Healing on the Inside: A History of Healthcare for Incarcerated Veterans

July 2024

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Introduction

In August 2022, the Council on Criminal Justice launched the Veterans Justice Commission, a national, nonpartisan panel of 15 top military, veterans, and criminal justice leaders chaired by former U.S. Defense Secretary Chuck Hagel. Its mission is to examine why so many military veterans land in jail and prison and produce recommendations for evidence-based policy changes that enhance safety, health, and justice.

To support the Commission's work, this brief examines the history of healthcare for incarcerated veterans. Research has consistently shown that healthcare from the U.S. Department of Veterans Affairs (VA) produces superior outcomes for veterans. Throughout most of its nearly 100-year history, the VA has sought to provide healthcare to incarcerated veterans. But it has faced challenges in pursuing that objective, and recent policy changes brought these efforts to a close. Today, federal regulations bar incarcerated veterans from receiving VA care. By illuminating the policy choices made in the past, this brief sheds light on opportunities for future action to improve outcomes for men and women who have served in the nation's military forces.

Key Takeaways

- Since World War I, the federal government has recognized that veterans returning home from war face multiple challenges that may lead to criminal activity and justice involvement.
- For most of modern American history, the federal government has been dedicated to providing veteran-specific care to incarcerated veterans. Care was provided within

correctional facilities and veterans were transported from facilities to VA facilities.

- The provision of veteran-specific care in correctional settings has faced substantial practical obstacles. These include the location of correctional facilities, coordination with correctional stakeholders, and the delivery of care in secure settings.
- An administrative rule prohibiting incarcerated veterans from receiving VA care was formalized in 1999 and was primarily justified by a concern about costs.
- Research conducted among non-incarcerated veterans in the community consistently shows that those who receive VA care experience superior health outcomes compared to those who do not. Despite such findings, incarcerated veterans are not provided VA care designed to address their unique service-related physical and mental health needs.
- The recent expansion of Medicaid to certain incarcerated individuals, along with technological advancements in areas like telehealth, present opportunities to expand VA healthcare access for incarcerated veterans, although practical obstacles remain.

Origins: Caring for World War I Veterans

Following the end of World War I, concerns grew about the rising number of service members returning from Europe with a range of distressing symptoms, including “fatigue, tremor, confusion, nightmares, and impaired sight and hearing.” Over time, these symptoms became known as “shell shock,” and they seemed connected to criminal behavior.[1] As early as 1922, observers noted that “many of the service men who had been arrested and sentenced for various crimes were in the main not responsible, but suffering from shell shock and other inheritances of the World War, and not in a position to judge right from wrong.”[2]

A new response to this concern developed in Wisconsin under the direction of Dr. William F. Lorenz, a psychiatrist and World War I Army major, and the state’s governor, John J. Blaine. Together, the men established a program to identify incarcerated veterans in all Wisconsin prisons and jails, and send mental health providers into the state’s prisons to conduct evaluations assessing whether military service conditions had contributed to veterans’ offenses. As part of this effort, a survey conducted in 1923 indicated that more than one fifth of Wisconsin’s incarcerated veterans “were made criminals by their war service.”[3] A similar survey in a New York prison found that every one of the 48 incarcerated veterans was suffering from shell shock.[4]

These findings provided support for the Veterans Bureau, the predecessor to today’s

Veterans Health Administration (VA), to create a national plan to provide psychiatric rehabilitation within penal institutions.[5] In 1922, the first director of the Veterans Bureau, Col. Charles Forbes, recognized the need to serve incarcerated service members and veterans. He wrote, "Where we find beneficiaries in penitentiaries and jails, you must remember that there is nothing in the law to prevent them from having care, treatment and compensation."[6]

As the national campaign developed under the bureau's second director, Gen. Frank T. Hines, increased emphasis was placed on transferring incarcerated veterans from correctional facilities and into government hospitals, where they could more easily receive care.[7] This effort culminated in a 1923 plan that was cosigned by the Department of Justice. Under the plan, Veterans Bureau physicians would be allowed to visit incarcerated veterans and determine appropriate measures, including "the possibility of parole of prisoners under care of welfare organizations."[8] This plan was subsequently piloted by three federal prisons, with the eventual goal of nationwide adoption.

