GOINS ET AL., AM. ASS'N OF RETIRED PERSONS PUB. POLICY INST., LIFELONG DISPARITIES AMONG OLDER AMERICAN INDIANS AND ALASKA NATIVES 9 (2015)

only about a quarter of AI/ANs age 50 and over have a college degree or more while about 33% of the general U.S. population of the same age has obtained the equivalent education level.[138]

Many of the educational disparities among AI/ANs start young. A report by *Education Week* found that:

> [S]chools run by the beleaguered Bureau of Indian Education—which serves just 5 percent of the country's Native American children—are often dilapidated and unsafe, plagued by unstable governance and tangled bureaucracy. And within the regular school system, Native American students' performance still lags far behind that of their peers.[139]

AI/ANs are more likely than any other racial group to be placed in special education classes, and only black students have higher discipline rates.[140] Formal educational attainment is significantly associated with individual health outcomes and attainment including smoking, drug abuse, and the contraction of many diseases.[141]

> Education is a strong determinant of future employment and income . . . [I]t captures both the long-term influence of early life circumstances and the influence of adult circumstances on adult health. Income is the indicator that most directly measures material resources. Income can influence health by its direct effect on living standards (e.g., access to better quality food and housing, leisure-time activities, and health-care services).[142]

The low educational attainment levels among AI/ANs is alarming due to the direct and indirect effect of education on health.

D. Unemployment

Unemployment impacts health in a major way, both directly and indirectly. Unemployment causes vulnerability to health issues. Depression,

---

(citing analysis by the Int'l Ass'n for Indigenous Aging using 2008-12 American Community Survey data, available at https://perma.cc/RRE2-GUDA).

138. *Id.* at 9-10.

139. Alia Wong, *The Subtle Evolution of Native American Education*, THE ATLANTIC (Sept. 1, 2015) https://perma.cc/8CHN-FUX8.

140. *Id.*

141. David P. Baker et al., *The Education Effect on Population Health: A Reassessment*, 37 POPULATION DEV. REV. 307, 307 (2011).

142. Gloria L. Beckles & Benedict I. Truman, *Education and Income—United States, 2005 and 2009*, 60 MORBIDITY & MORTALITY WKLY. REP. (SUPPLEMENT) 13, 13 (2011).

CVDs, substance abuse, and other health problems are all associated with unemployment.[143] Employment provides income to help pay for health care. Often, it also provides affordable health insurance for employees and even their families, which encourages people to seek regular preventive care.[144] People who are employed are generally also able to afford basic necessities and commodities that contribute to good health, including healthy and adequate housing and regular food.[145] Stress, anxiety, and tension caused by unemployment can also increase the likelihood of engaging in behaviors that can lead to increased health risks, such as tobacco and alcohol abuse.[146]

Although Natives are eligible to receive health care services free of charge through IHS,[147] the quality of health care services is often better through private insurers, whereas the providers do not face the same issues of underfunding and understaffing that many IHS facilities face.[148] Further, although the IHS supposedly provides universal health coverage for AI/ANs, a shockingly large number of AI/ANs report being uninsured.[149]

E. Limited Access to Healthy Food

One major factor impacting the health of the poor and minorities is a lack of access to healthy food. Individuals living in low-resource communities often have limited access to nutritious food sources,[150] including supermarkets that sell fresh produce or other healthy food

---

143. *See* William T. Gallo et al., *Health Effects of Involuntary Job Loss Among Older Workers: Findings from the Health and Retirement Survey*, 55 J. GERONTOLOGY: SOC. SCI. S131, S136 (2000); *see also* Partha Deb et al., *The Effect of Job Loss on Overweight and Drinking*, 30 J. HEALTH ECON. 317 (2011) (finding that the health effects of job loss could lead to negative outcomes for at-risk individuals, their families, and society at large).

144. *See* Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713 (2013); *see also*, *generally*, Benjamin D. Sommers et al., *Changes in Mortality After Massachusetts Health Care Reform: A Quasi-Experimental Study*, 160 ANNALS INTERNAL MED. 585 (2014).

145. NANETTE GOODMAN, LEAD CTR., THE IMPACT OF EMPLOYMENT ON THE HEALTH STATUS AND HEALTH CARE COSTS OF WORKING-AGE PEOPLE WITH DISABILITIES 4 (2015).

146. Robert S. Peirce et al., *Relationship of Financial Strain and Psychosocial Resources to Alcohol Use and Abuse: The Mediating Role of Negative Affect and Drinking Motives*, 35 J. HEALTH & SOC. BEHAV. 291, 291-92, 304 (1994); Ralph Catalano et al., *The Health Effects of Economic Decline*, 32 ANN. REV. PUB. HEALTH 431, 443 (2011); *see also*, *generally*, Sarah H. Wilson & G.M. Walker, *Unemployment and Health: A Review*, 107 PUB. HEALTH 153 (1993).

147. Dixon, *Unique Role, supra* note 23, at 61.

148. Timothy M. Westmoreland & Kathryn R. Watson, *Redeeming Hollow Promises: The Case for Mandatory Spending on Health Care for American Indians and Alaska Natives*, 96 AM. J. PUB. HEALTH 600, 600 (2006) (citing Mim Dixon & Yvette Roubideaux, *Introduction* to PROMISES TO KEEP: PUBLIC HEALTH POLICY FOR AMERICAN INDIANS AND ALASKA NATIVES IN THE 21ST CENTURY, at xix-xxi (Mim Dixon & Yvette Roubideaux eds., 2001)).

149. Hutchinson & Shin, *supra* note 9, at 7.

150. Jayanta Bhattacharya et al., *Poverty, Food Insecurity, and Nutritional Outcomes in Children and Adults*, 23 J. HEALTH ECON. 839, 857 (2004).

options.[151] Low-income people are more likely to live in neighborhoods with food deserts, defined as "parts of the country vapid of fresh fruit, vegetables, and other healthful whole foods."[152] Littered with bodegas, liquor stores, and corner stores, low-income communities are often left with a shortage of restaurants offering healthy food options.[153]

Many Native people live in areas where the nearest grocery store is hours away, which can make accessing healthy foods very difficult.[154] A trip to Pine Ridge Reservation in South Dakota proved that grocery stores are limited, and the busiest and highest grossing store in the area was in fact a local gas station and convenience store.[155] The store was full of high-sugar and high-fat snacks and beverages, and featured a very small produce section in the back corner with a limited selection of wilted and rotting fruits and vegetables.[156] In addition to living in food deserts, many of the staples of the average AI/AN diet in the 21st century are not heart healthy. While historically, many tribal diets consisted of healthy fruits and vegetables, they have been replaced with canned foods that are high in fat and calories.[157] This leads to obesity, which is reaching alarming rates among the AI/AN community. In fact, AI/AN youth are 30% more likely to be obese than non-Hispanic whites, and AI/AN adults are 50% more likely to be obese than non-Hispanic whites.[158] This is a concern because obesity is a risk factor for several diseases including diabetes, heart disease, and stroke.[159]

