1 More Than 40 Years Since *Estelle v. Gamble*: Looking Forward, Not Wayward

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It is the first summer since the appearance of SARS-CoV-2 on the planet. By the end of August 2020, the once-in-a-century COVID-19 pandemic has already killed more than 800,000 people worldwide, on a trajectory toward millions before an effective vaccine is developed, distributed and administered (New York Times, 2020). To no thinking person's surprise, prisons, jails, and detention facilities are raging hotspots: dangerous for inmates and staff, incubators of infection, and amplifiers of transmission. With little ability for mitigation and poor readiness for containment, these institutions have experienced large outbreaks, especially in the United States, where an absence of both leadership and a unified national strategy has led to many preventable deaths. By the end of August 2020, with very little mass testing, there have been more than 100,000 reported cases in US correctional facilities, including 898 deaths (COVID Prison Project, 2020).

Like floodwaters exploiting the cracks in criminal justice policy, we are already looking back at the nexus of mass incarceration, lack of preparedness, and the pandemic. We may gain no new insights, but perhaps the look back will lead to more progressive and needed policy changes. Perhaps a focus on social justice, reintegration of populations of color from penal institutions returning to communities, acknowledgement of the injustices of the journey of enslaved people, and the strengths derived from multiculturalism can speed us to significant improvements.

The interim, until we reach a more just society, is a time for both reflection and action on the next steps toward humanizing criminal justice, in the interest of public health and public safety. Be it bail reform, sentencing reform, addiction treatment, eschewal of custodial segregation, or reentry continuity, it will be driven by reducing disparities in health and health care, increasing diversity of the workforce, raising the public's regard for correctional reform, and reversing a punitive culture, steeped in cynicism and stereotyping.

In the first edition of this book, we asked a series of questions, still relevant to thoughts of the future: How far have we come in the 44 years since the Supreme Court issued its landmark decision in *Estelle v. Gamble* (Estelle, 1976)? And how much will correctional health care develop in the upcoming decades? For all of these years, correctional health care has been isolated from public health and isolated further from community health care; two systems that are already remote from each other. How do we make the argument that medical care interventions behind bars have so much

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to do with the health of the communities to which the inmates return? How do we make the argument that public health is a significant piece of public safety? How easy is it to identify the barriers that prevent the application of public health and community health approaches to correctional medicine? How easy is it to break down these barriers and build bridges to enable timely access to reasonable and humane health care? Where exactly is the low-hanging fruit?

There are additional questions that need thought and analysis: how can we understand and empower correctional professionals? How can we link correctional health care with public health and community health providers? How can we increase the health literacy of public policy makers and correctional administrators?

The purpose of this book is to tackle these questions. The intent is to help develop a persuasive rationale to direct public policy toward seizing the public health opportunities that present themselves in a captive population, one that is beset by an extraordinary burden of illness. Much of this burden derives from poverty and drug abuse. This book is:

- An exploration of the next evolutionary steps in public health practice from the perspective of the criminal justice system.
- About the implications on public health when prevention opportunities are seized behind bars.
- About reentry and the public health impact of the cycle of incarceration.

The chapters of this book are authored by some of the foremost experts in correctional health care, public health, criminal justice and civil rights law. The objective is to outline the elements of an infrastructure for improving the health of the community through attention to prisoners' medical care. If we want to protect the public health, the time is ripe to develop public policy that takes advantage of the period of incarceration. In this introductory chapter, I will describe current prominent topics in public policy and correctional health care:

1. Constitutional requirements to provide access to medical care.
2. Changes in population dynamics.
3. The burden of underlying illness in correctional populations and the profound effects of the novel corona virus pandemic, COVID-19.
4. The effects of *Estelle*.
5. Eight conundrums of public policy, medical care, and public health behind bars.

Constitutional Standard: No Deliberate Indifference to Serious Medical Needs

In the United States, the legal foundation for reasonable medical care behind bars is the case of *Estelle v. Gamble*, decided by the Supreme Court in 1976. For the first time in almost 200 years, the Court codified what it called "the evolving standard of decency" for health care behind bars. The Eighth Amendment constitutional standard prohibiting cruel and unusual punishment was applied to the personal medical services provided to prisoners. Because they were deprived of their liberty, the Court ruled that it was unconstitutional to deny medically necessary care to a prisoner. The Court concluded that "deliberate indifference to serious medical needs" was the "unnecessary and wanton infliction of pain," and thereby a violation of the Eighth Amendment. In *Estelle*, the Court ruled that prisoners were entitled to:

1. Access to care for diagnosis and treatment.
2. A professional medical judgment.
3. Administration of the treatment prescribed by the physician.