Consistent Dedication, Inconsistent Implementation

The creation of the plan described above demonstrates that the government believed incarcerated veterans were entitled to veteran-specific care, and that this care should be provided in hospitals rather than penal institutions. But the period that followed this initial plan reveals the difficulty of translating these goals into action.

Two primary obstacles stood in the way of providing veteran-specific care to those in correctional settings. First, as a federal agency, the Veterans Bureau, and subsequently the VA, had trouble mandating cooperation with the wardens and other correctional administrators in charge of prisons and jails. Second, the effort ran into practical difficulties. Limited monetary and personnel resources made it challenging to provide care to all incarcerated veterans, even when there were willing correctional partners. The result was a patchwork approach to care; incarcerated veterans in some states received treatment and occasional exonerations, such as in Wisconsin where Governor Blaine directed state institutions to help, while veterans in other states found little assistance.

In the face of this inconsistency, two elements remained the same as history progressed. First, veteran involvement in the criminal justice system stayed relatively high. A 1951 survey of 11 prisons in the upper Midwest found that one third of those incarcerated were veterans of World War II.[9] Rhetoric about providing benefits and care to incarcerated

veterans also remained constant. In 1948, Col. John N. Andrews of the VA made this fact plain, writing that “veterans benefits … are not denied to a veteran … serving a prison sentence.”[10] Further, Andrews said, ”It had been Congress’ view that what a veteran did after he got out of service shouldn’t affect his right to veterans’ benefits unless he was convicted of aiding and assisting the enemy. It felt that the benefits were rights earned before he got into trouble with civilian authorities; that any wrong-doing in civilian life shouldn’t have any bearing on honorable military duty served previously.” His rationale was that Congress had made it clear that benefits were earned prior to a veteran’s legal involvement, and thus acts that occurred after military service could not change this compensation.[11]

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– Col. John N. Andrews, 1948

The one exception happened in 1957, when Congress suspended veteran pensions between the 61st day of incarceration and the end of the prison term, a policy that still applies today.[12] At the time, these pensions were reserved for veterans with disabilities so severe that they were unable to work or meet their living expenses. Congress reasoned that incarcerated veterans did not have living expenses during confinement, making the payment unnecessary.[13] Despite its suspension of pensions, however, Congress left other disability and medical benefits for incarcerated veterans untouched.

A Growing Problem: Vietnam Veterans

The suspension of incarcerated veterans’ pensions required the VA to coordinate more routinely with prisons and jails, a relationship that gained importance following the Vietnam War and the substantial growth in the number of incarcerated veterans. Estimates indicate that more than a quarter of all people in U.S. prisons in the late 1970s had served in the military, constituting between 58,000 and 125,000 veterans.[14] In speaking to this issue, a U.S. Comptroller General study found that 81% of the incarcerated veterans interviewed had not been advised about their eligibility for benefits since being taken into custody, and 53%

believed that they had lost all VA benefits due to their incarceration.[15]

As outreach efforts aimed to increase awareness about VA benefits, the government continued to emphasize eligibility. In a 1978 memo, President Jimmy Carter mandated the identification and publication of the incarceration rate for veterans and reminded Congress that "[e]ligible incarcerated veterans [were then] entitled to all education, health, employment and other benefits from the Federal government."[16]

Echoing this call, several programs throughout the 1970s worked to provide VA care to incarcerated veterans. Beginning in 1976, the Veterans in Prison Program at the Brentwood VA Medical Center in Los Angeles regularly sent social workers to visit more than 10 correctional facilities to provide counseling on combat readjustment issues to an average of 150 incarcerated veterans per week.[17]

Such efforts were bolstered in 1979 when Congress held its first hearing on incarcerated veteran outreach. Witnesses described the many difficulties with bringing VA doctors into prisons and jails, including logistical issues related to the far-flung locations of most correctional facilities, challenges with collaborating with wardens and other administrators, and concerns that pulling doctors into correctional facilities might result in delayed services for veterans seeking VA services in the community. On a related note, witnesses also provided evidence that VA hospitals were not meeting the unique needs of Vietnam veterans, whose mental health issues and substance abuse conditions were poorly understood by veterans who had served in earlier eras.[18]

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During the hearing, Congress urged operators of the VA's newly formed community-based counseling centers, known as Vet Centers, to offer services to incarcerated veterans – specifically to those who had served in Vietnam. This call was heeded, and by 1993, approximately one third of all Vet Centers provided assistance inside of correctional facilities.[19] Among their other contributions, Vet Centers became known for their instrumental role in providing "group therapy" to veterans who suffered from a range of readjustment and mental health issues related to their military service.