F. Geographic Isolation

One of the major obstacles to health care that AI/ANs face has to do with their geographic location. Many AI/ANs live in rural areas that can be hard to reach by emergency services and far from hospitals and other health

151. POLICYLINK & THE FOOD TRUST, ACCESS TO HEALTHY FOOD AND WHY IT MATTERS: A REVIEW OF THE RESEARCH 6 (2013).

152. *USDA Defines Food Deserts*, AM. NUTRITIONAL ASS'N: NUTRITION DIGEST, https://perma.cc/36B5-GK2E (last visited June 28, 2018).

153. Kimberly Morland & Susan Filomena, *Disparities in the Availability of Fruits and Vegetables Between Racially Segregated Urban Neighbourhoods*, 10 PUB. HEALTH NUTRITION 1481, 1484 (2007); *see also* Kimberly Morland et al., *Neighborhood Characteristics Associated with the Location of Food Stores and Food Service Places*, 22 AM. J. PREVENTIVE MED. 23, 27–28 (2002).

154. *Native American Foods, Dietary Habits Take Center Stage*, NAT'L HEART, LUNG, & BLOOD INST. (Nov. 21, 2016), https://perma.cc/GL5B-9PY7.

155. Two of the authors (Gallagher & Heydt) visited Pine Ridge Reservation in South Dakota and toured a local gas station and convenience store, June 29, 2017.

156. *Id.*

157. NAT'L HEART, LUNG, & BLOOD INST., *supra* note 154.

158. *Obesity and American Indians/Alaska Natives*, U.S. DEP'T HEALTH & HUM. SERVS. OFF. MINORITY HEALTH, https://perma.cc/WFQ8-H26X (last visited July 1, 2018).

159. *Id.*

care facilities.[160] This is not only problematic in the event of an emergency, but it also prevents individuals from seeking preventive care and regular health maintenance services, which can make typically manageable ailments or illnesses progress and worsen over time resulting in more difficult and costly treatment.[161]

Another major factor impacting AI/AN access to health care services has to do with the fact that more and more AI/ANs are living off-reservation, and the number of AI/ANs who live away from their reservations is expected to continue to grow.[162] This means that there are increasing numbers of AI/ANs who are located further from IHS services, which are a primary source of health care for many AI/ANs, especially for those that are ineligible for Medicare or Medicaid.[163] As a consequence, many AI/ANs will not have health insurance coverage that is easily accessible to them, and the services that are available will likely not be staffed by Natives or by people who are sensitive to the cultural and language barriers that many AI/ANs face. This decreases the chances that AI/ANs living off-reservation will seek out preventive health care services.

The conditions that plague many Natives living on reservations, including racism, poverty, inadequate education, alcoholism, and drug dependence, are not easily left behind by Natives who move from reservations to urban areas.[164] There are additional issues that urban Natives face in cities, including a lack of cultural identity, family support, and social contact, as well as pressure related to jobs and money.[165] All of these compounding issues create an environment that places urban-dwelling AI/ANs in danger of health problems caused by physical and emotional risk factors.[166]

G. Cultural Barriers

There are several cultural considerations that affect the health of Natives, including spirituality—and cultural practices—and cultural and linguistic competency. A general lack of understanding of Native culture and identity is common, especially when it comes to health care providers. This can range from language and communication barriers to different cultural and

160. Eric Whitney, *Native Americans Feel Invisible In U.S. Health Care System*, NAT'L PUB. RADIO (Dec. 12, 2017, 5:00 AM), https://www.npr.org/sections/health-shots/2017/12/12/569910574/native-americans-feel-invisible-in-u-s-health-care-system.

161. KAUFFMAN & ASSOCS., DEP'T HEALTH & HUM. SERVS., LTSS RESEARCH: NURSING HOME FACILITY INVENTORY 1 (2015).

162. RALPH FORQUERA, HENRY J. KAISER FAM. FOUND., URBAN INDIAN HEALTH 3, 15 (2001).

163. Samantha Artiga et al., *Health Coverage and Care for American Indians and Alaska Natives*, KAISER FAMILY FOUND. (Oct. 7, 2013), https://perma.cc/E7C6-SBSR.

164. FORQUERA, *supra* note 162, at 15.

165. *Id.*

166. *Id.*

religious beliefs.[167] One such example is the fact that some Natives believe in reclaiming amputated body parts for proper burial.[168] A non-Native medical professional may not be sensitive to the cultural beliefs that go along with such a request and could potentially offend the patient.[169] The lack of cultural sensitivity that Natives often encounter when they seek health care services in hospitals and other facilities can lead to a sense of distrust in the health system and may cause AI/ANs to avoid going to such facilities and thus seek care at later stages of their illnesses.[170] Increased cultural sensitivity can come in a variety of forms such as simply asking a health related question in a different way that is easier to understand.[171]

V. HEALTH IN PRISON

There are over 11 million individuals passing through U.S. correctional facilities annually—more than any other country.[172] Incarceration can have both positive and negative health impacts. It provides steady meals and health screenings for people who otherwise would not have access.[173] "[P]risons are increasingly recognized as presenting a pivotal opportunity to screen and initiate treatment of infected individuals."[174] It should be recognized, however, that release from custody often triggers a breakdown in treatment adherence. Increased infectivity and an increase in

167. *See generally* Levanne R. Hendrix, *Intercultural Collaboration: An Approach to Long Term Care for Urban American Indians*, 4 CARE MGMT. J. 46 (2003).

168. SUSAN B. BASTABLE, ESSENTIALS OF PATIENT EDUCATION 278 (2d Ed. 2017).

169. *See When Medicine and Culture Intersect*, CAN. MED. PROTECTIVE ASS'N (Mar. 2014), https://perma.cc/NVF6-5287; *see also* Participants of the National Alaska Natives American Indian Nurses Association (NANA-INA) Founding Members and Georgetown University Health Law Initiative Conference, held on August 14-15, 2017, in Polson, Montana, included Dr. Bette Jacobs, Sandra Haldane, Sandra Littlejohn, Dr. Margaret Moss, Dr. Lillian Tom-Orme, Jacque Dolberry, Nicole Heydt, & Mehgan Gallagher [hereinafter NANA-INA Conference].