The same standards apply to pretrial detainees and juveniles in detention, through the due process clause in the Fourteenth Amendment (Bell, 1979).

In court, the plaintiff must first establish that a "serious medical need" was present. A good working definition for corrections should be consistent with the definition used by managed care organizations as part of their process to consider whether to approve diagnostic tests and treatments. In effect, this is a community standard. A good working definition for this objective test is as follows:

> A serious medical need is defined as a valid health condition that, without timely intervention, will result in unnecessary pain, measurable deterioration in function (including organ function), death or substantial risk to the public health. (Greifinger, 2006).

"Deliberate indifference" is a trickier phrase. Nevertheless, it is a term we are stuck with. In 1994, the Supreme Court helped define the meaning of this oxymoron. The Court ruled that, although defendants did not necessarily have to show malicious intent to do harm, the plaintiff must demonstrate that the defendants knew of and disregarded the risk to the prisoner (Farmer, 1994). This is a subjective test that follows the objective test of establishing that there is a serious medical need.

Changes in Population Dynamics

The incarceration rate in the United States had an historical zenith in the late 2000s (Sentencing Project, 2019), straining corrections systems resources, particularly in health care (Federal Bureau of Prisons, 2006). Since that time, there has been increasing public policy attention to the cost of mass incarceration, both fiscally and (to some extent) socially. Incarceration rates are down as a result of bail reform and sentencing reform. The incarceration rate has declined 18% since 2009, and in 2016 was at its lowest rate since 1996. The number of prisoners under state or federal jurisdiction decreased by 18,700 (down 1.2%), from 1,508,100 at year-end 2016 to 1,489,400 at year-end 2017 (all from Kaeble & Cowhig, 2018). The jail incarceration rate declined from 259 inmates per 100,000 US residents at midyear 2007 to 229 per 100,000 at midyear 2017, a 12% decrease. In 2017, males were incarcerated in jail at a rate (394 per 100,000 male US residents) 5.7 times that of females (69 per 100,000 female US residents). In 2017, jails reported 10.6 million admissions, a 19% decline from 2007 (Zeng, 2019).

These declines are positive, but not substantial enough to achieve rates comparable to those in other western democracies for many decades. In focused areas, there have been tremendous improvements. For example, the AIDS-related mortality rate for state prisoners decreased from 23/100,000 prisoners in 2001 to 3/100,000 in 2016, all due to advances in medication for what is now a chronic disease (Carson & Cowhig, 2020).

The highest number of mortalities occurred among prisoners age 55 or older, as their numbers tripled between 2001 and 2016. Suicide, homicide, and deaths from all causes among state prisoners between 2001 and 2016 tell another sad story.

- Suicide rates increased by 50% (from 14 to 21/100,000).
- Homicide rates increased by 260% (from 3/100,000 to 8/100,000).
- Deaths from all causes increased by 25% (from 242 to 303/100,000).
- Deaths from alcohol/drug intoxication increased by 25% (from 3 to 8/100,000).
- Mortality rates for black prisoners increased by 25% (from 234 to 293,000).
- Mortality rates for white prisoners increased by 55% (from 345 to 535/100,000) (Carson & Cowhig, 2020).

These data help focus on the current prevention challenges in correctional health care, that is, older prisoners' chronic disease, violence, suicide, drug overdoses, and racial disparities.

Burden of Illness

As a result of poverty and drug abuse, prisoners have a uniquely high prevalence of communicable disease, including HIV/AIDS, tuberculosis, sexually transmitted diseases, and viral hepatitis B and C (NCCHC, 2002) owing in part to their drug abuse. As a result of their poverty, inmates have high rates of mental illness and chronic diseases, such as asthma, diabetes, and hypertension. Drug addiction, poor access to health care, poverty, substandard nutrition, poor housing conditions, and homelessness contribute to increased morbidity from these and other debilitating conditions.