Changing Sentiment: The Aftermath of Vietnam

Opposition to the Vietnam War shifted public sentiment toward veterans, and many service members returning home were met with indifference, or worse.[20] This shift spilled over into police as well. During the 1980s, the receipt of benefits among incarcerated individuals received extra scrutiny from Congress, a trend that was epitomized by public outrage over David Berkowitz, the "Son of Sam" serial murderer and honorably discharged veteran of the U.S. Army, receiving Social Security Disability Insurance income.[21]

Congress responded to these concerns with a series of hearings and legislative proposals about the benefits provided to incarcerated veterans. After initially considering drastic cuts to VA disability compensation for incarcerated veterans, lawmakers ultimately settled on a more modest reduction.[22] Notably, the fact that prisons and jails were responsible for providing living expenses and essential services was rejected as a rationale for completely stripping incarcerated veterans of disability compensation benefits.

The initially modest reduction in benefits was expanded in 1986 when Congress passed a law stating that the VA was not obligated to provide healthcare to veterans when they were under the supervision of another government agency with a duty to furnish that care, such as prisons and jails.[23] While this law removed the VA's *obligation* to care for incarcerated veterans, it did not function as a *prohibition* on providing that care. Ultimately, the law gave individual VA medical centers the authority to decide how they would proceed.

Some created policies that prohibited visits by staff to incarcerated settings. Others, however, continued to provide care. For example, the Colorado VA Medical Center at Grand Junction permitted Daniel Frederick Taylor, an incarcerated veteran who had been sentenced to ten to 20 years in prison for attempted murder, to undergo ten weeks of inpatient treatment for post-traumatic stress disorder (PTSD), after which time he was returned to prison.[24] In 1988, the Court of Appeals for Veterans Claims confirmed that incarcerated veterans remained entitled to "the same care and consideration" as non-incarcerated veterans.[25]

Seeking to formalize this ruling in an arrangement capable of overcoming obstacles to delivering care to incarcerated veterans, Congress in 1990 considered legislation to mandate treatment of veterans in federal prisons through Vet Centers. The bill failed, in part due to VA objections that such a mandate would siphon resources away from other veterans. But the effort highlighted the continued interest in identifying ways for the VA to provide care to

veterans during confinement. As recently as 1998, the VA policy manual noted that incarcerated veterans did "not forfeit any right of hospital or domiciliary care by VA."[26]

Ending a Duty to Care: The 1999 Regulatory Bar

In 1996, a new federal law called for clarifying the VA services to which veterans were entitled.[27] As part of the law's implementation, the VA in 1999 created exclusionary criteria for the receipt of medical benefits. These criteria prohibited "[h]ospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency, if that agency has a duty to give the care or services."[28] This exclusion was housed within the massive rulemaking petition. While the VA received numerous comments on the regulation, the move to exclude incarcerated veterans did not attract a single comment from the field.[29] The final rule was issued without supportive analysis or input from incarcerated veterans, congressional representatives, or veterans organizations. Its impact was pivotal. Through the rule, the VA cemented a shift from a practice that had existed since its founding days as the Veterans Bureau: veterans behind bars were now restricted from receiving VA medical care.

The ramifications were immediately evident. For example, the Rutherford County Adult Detention Center in Murfreesboro, TN, had been regularly transporting an average of ten to 15 incarcerated veterans every month to the York VA Medical Center for care ranging from mental health treatment to treatment for a heart condition.[30] Another 15 to 20 veterans in the detention center received medications from the VA each month.[31] Following the rule change, transported veterans were turned away at the facility's door, informed that they could no longer receive treatment. In addition, only medical prescriptions written prior to the directive were henceforth to be filled, while new prescriptions and refills were not to be provided.[32]

Appeals were soon brought forth from the Rutherford County Sheriff's Department, noting that medication expenses alone ranged from $200 to $300 per month per incarcerated veteran.[33] Local Congressman Bart Gordon further argued that interrupting VA care was not beneficial for the community or the veteran, while prison psychologists claimed that the new policy was "dangerous."[34] In response, the VA defended the rule change primarily on economic grounds, noting that it needed to conserve scarce resources for non-incarcerated veterans.[35] Although this rule effectively ended systematic VA programming for incarcerated veterans, in 2001 the VA created a workgroup to establish best practices for serving veterans

in correctional facilities and those experiencing homelessness with partners at the Bureau of Prisons and veterans service organizations.[36] The recommendations of this workgroup resulted in many of the outreach programs which still function today.