170. *See generally* Hendrix, *supra* note 167.

171. *See generally* P.S. Seibert et al., *A Checklist to Facilitate Cultural Awareness and Sensitivity,* 28 J. MED. ETHICS 143 (2001); *see also* NANA-INA Conference, *supra* note 169.

172. TODD D. MINTON & DANIELA GOLINELLI, U.S. DEP'T JUST., BUREAU JUST. STAT., JAIL INMATES AT MIDYEAR 2013-STATISTICAL TABLES 1, 4 (2014) (citing jail admission data during the twelve-month period ending June 30, 2013); *see also* Peter Wagner & Alison Walsh, *States of Incarceration: The Global Context 2016*, PRISON POL'Y INITIATIVE (June 16, 2016), https://perma.cc/7V44-PD3Z.

173. Stuart A. Kinner & Emily A. Wang, *The Case for Improving the Health of Ex-Prisoners*, 104 AM. J. PUB. HEALTH 1352, 1352 (2014).

174. *Id.* at 1353 (citing G.E. Macalino et al., *Hepatitis C Infection and Incarcerated Populations*, 15 INT'L J. DRUG POL'Y 103 (2004); Ryan P. Westergaard et al., *HIV Among Persons Incarcerated in the USA: A Review of Evolving Concepts in Testing, Treatment, and Linkage to Community Care*, 26 CURRENT OPINION INFECTIOUS DISEASES 10 (2013)).

risky behaviors—such as unprotected sex and needle sharing—also follows, which can impact public health broadly.[175]

There are also many negative health impacts that are associated with incarceration. "Inmates and ex-inmates appear consistently more likely to report health problems that are associated with stress or communicable infectious disease. In contrast, there appears to be little or no relationship between incarceration status and illnesses unrelated to stress or infectious disease."[176] The nutritional value of meals in detention is not ideal as they generally consist of high-fat and high-calorie foods.[177] Communicable diseases, including tuberculosis, hepatitis C, and HIV, as well as sexually transmitted infections, are highly prevalent in prison populations.[178] Smoking is prevalent—which is tied to NCDs—although there is a trend toward smoke-free detention facilities.[179] Overcrowding and increased stress can exacerbate chronic and mental health conditions.[180]

There is also an increased risk of violence and assault, including sexual assault, in prison.[181] In addition, there are several other conditions that are detrimental to inmate physical and mental health. These include lack of privacy and family visits, poor sanitation, infestations with bugs and vermin, tension, noise, and cross-gender searches, which can be traumatizing, particularly for those who have previously been sexually abused.[182]

A. Mortality in Detention

The mortality rate in local jails increased from 128 per 100,000 jail inmates in 2012 to 135 per 100,000 in 2013.[183] On average, each year in prison takes two years off of a person's life expectancy.[184] Since 2000,

175. Grace E. Macalino et al., *Prevalence and Incidence of HIV, Hepatitis B Virus, and Hepatitis C Virus Infections Among Males in Rhode Island Prisons*, 94 AM. J. PUB. HEALTH 1218, 1218 (2004).

176. Massoglia, *supra* note 97, at 57.

177. AMY SMITH, NAT'L ACAD. SCI., HEALTH AND INCARCERATION: A WORKSHOP SUMMARY 7, 8 (2013).

178. Theodore M. Hammett et al., *The Burden of Infectious Disease Among Inmates of and Releasees from U.S. Correctional Facilities, 1997*, 92 AM. J. PUB. HEALTH 1789, 1789, 1792 (2002); Kate Dolan et al., *HIV in Prison in Low-Income and Middle-Income Countries*, 7 LANCET INFECTIOUS DISEASES 32, 32 (2007); Macalino et al., *supra* note 174, at 110.

179. KERRY CORK, PUB. HEALTH LAW CTR., TOBACCO BEHIND BARS: POLICY OPTIONS FOR THE ADULT CORRECTIONAL POPULATION 1 (2012).

180. SMITH, *supra* note 177, at 8.

181. *See generally* Nancy G. La Vigne et al., *Preventing Violence and sexual Assault in Jail: A situational Crime Prevention Approach*, URB. INST. (Dec. 2011), https://perma.cc/TCA9-4MKK.

182. SMITH, *supra* note 177, at 9.

183. MARGARET NOONAN ET AL., U.S. DEP'T JUSTICE, BUREAU JUSTICE STATISTICS, MORTALITY IN LOCAL JAILS AND STATE PRISONS, 2000–2013-STATISTICAL TABLES 1 (2015).

184. Evelyn J. Patterson, *The Dose–Response of Time Served in Prison on Mortality: New York State, 1989–2003*, 103 AM. J. PUB. HEALTH 523, 526-27 (2013).

suicide has been the leading cause of death in jails, with heart disease following as the second.[185] There is also a high association with increased death upon being released from detention. Several studies show high mortality rates in individuals released from prison compared to the general population.[186] There are several causes that contribute to this alarming pattern, and mortality caused by drug overdose is especially high following release from detention.[187]

B. Impact on Mental Health

Incarceration has many negative impacts on health generally, and mental health in particular. Worldwide, an estimated 450 million people suffer from mental or behavioral disorders,[188] and such disabilities are especially prevalent among prison populations.[189] There is a disproportionately high number of people with mental disabilities in prisons.[190] This is due to a number of factors including the widespread misconception that people with mental disabilities are a danger to the public, the general intolerance of difficult or disturbing behavior, the failure to promote care and rehabilitation, and poor access to mental health services,[191]

185. NOONAN ET AL., *supra* note 183, at 1.

186. *See generally* Ingrid Binswanger et al., *Release from Prison—A High Risk of Death for Former Inmates*, 356 N. ENGL. J. MED. 157 (2007); Jakov Zlodre, & Seena Fazel, *All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis*, 102 AM. J. PUB. HEALTH e67 (2012); Jessica Y. Andrews & Stuart A. Kinner, *Understanding Drug-Related Mortality in Released Prisoners: A Review of National Coronial Records*, 12 B.M.C. PUB. HEALTH 1 (2012); Susan Calcaterra et al., *Psychostimulant-Related Deaths Among Former Inmates*, 6 J. ADDICT. MED. 97 (2012); Simon J. Forsyth et al., *Striking Subgroup Differences in Substance-Related Mortality After Release from Prison*, 109 ADDICTION 1676 (2014); Axel Haglund et al., *Suicide After Release from Prison: A Population-Based Cohort Study from Sweden*, 75 J. CLINICAL PSYCHIATRY 1047 (2014); A. Hakansson & M. Berglund, *All-Cause Mortality in Criminal Justice Clients with Substance Use Problems—A Prospective Follow-Up Study*, 132 DRUG & ALCOHOL DEPENDENCE 499 (2013); Stuart A. Kinner et al., *Substance Use and Risk of Death in Young Offenders: A Prospective Data Linkage Study*, 34 DRUG & ALCOHOL REV. 46 (2015).