Close to 80% of chronically ill inmates have not received routine medical care prior to incarceration and are likely to have used hospital emergency rooms as their source of primary care (Conklin et al., 1998; Davis & Pacchiana, 2004; Hammett, 1998). As a group, inmates report more disabling conditions, have poorer perceptions of their health status, and have lower utilization of primary health-care services than the general population. While the focus of correctional health care is often on the people behind bars, correctional health-care interventions benefit custody staff, their families, prisoner families, and the communities to which inmates return. Correctional facilities are linked to our nation's communities through population dynamics. Virtually all return to their communities and families (Corrections, 2003; Roberts et al., 2004).

In early 2020, as this volume is being prepared for publication, SARS-CoV-2 emerged worldwide causing a deadly pandemic of COVID-19. Transmitted primarily through respiratory secretions, with a high degree of contagion, people are most at risk through prolonged contact in confined spaces. Just like nursing homes and other institutions, jails, prisons, and detention centers are the foci for amplification and accelerated transmission (Barnert et al., 2020). In other words, the virus circulates like wildfire within the walls of the institutions. In addition, it spreads to communities through recycling; in other words, staff and prisoners are at risk of acquiring infection, bringing it back to their families and communities, and then cycling a return of the infection to the correctional facilities (Reinhart & Chen, 2020). Vulnerability increases with serious underlying illness. It is yet to be seen whether this once-in-a-century pandemic will shape the culture of mass incarceration in a positive way. The potential is here to wholly rethink the nature of the system for justice-involved persons.

The Effects of *Estelle*

The consequence of *Estelle* and ensuing decisions on medical care for inmates has been considerable. In large part, driven by litigation based on *Estelle* and other related Court decisions, we have witnessed improvements in health care behind bars since 1976:

- Standards have evolved, such as those promulgated by the National Commission on Correctional Health Care, the Joint Commission on Accreditation of Healthcare Organizations, the American Correctional Association, and the American Public Health Association.
- Policies and practices have improved.
- There is more professionalism in correctional health care.
- Timely access to care is more the rule than the exception.
- Staff are better qualified and have better training and supervision.
- There is better continuity and coordination of care.
- Performance measurement and quality management programs have improved with increasing self-criticism.
- Oversight has increased somewhat.

In 1996, Congress passed the Prison Litigation Reform Act (PLRA, 1995), a law that restricted some of the legal remedies that had been available to prisoners through class-action litigation for injunctive relief and individual complaints for damages. But Congress opened another avenue for litigation to improve health care behind bars with the Americans with Disabilities Act (ADA, 1990), passed in 1990. In 1998, the US Supreme Court ruled that the ADA applies in the prison context. Prisoners are entitled to reasonable accommodations for their disabilities under Title II of the ADA (Pennsylvania, 1998). The latter decision became a new avenue for prisoners to seek redress through the Courts.

Conundrums[1] Behind Bars

The list of improvements (above) in correctional health care is not to say that our correctional health-care systems are uniformly excellent. Too often, correctional health care is compromised by strained resources, professional isolation, and pressures to conform to the punitive aspects of command-control environments. Too often, correctional health professionals begin to stereotype their patients and thereby distrust them. This stereotyping results in cynicism that is destructive to therapeutic relationships. And too often, there are inadequate linkages to community health-care providers and public health authorities.

Isolation of Correctional Health Professional from Mainstream Medicine

We have a triple-tiered system (better described as a nonsystem) of medical care in the United States: care for the affluent in private offices and group practices; care for the poor in community health centers and hospital clinics; and care for prisoners behind bars. But at least 95% of these prisoners will return to their communities (Hughes & Wilson, 2003). The first conundrum for public policy makers to solve is how to coalesce these diverse medical care systems for better communication of medical information, access to specialty care and hospitals, and linkages for continuity of care on release.

Nexus of Correctional Medical Care with Public Health

A second conundrum is how to address the nexus of personal medical care and public health. We have learned lessons at the interface of public health and criminal justice. In the 1980s, we learned about HIV and the disproportionate percentage of infected people who were behind bars. In the 1990s, we learned about the prevalence and incidence of tuberculosis and the high risk of transmission in correctional facilities. In the first decade of the twenty-first century, we learned about viral hepatitis C and community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA). In this third decade of the twenty-first century, we are learning about the profound failure of the public health infrastructure of the United States. We are learning of the tens of thousands of excess and unnecessary deaths caused by inadequate funding and diabolical leadership, tossed with hyperpartisanship. All are victims, but the concentration of victims falls to the mostly minority poor.