Opportunities Ahead

From World War I to the end of the 20th century, the federal government was dedicated to providing healthcare to veterans in both correctional and community settings. The exclusion of incarcerated veterans from VA care emerged just 25 years ago, created through the VA rulemaking process rather than through a more visible congressional mandate. In demonstrating that a desire to care for incarcerated veterans has been the norm, rather than the exception, this history highlights pathways for returning to a more supportive approach for veterans incarcerated in our nation's prisons and jails.

There has been movement back in this direction. Started in 2006, the VA's Health Care Reentry for Veterans (HCRV) program helps veterans as they are released from incarceration, linking them to medical services and benefits. Because the HCRV engages with veterans prior to their release from custody, however, it has had to contend with the 1999 prohibition discussed above. In 2011, the VA added an exception to the rule to clarify that while the HCRV could not provide healthcare treatment, it could provide counseling, screening, assessment, and referrals to veterans released from incarceration who were in halfway houses or transition programs, even when those programs were responsible for providing healthcare services.[37] This meant that the VA would allow HCRV to provide assistance despite the 1999 prohibition.[38] Ultimately, this change was motivated by and acknowledges the difficulty that many released veterans face in obtaining care during the transition from incarceration to the community.

It is clear that the provision of VA care to incarcerated veterans faces many logistical obstacles. While this history shows that the federal government has generally felt an obligation to provide such care, it also reveals the difficulty faced in arranging it. Recent administrative changes may prove instructive. In April 2023, the Department of Health and Human Services released guidance allowing Medicaid to provide care during an incarcerated person's transition back to the community.[39]

Ultimately, identifying strategies to connect incarcerated veterans to veteran-specific care

through the VA is essential to both honor the sacrifices veterans made for their country and to protect public safety upon their release.

While states are just now figuring out how to provide this care, the rollout in several states may highlight ways for the VA to engage in a similar effort with incarcerated veterans. The Health and Reentry Project, a cross-sector policy and practice initiative, explored avenues to maximize the benefits of Medicaid policy changes to enhance public health and safety for those leaving correctional settings; this work may provide a blueprint for success with veterans.[40]

On another track, veteran-specific housing units have proliferated in recent years in prisons and large jail systems. Comprehensive, rigorous evaluations of these programs have not been conducted, but in general, veterans indicate that these units helped prepare them for reentry. Such units were not designed to focus on health care, but some veterans said they received referrals to treatment. That said, a study of one such unit in Connecticut indicated that although 72% of participants self-reported health needs, only 31% said the program connected them with needed mental health care and 43% were connected to needed substance use disorder treatment.[41] Despite such findings, such units could provide an avenue for incarcerated veterans to access veteran-specific health education and healthcare tailored to their needs

In addition, although the VA's history of care relied on either bringing incarcerated veterans to VA facilities or getting VA personnel into prisons and jails, technological improvements have opened new doors. The COVID-19 pandemic accelerated the use of telehealth in correctional settings, suggesting another potential avenue that could extend the reach of VA care into correctional settings across the nation.

Ultimately, identifying strategies to connect incarcerated veterans to veteran-specific care through the VA is essential to both honor the sacrifices veterans made for their country and to protect public safety upon their release. The VA is dedicated to developing sophisticated treatments tailored to the needs of veterans, and research indicates that VA care is associated with a range of improved outcomes, including mortality, quality and safety of care, patient experience, and medication management.[42] These findings are consistent with research showing that non-VA providers are often poorly trained in evidence-based care for veterans' issues, such as using Cognitive Processing Therapy to treat PTSD.[43] Expanding access to VA services for those in prison and jail can help us better address the root causes of veterans' criminal behavior and enhance the safety of the communities they once fought to protect.

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Seamone worked tirelessly to improve outcomes for veterans. This report was completed prior to his death in July 2023. He will be inducted into the U.S. Veterans Hall of Fame on November 16, 2024.

Suggested Citation

Seamone, E. R. (2024). *Healing on the inside: A history of healthcare for incarcerated veterans*. Council on Criminal Justice. https://counciloncj.org/healing-on-the-inside-a-history-of-healthcare-for-incarcerated-veterans/