187. Ingrid A. Binswanger et al., *Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends from 1999 to 2009*, 159 ANNALS INTERNAL MED. 592, 592 (2013).

188. WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2001: MENTAL HEALTH: NEW UNDERSTANDING, NEW HOPE 3 (2001).

189. *See generally* Philip M. Brinded et al., *Prevalence of Psychiatric Disorders in New Zealand Prisons: A National Study*, 35 AUSTL. & N.Z. J. PSYCHIATRY 166 (2001); Traolach Brugha et al., *Psychosis in the Community and in Prisons: A Report from the British National Survey of Psychiatric Morbidity*, 162 AM. J. PSYCHIATRY 774 (2005); Heather L. Holley et al., *Lifetime Prevalence of Prior Suicide Attempts in a Remanded Population and Relationship to Current Mental Illness*, 39 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 191 (1995).

190. WHO & ICRC, *Information Sheet*, *supra* note 101, at 1.

191. *Id.*

particularly among certain disadvantaged populations such as AI/ANs.[192] While mental disabilities may be present prior to admission to a detention facility, they are often exacerbated by the stress of incarceration.[193] In addition, many mental disabilities may develop during imprisonment as a consequence of prevailing conditions in the detention facility including torture, isolation, and other human rights violations.[194]

Prisons are inherently bad for mental health. Overcrowding, violence, enforced solitude—or conversely—lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects (work, relationships, et cetera), and inadequate health services—especially mental health services—all contribute to the negative impacts prisons have on individual mental health.[195] Additionally, the risk of suicide, one of the cumulative effects of these factors, is also increased with incarceration.[196]

VI. CRIMINAL JUSTICE SYSTEM AND AI/ANS

A. History

There has been a long history of mistreatment of AI/ANs in the United States, which has created distrust among Natives.

> [M]any American Indian and Alaska Native (AI/AN) peoples have learned to distrust the people who came to their land as colonizers and the institutions they created, as a result of oppressive actions and policies, numerous treaties that have been violated, and promises that have been broken. European-American service providers, educators, and researchers have also earned the distrust of the AI/AN peoples because they have often intentionally or inadvertently imposed their values, beliefs, and systems of care upon individuals, families, and communities, for whom these services or practices may be ineffective and/or harmful.[197]

---

192. *Id.*; *see also*, *generally*, *Mental Health Disparities: American Indians and Alaska Natives*, AM. PSYCHIATRIC ASS'N (2017), https://perma.cc/9FQF-NX3Y (citing SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., THE NATIONAL TRIBAL BEHAVIORAL HEALTH AGENDA (2016)).

193. WHO & ICRC, *Information Sheet*, *supra* note 101, at 1.

194. *Id.*

195. *Id.*

196. *Id.*

197. Jessica R. Goodkind et al., *Rebuilding Trust: A Community, Multiagency, State, and University Partnership to Improve Behavioral Health Care for American Indian Youth, their Families, and Communities*, 39 J. COMMUNITY PSYCHOL. 452, 453 (2011).

The U.S. government has haphazardly tried to reconcile some of this mistreatment by enacting laws and policies that give AI/ANs and tribes sovereign rights. Unfortunately, while some of these policies may have been well-intentioned, they do not always benefit AI/ANs. One example is the Plenary Power Doctrine, which allows Congress to presume for itself that it has absolute power over AI/ANs and their resources without consent from tribes.[198] Congress is given the power, through the Constitution, to "regulate Commerce . . . with the Indian tribes,"[199] and the President's treaty power[200] extends to Indian affairs.[201]

B. "The Marshall Trilogy"

The U.S. government has created a unique relationship with AI/AN tribes establishing them as "domestic dependent nations" within the United States, thus giving the federal government criminal jurisdiction over most crimes committed within Indian country.[202] There are three important cases that define modern day AI/AN law, referred to as "The Marshall Trilogy."[203] In 1831, the U.S. Supreme Court in *Cherokee Nation v. State of Georgia* held that a tribal government is not a "foreign state" within the meaning of the Constitution and cannot sue in the courts of the United States.[204] Further, Justice John Marshall stated that the relationship of tribes to the United States "resembles that of a ward to his guardian,"[205] but state laws "can have no force."[206] Based on the principles established by the Constitution and these Supreme Court cases, Native tribes have inherent sovereignty over criminal matters. This frees them from state interference but also subjects them to federal law.[207]

198. Gilio-Whitaker, *supra* note 7.

199. U.S. CONST. art. I, § 8, cl. 3.

200. *See* U.S. CONST. art. II, § 2, cl. 2.

201. *See id.*; *see also* Saikrishna Bangalore Prakash, *The Boundless Treaty Power Within a Bounded Constitution*, 90 NOTRE DAME L. REV. 1499, 1507 (2015).

202. Timothy J. Droske, *Correcting Native American Sentencing Disparity Post-Booker*, 91 MARQ. L. REV. 723, 724 (2008).

203. The three cases that comprise "The Marshall Trilogy" are Johnson v. M'Intosh, 21 U.S. (8 Wheat.) 543 (1823), Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1 (1831), and Worcester v. Georgia, 31 U.S. (6 Pet.) 515 (1832). Jennifer Butts, Note, *Victims in Waiting: How the Homeland Security Act Falls Short of Fully Protecting Tribal Lands*, 28 AM. INDIAN L. REV. 373, 376 (2004).

204. *Cherokee Nation*, 30 U.S. at 20.

205. *Id.* at 17.

206. *Worcester*, 31 U.S. at 561.

207. Over and over the Supreme Court has affirmed Congress's legislative power over crime in Indian country. In United States v. Rogers, the Court held that "[C]ongress may by law punish any offence [in Native territory], no matter whether the offender be a white man or an Indian." 45 U.S. (4 How.) 567, 572 (1846). In United States v. Kagama, the Court upheld Congress's authority to pass the Major Crimes Act based on the federal government's duty to protect the Indian tribes. 118 U.S. 375, 384-85 (1886). In United States v. Antelope, the Court stated, "Congress has undoubted constitutional power to

C. The Major Crimes Act

The Major Crimes Act[208] was enacted by Congress in 1885 as a result of the Supreme Court's decision in *Ex Parte Crow Dog*,[209] where the Court held that the federal government does not have "jurisdiction over the murder of an Indian by an Indian in Indian territory."[210] Under the Act, the federal government has jurisdiction over a specified set of major offenses committed by a Native in Indian country.[211] The Major Crimes Act originally conferred federal jurisdiction over seven offenses—murder, manslaughter, rape, assault with intent to kill, arson, burglary, and larceny.[212] The Act has since expanded its scope to cover fifteen classes of felonies.[213] Importantly, although the Major Crimes Act was passed in response to a crime by a Native against a Native, the Act also applies to crimes by a Native against a non-Native in Indian country.[214] The Act is troublesome because it gives federal jurisdiction for crimes that would otherwise be state jurisdiction, subjecting AI/ANs to harsher sentences than their white counterparts.[215] It also exposes AI/ANs convicted of these qualifying crimes to be charged twice for the same crime, as explained in Section E below.

This sentencing disparity impacts the lives of Natives by exposing them to longer and harsher sentences. "Systemically reducing the level of sentencing disparity for Native Americans would require either substantial revision to the Federal Sentencing Guidelines or modification of the Major Crimes Act."[216] The sentencing disparity was marginally reduced for AI/ANs when the Sentencing Commission attempted to modify the Guidelines following concern from the Native community.[217] However, this

---

prescribe a criminal code applicable in Indian Country." 430 U.S. 641, 648 (1977). *See also* NATIVE AM. ADVISORY GRP., U.S. SENTENCING COMM'N, REPORT OF THE AD HOC ADVISORY GROUP ON NATIVE AMERICAN SENTENCING ISSUES 5-6 (2003).

208. Act of March 3, 1885, ch. 341, § 9, 23 Stat. 362, 385 (1885) (codified at 18 U.S.C. § 1153).

209. 109 U.S. 556 (1883).

210. WILLIAM C. CANBY, JR., AMERICAN INDIAN LAW IN A NUTSHELL 165 (4th ed. 2004).

211. 18 U.S.C. § 1153 (2012 & Supp. II 2015).

212. § 9, 23 Stat. at 385.

213. The thirteen categories are: (1) "murder," (2) "manslaughter," (3) "kidnapping," (4) "maiming," (5) "a felony under chapter 109A [of title 18]," (6) "incest," (7) "a felony assault under section 113 [of title 18]," (8) "an assault against an individual who has not attained the age of 16 years," (9) "felony child abuse or neglect," (10) "arson," (11) "burglary," (12) "robbery," and (13) "a felony under section 661 of [title 18]." § 1153(a).

214. United States v. Bruce, 394 F.3d 1215, 1221 (9th Cir. 2005). Also of importance, jurisdiction under the Major Crimes Act exists if any part of the crime occurred in Indian country. United States v. Van Chase, 137 F.3d 579, 582 (8th Cir. 1998).

215. Droske, *supra* note 202, at 724.

216. *Id.* at 811.

217. *Id.*

is not enough, and Congress does not seem likely to amend the Major Crimes Act to eradicate the issue anytime soon.[218]

D. Harsher Sentencing

Due to the relationship of Native tribes to the federal government, Natives who are convicted of certain crimes within Indian country under the Major Crimes Act are subject to harsher sentences than the general population because they are subject to federal (as opposed to state) laws, which tend to be more severe.[219] This includes offenses that are almost exclusively within states' criminal jurisdiction, such as manslaughter, assault, and sex offenses.[220] Thus, essentially due to their race, AI/ANs face disproportionately harsher sentences than their American counterparts. It should be noted, however, that crimes committed by non-Natives against non-Natives within Indian country are prosecuted in state courts according to state substantive law.[221] The Federal Sentencing Guidelines, which have greatly restricted judicial discretion to correct for this disparity, have only made this disparity worse.[222]

E. Double Sentencing

The issue of double sentencing is a major concern for Natives. AI/ANs are subject to laws and sentencing in both the Native community (under tribal law) and under federal law. This is a result of the U.S. Constitution, the Indian Civil Rights Act, the Supreme Court's decisions on the issue, and subsequent legislation.[223] This essentially exposes AI/ANs to double jeopardy and allows them to be tried, convicted, and sentenced twice for the same crime. It should be noted that all other Americans are protected against double jeopardy by the Fifth Amendment to the United States Constitution.[224]

F. High Incarceration Rates

AI/ANs are incarcerated at a rate of 895 per 100,000, while their white counterparts experience an incarceration rate of 450 per 100,000.[225] This is due to a number of factors, including criminal justice policies and

---

218. *Id.*
219. *Id.*
220. *Id.* at 724.
221. Gregory D. Smith, Comment, *Disparate Impact of the Federal Sentencing Guidelines on Indians in Indian Country: Why Congress Should Run the Erie Railroad into the Major Crimes Act*, 27 HAMLINE L. REV. 483, 494 (2004).
222. Droske, *supra* note 202, at 811.
223. *See generally id.*
224. U.S. CONST. amend. V.
225. PRISON POLICY INITIATIVE, *supra* note 10.

laws that negatively impact AI/ANs, many of which are discussed above, including the fact that AI/ANs are subject to harsher sentences because they are subject to federal prosecution for serious crimes committed on reservations. Another explanation has to do with the high level of alcohol-related crimes committed by AI/ANs. Alcohol was used in 55% of homicides, 56.1% of child abuse, 52.1% of sexual assaults, and 46.2% of assaults according to a study of alcohol-related crime conducted in five Western states and Alaska by the Bureau of Indian Affairs (BIA).[226]

G. Impact on Youth

The disparities in the criminal justice system for AI/ANs start young. AI/AN youth are 30% more likely than their white counterparts to be referred to juvenile court than have their charges dropped.[227] In addition, a conversation with the Pine Ridge Court Administrator pointed out that for many youths, their first encounter with tribal code and the justice system is upon arrest or through watching a family member arrested, instead of in a teaching environment or classroom.[228] When young people are exposed to the criminal justice system at an early age, it increases their chances of remaining in the system.[229] Further, juvenile records are not automatically expunged or sealed, which can lead to many consequences further in life such as difficulty obtaining employment, serving in the military, or obtaining financial aid for college, all of which increase the likelihood of being involved with the criminal justice system.[230]

H. Lifelong Impact of Incarceration

Even after release, the impacts of incarceration can have lifelong impacts on health and well-being, effecting not only the individual, but also their families and loved ones. A recent study found that young adults who have been incarcerated were more likely than their counterparts, who have not experienced incarceration, to engage in unhealthy, stress-inducing

---

226. GARY R. LEONARDSON, MONT. BD. OF CRIME CONTROL, NATIVE AMERICAN CRIME IN THE NORTHWEST: 2004-2008—BIA INFORMATION FROM ALASKA, MONTANA, WYOMING, IDAHO, OREGON, AND WASHINGTON 5 (2009).

227. Flanagin, *supra* note 6 (citing Christopher Hartney, *Native American Youth and the Juvenile Justice System*, FOCUS (Nat'l Council on Crime and Delinquency, Madison, Wis.), Mar. 2008, at 5).

228. Interview with Bette Goings, Adm'r, Pine Ridge Court, Pine Ridge Reservation, S.D. (June 29, 2017).

229. *See* Amélie Petitclerc et al., *Effects of Juvenile Court Exposure on Crime in Young Adulthood*, 54 J. CHILD PSYCHOL. PSYCHIATRY 291 (2012).

230. NAT'L RESEARCH COUNCIL, LOSING GENERATIONS: ADOLESCENTS IN HIGH-RISK SETTINGS 151 (1993); *Youth in the Justice System: An Overview*, JUVENILE LAW CTR., https://perma.cc/3MMZ-7VK2 (last visited July 24, 2018).

behaviors, such as binge eating and cigarette smoking.[231] Not only do these sorts of behaviors lead to immediate, poor physical health, but they can also lead to poor health habits that last into adulthood. Incarceration can also lead to elevated and chronic stress, which can damage health long after incarceration.[232] Further, second-degree contact with incarceration (when a family member or parent is incarcerated) has shown to be predictive of poor mental and physical health in childhood and adulthood.[233]

There are several short-term and long-term negative consequences that go along with being incarcerated. For example, "current and former inmates are more likely to contract infectious diseases, have higher risk of death, and are more likely to develop either chronic physical or mental conditions than members of the general population."[234] Due to budget constrictions, jurisdictional, and policy issues, many incarcerated AI/ANs in tribal jails do not receive basic health care services. Because there is rarely screening done during admission to detention facilities, sick and contagious individuals can actually put other inmates and employees at risk of contracting illnesses.[235]

Upon leaving prison, former inmates earn lower wages and often face difficulties finding employment and housing compared to individuals who have never been incarcerated.[236] Further, when reentering the community, they often face additional barriers to rebuilding their lives such as discrimination, social stigma, and isolation.[237]

---

231. Lauren C. Porter, *Incarceration and Post-release Health Behavior*, 55 J. HEALTH SOC. BEHAV. 234, 235 (2014).

232. Steven A. Hass, *The Long-Term Effects of Poor Childhood Health: An Assessment and Application of Retrospective Reports*, 44 DEMOGRAPHY 113, 113-14 (2007); Daniel R. Hale et al., *Adolescent Health and Adult Education and Employment: A Systematic Review*, 136 PEDIATRICS 128, 129 (2015).

233. Hedwig Lee et al., *A Heavy Burden: The Cardiovascular Health Consequences of Having a Family Member Incarcerated*, 104 AM. J. PUB. HEALTH 421, 421-22 (2014); Roettger & Boardman, *supra* note 97, at 636-37; Christopher Wildeman et al., *Despair by Association? The Mental Health of Mothers with Children by Recently Incarcerated Fathers*, 77 AM. SOC. REV. 216, 218-19 (2012).

234. Michael H. Esposito et al., *The Consequences of Contact with the Criminal Justice System for Health in the Transition to Adulthoo*d, 8 LONGITUDINAL & LIFE COURSE STUDIES 57, 58 (2017) (citing Mana Golzari et al., *The Health Status of Youth in Juvenile Detention Facilities*, 38 J. ADOLESCENT HEALTH 776 (2006); LAURA M. MARUSCHAK, BUREAU JUST. STAT., HIV IN PRISONS, 2001–2010 (2015); Massoglia, *supra* note 97; Michael Massoglia & William Pridemore, *Incarceration and Health*, 41 ANN. REV. SOC. 291 (2015)).

235. *See, e.g.*, BRIAN CLADOOSBY, NAT'L CONG. AM. INDIANS, FUNDING FOR CORRECTIONAL HEALTH CARE IN TRIBAL AND BIA FACILITIES 1 (2017).

236. Harry Holzer et al., *How Willing are Employers to Hire Ex-Offenders?*, 23 FOCUS 40, 40 (2004); Bruce Western, *The Impact of Incarceration on Wage Mobility and Inequality*, 67 AM. SOC. REV. 526, 526-27 (2002); Bruce Western et al., *The Labor Market Consequences of Incarceration*, 47 CRIME & DELINQ. 410, 411 (2001).

237. Dina R. Rose & Todd R. Clear, *Incarceration, Social Capital, and Crime: Implications for Social Disorganization Theory*, 36 CRIMINOLOGY 441, 450-51 (1998); Western et al., *supra* note 236.

I. Impact of Disparities in the Criminal Justice System

There are dramatic implications caused by disparities in the criminal justice system for AI/ANs that reach far beyond the physical repercussions. Natives have expressed feelings of discrimination, hopelessness, and helplessness due to the double standards they face within the criminal justice system compared to other Americans.[238] They feel that they live in a hostile environment that treats them differently than their white counterparts simply due to their race.[239] "Native Americans voiced feelings that racism 'permeated' the federal and state levels of justice and that crimes committed by Indians against whites were prosecuted more vigorously than those committed by whites against Indians."[240]

VII. BUREAU OF INDIAN AFFAIRS (BIA) AND TRIBAL JAILS

There are over 90 detention centers throughout Indian country in the U.S. The BIA Office of Justice Services (OJS) staffs and operates about a quarter of these facilities.[241] The rest are operated by individual tribes through Public Law 93-638, Self-Government Compacts.[242] A small number are fully funded and operated completely by tribes.[243] According to the U.S. Department of the Interior Indian Affairs website, "the ultimate mission of BIA OJS Corrections is ensuring Indian Country facilities are operated in a safe, secure, and humane manner."[244]

The BIA has no correctional health care budget, and as a result, does not provide health care personnel or services in its detention facilities.[245] The absence of medical personnel and care in detention facilities compromises the health and safety of both inmates and detention personnel. BIA detainees are not given a medical evaluation when they are taken into custody,[246] and this practice exposes everyone else in the detention center to infectious diseases. This practice is traced back to a case which resulted in a serious tuberculosis outbreak in a newly constructed tribal jail infecting over 40 inmates and staff.[247]

The federal government provides health care in the Federal Bureau of Prisons (BOP) and Immigration and Customs Enforcement (ICE)

238. *See generally* S.D. ADVISORY COMM., U.S. COMM'N ON CIVIL RIGHTS, NATIVE AMERICANS IN SOUTH DAKOTA: AN EROSION OF CONFIDENCE IN THE JUSTICE SYSTEM ch. 2 (2000).

239. *Id.*

240. Droske, *supra* note 202, at 741 (citing S.D. ADVISORY COMM., *supra* note 238).

241. *Division of Corrections*, OFFICE OF JUSTICE SERVS., BUREAU OF INDIAN AFFAIRS, https://perma.cc/H497-JWSN (last visited July 24, 2018).

242. *Id.*

243. *Id.*

244. *Id.*

245. CLADOOSBY, *supra* note 235, at 1.

246. *Id.*

247. *Id.*

detention facilities using Public Health Service Commissioned Corps officers; however, none of these personnel work in BIA jails.[248] Because there are no health care facilities or personnel at BIA correctional facilities, correctional officers must transfer inmates to their local IHS or tribal 638 health care provider for all medical services.[249] As a result, tribes must use significant portions of their BIA corrections allocations to transport and supervise inmates receiving health care. For example, an inmate with diabetes may need to be transported three times a week for dialysis and must be supervised at the health facility for three hours each visit.[250] This becomes very costly and inefficient.[251]

There are additional gaps in health care coverage for BIA prisoners. The IHS is chronically underfunded and has no correctional health care budget, forcing tribal health facilities to increasingly rely on Medicaid reimbursements to help make up for the shortage of AI/AN health care appropriations.[252] However, Medicaid has an exclusion for outpatient health services for inmates, whereas Congress already directly appropriates funds to pay for federal prisoners' health care costs, and state and local jurisdictions do the same.[253] This essentially leaves BIA inmates without health care.

VIII. RECOMMENDATIONS

Below are several recommendations to help realize the goal of ensuring adequate health care is provided for AI/ANs both inside and outside the prison system in hopes of reducing the health impacts caused by discrimination and disparities within the justice system. These are listed and described in detail below.

1. Create a catastrophic inmate health care fund for major medical care in tribal prisons

There is currently no funding for tribal prison health care needs. This is a major public health concern because inmates and jail employees alike are exposed to infection and disease. Prisoners do not receive the health care they need due to budget restraints.[254] This would be unconstitutional if it were not on sovereign Indian land. Congress should create catastrophic inmate health care that can be used if an inmate sentenced in tribal court needs major medical care. This will help fund health care needs in tribal jails

248. *Id.* at 2.
249. *Id.* at 1.
250. *Id.*
251. *Id.*
252. *Id.* at 2.
253. *Id.*
254. *See id.* and accompanying text; *see also supra* notes 245-247 and accompanying text.

and help to ensure that prisoners in tribal jails have access to basic medical care.

2. Provide counseling, support, and mental health services to all AI/ANs, including those in prisons and jails

It is important to provide counseling and support services to prisoners to help them adjust to prison life and to help them reintegrate into society upon release. This can help improve inmate mental health and help prevent recidivism. The majority of prisoners have mental health and substance abuse issues, and this is particularly true among the AI/AN prison population.[255] Such issues are often left untreated in detention, and they become worse. Those who enter prison without these conditions are often subjected to circumstances in prison where they become susceptible to mental health and substance abuse issues. Simply being in detention is a traumatic and life-changing experience, and many experience further trauma including mental, physical, and sexual abuse.[256] It is important to provide therapy and support for these populations as they are among the most vulnerable. Addressing mental health needs will improve the health and quality of life of prisoners with mental disabilities as well as the prison population as a whole. This is particularly important with AI/AN prisoners whereas they suffer from higher rates of suicide than their counterparts and are incarcerated at higher rates proportionately than other Americans.[257]

3. Provide health care support services and personnel for AI/ANs in tribal jails

Due to jurisdictional issues and past treaties, tribal jails do not fall under the jurisdiction of the U.S. government. Prisoners in these jails often do not have access to basic health care services, which would be unconstitutional anywhere else in the U.S. Tribal jails are traditionally underfunded and understaffed.[258] This is harmful to prisoners and their health. Many basic necessities are not met in tribal jails. Because there is no basic health system in tribal jails, when a medical emergency does arise, it becomes more costly and less efficient to treat. Further, it is also important to integrate a more holistic approach to health care services, which will help to deter disjointed care and improve overall health and wellbeing of patients by recognizing that wellbeing is not just physical health, but a generally healthy human experience.

---

255. *See supra* notes 97-98 and accompanying text.

256. *See supra* notes 180-183 and accompanying text.

257. *See* PRISON POLICY INITIATIVE, *supra* note 10 and accompanying text; *see also* Leavitt et al., *supra* note 12 and accompanying text.

258. *See* CLADOOSBY, *supra* note 235 and accompanying text.

4. Establish a partnership between BIA and the U.S. Public Health Service to assign Commission Corps officers to tribal jails

Currently, the U.S. Public Health Service assigns Commission Corps officers to detention centers including immigration detention centers; however, there is no such arrangement for tribal jails.[259] Whereas tribal jails are so understaffed and underfunded, additional support is needed. Such a partnership would allow officers to provide health care services to tribal prisoners just as they do for BOP and ICE detention facilities. BIA should allow for correctional health care funding in its annual budget to fund officers in tribal jails, and Congress should appropriate funds for Commission Corps officers to be assigned to tribal jails.[260]

5. Increase stability and congruence in health care services for AI/ANs

There needs to be more stability and congruence in health care services for AI/ANs. It is vital to coordinate health care needs among health care providers and health care facilities to prevent fragmentation and unnecessary costs. This is especially important for patients who are detained and require continuity of care. Fragmentation can result in increased hospitalization and decreased patient satisfaction. This is especially true for AI/ANs whereas they suffer the worst health disparities in the United States.[261]

6. Substantially revise the Federal Sentencing Guidelines and the Major Crimes Act

The Federal Sentencing Guidelines and the Major Crimes Act allow for double sentencing as well as harsher sentences for AI/ANs. The current policies essentially allow for double jeopardy, something that is unconstitutional for other Americans. These policies also allow for longer and harsher sentences for AI/ANs.[262] Both the Guidelines and the Major Crimes Act need to be revised so AI/ANs are no longer disproportionately sentenced and discriminated against within the criminal justice system based on race.

7. Educate health care providers on or near reservations about the specific needs of AI/ANs

One of the major barriers for AI/ANs receiving health care—especially regular and preventive services—has to do with cultural

259. *See supra* note 248 and accompanying text.
260. *See* CLADOOSBY, *supra* note 235.
261. *See Disparities*, *supra* note 2 and accompanying text.
262. *See* Droske, *supra* note 202 and accompanying text.

barriers.[263] Many AI/ANs do not trust white health care providers due to a long history of discrimination and distrust created through government promises.[264] Further, many non-Native health care providers do not understand or appreciate the special issues and concerns that Natives face. Traditional languages and beliefs often do not translate well, and misunderstanding and confusion can create frustrating health care experiences for AI/ANs. In order to provide more culturally appropriate care to AI/ANs, it is imperative that healthcare providers caring for them are aware of cultural sensitivities as well as traditions and beliefs. This will ensure more trust from patients and better overall care.

8. Congress should amend Medicaid to allow for reimbursement for outpatient services for AI/ANs incarcerated in tribal jails

The current Medicaid bill does not allow reimbursement for outpatient services for individuals in tribal detention facilities.[265] This is because Congress already directly appropriates funds to pay for federal prisoners' health care costs, and state and local jurisdictions do the same.[266] This ensures no reimbursement for tribal prisoners, making it more difficult for AI/ANs in tribal jails to receive medical care. This is an example of another barrier to health care for AI/ANs, caused by U.S. policies affecting their health and contributing to their health disparities.

9. Increase research on AI/ANs in prison, and ensure data breaks up populations to include AI/ANs

There needs to be more data on AI/ANs in the prison system. Much of the data breaks down statistics in three categories, namely white, black, and Hispanic. The data also needs to encompass the Native community. This will help to identify gaps in resources and help to increase funding and support for policies that help to improve the health of AI/ANs generally and for those who have been involved in the criminal justice system. The data will help bring awareness and attention to the issue of discrimination and health and justice disparities that impact AI/ANs, particularly their health.

10. Establish and fund programs that help reintegrate AI/ANs into society after release from detention

The period after release from incarceration is associated with high risk for various negative health outcomes.[267] It is important to recognize that

263. *See* Hendrix, *supra* notes 167, 170 and accompanying text.
264. *See* Goodkind et al., *supra* note 197 and accompanying text.
265. *See supra* note 253 and accompanying text.
266. *See* CLADOOSBY, *supra* note 235.
267. *See generally* Kinner & Wang, *supra* note 173.

an individual's life is put on hold when sent to prison, and individuals often leave detention without a secure job, housing, or a support system. It is essential that there are systems in place to mentally prepare prisoners for release from detention so they can contribute to society in a meaningful way upon release. This is especially true for AI/AN populations who suffer from longer prison sentences and greater health disparities than other Americans.[268] It is imperative that there are support systems in place to help integrate prisoners back into society for individual health, as well as public health.

CONCLUSION

AI/ANs face barriers to health that date back centuries.[269] Although the U.S. government has implemented laws, policies, and programs in attempts to improve access to food and health care for AI/ANs, they still suffer some of the worst health disparities in the country, even among minorities.[270] Incidences of NCDs, including CVDs, diabetes, and cancer, are alarmingly high among AI/AN populations.[271] Poverty, low educational levels, high unemployment rates, inadequate and unhealthy housing, geographic isolation, and cultural barriers contribute to poor health among Native communities.[272] Diets that are high in processed red meat[273]—supplied by the U.S. government[274]—and other high fat, low nutrient foods, as well as high rates of tobacco and alcohol use, add to health concerns.[275] Such health disparities exist among AI/ANs living both in urban areas and in and around reservations. However, these disparities are exacerbated for AI/ANs who are or have been incarcerated, where they are exposed to additional communicable and non-communicable diseases, including HIV and hepatitis,[276] as well as physical and emotional abuse[277]—all of which can last long after release from detention. This is a public health concern whereas incarceration impacts individuals as well as families and communities.

Aside from the underlying health issues that all Americans face in detention, AI/ANs are exposed to additional health issues due to their existing health disparities as well as disparities within the criminal justice system that expose them to longer periods of incarceration—a result of

268. *See supra* notes 8-10 and accompanying text.

269. *See* Goodkind et al., *supra* note 197 and accompanying text.

270. *See* Gilio-Whitaker, *supra* note 7 and accompanying text; *see also,* Hutchinson & Shin, *supra* note 9 and accompanying text.

271. *See Disparities*, *supra* note 2 and accompanying text; *see also supra* note 58 and accompanying text.

272. *See supra* note 4 and accompanying text.

273. *See supra* note 73, 75 and accompanying text.

274. *See supra* notes 82-83 and accompanying text.

275. *See* Fretts et al., *Physical Activity*, *supra* note 72 and accompanying text; *see also,* Fretts et al., *Red Meat*, *supra* note 72 and accompanying text.

276. *See supra* note 178 and accompanying text.

277. *See supra* note 181 and accompanying text.

criminal justice policies that essentially subject AI/ANs to double jeopardy, a concept that is unconstitutional for all other Americans.[278]

There are many lasting and devastating impacts caused by the U.S. government's failure to budget and pay for tribal correctional health care. Not only does it place additional strain on inadequate tribal health care and corrections budgets, but it also "exacerbates the already challenging problem of health disparities for American Indians, undermines successful inmate re-entry, and contributes to recidivism."[279] A majority of tribal jails run by the BIA on reservations provide no health services for inmates. This would be considered unconstitutional if it were not on tribal land. Additionally, many BIA jails do not provide addiction services or treatment for inmates.[280] The absence of health services available for AI/ANs both in tribal and other jails makes for deplorable conditions and creates a public health concern, leaving open the possibility to spread infectious diseases to prisoners and prison employees while in detention, as well as to their families and communities when they are released.

The findings show significant disparities in the application of criminal justice and health outcomes among AI/ANs compared to other Americans. In particular, issues related to unemployment, substance abuse, and systemic legal disparities are precursors to many cases leading to disability and death. Incarceration affects one's life course and, consequently, one's health. Because AI/ANs are incarcerated at such high rates proportionally than any other ethnic/racial group in the U.S., the health consequences for individuals suggest the need for a more focused and engaged prevention and support strategy.

278. Droske, *supra* note 202, at 736.

279. CLADOOSBY, *supra* note 235.

280. Telephone interview with Joseph Hardgrave, Supervising Attorney, Indian Practice Grp., Mont. Legal Servs. Ass'n (Sept. 7, 2017).