Every inmate who leaves a correctional facility with untreated sexually transmitted disease, viral hepatitis, HIV, tuberculosis, or COVID-19 might be a source of transmission in the community. These

[1] In this section of the chapter, I use the term *conundrum* instead of *challenge, obstacle, barrier*, or *hurdle*. To me, these are puzzles that can be solved with rational analysis. Once the puzzles are solved, the barriers fall to the wayside.

are diseases typically addressed by public health authorities, agencies that because of their categorical funding may not have the resources to join efforts with correctional agencies. Every inmate who is treated for communicable disease behind bars reduces the risk to the public health. The community also benefits from treatment of chronic disease and mental illness behind bars through the savings from early intervention (Freudenberg et al., 2005).

Episodic Versus Primary Models of Care

A third conundrum is the archaic model of medical care in most prison and jail systems. Most facilities use what they call a "sick call" system. This episodic care is appropriate for acute illness, but it has no place in the care and treatment of patients with chronic disease and mental illness. There are nationally accepted guidelines, each with an evidence basis, for a wide variety of chronic conditions. If patients are treated according to these guidelines, including treatment plans for prisoners with special needs, there will be reduced morbidity and mortality. The reduction in morbidity is a substantial cost saving for the communities to which inmates return because of their dependence on public resources for access to care in the community.

Integration of Care for Patients with Coexisting Illness

The fourth conundrum is the artificial walls between treatment for drug abuse and mental illness behind bars. For a variety of reasons, correctional systems typically provide medical care and drug treatment through parallel but unrelated programs. And there is not enough drug treatment behind bars to help reduce recidivism. Despite strong evidence of effectiveness, there is far too little medication-assisted treatment for persons with drug addiction. These are barriers to recovery for patients with coexisting illness.

Transfer of Medical Information

The fifth conundrum is the challenge of transfer of medical information between community and correctional providers. It is a cumbersome process, even with recent widespread use of electronic medical records in correctional facilities. As a consequence, it happens infrequently. This interferes with continuity and coordination of care, putting incoming and outgoing prisoners at risk of harm.

Quality Management Systems

The sixth conundrum is the development of meaningful self-critical analysis, a process called quality management or quality improvement in community health-care facilities. Very few correctional agencies have incorporated valid and reliable performance measurement into their medical care programs. As a consequence, they are unable to measure their problems and then reduce barriers to improved outcomes of care. Performance measurement with quantitative and qualitative analysis of data is an opportune way to improve care and reduce risk of harm and costly litigation. This has been amply demonstrated in the community. There is no reason why the same approach cannot be used behind bars.

Command-Control Versus Collaboration

The seventh conundrum is the apparent contradiction of the command-control organizational model, so essential for safety, and the collaborative-autonomy model used in health care. For example, there are challenges to provide meaningful diagnosis and treatment for inmates who are confined in isolation for breaking facility rules, typically with disruptive behavior. Many inmates are disruptive because of mental illness. Segregation for 23 hours per day is not an effective treatment for mental illness. To the contrary, isolation is contraindicated for serious mental illness, yet correctional agencies often rely on deprivation as a putative way to reduce disruptive behavior. This is but one of the ongoing challenges between the command-control model of correctional facility operations and a public health model of care.

Command-control is critical to safety behind bars. It requires rigorous adherence to rules and does not easily tolerate uncertainty. Even in their most scientific modes, medicine and public health are filled with uncertainty, more uncertainty than is often tolerated in command-control environments. Physicians and other health professionals are used to managing with much more uncertainty than is often tolerated by custody staff. This creates a natural tension, even when the leadership of correctional facilities works hard both to keep a facility safe and to provide good medical care through autonomous health professionals.

Reentry—Seven Tasks

The eighth conundrum is reentry. Until recently, the responsibility of correctional agencies stopped at the gate. Recent public attention to reentry offers correctional and public health professionals the finest opportunity to make a difference for the prisoners themselves and for the communities to which they return. But it requires a revised scope of responsibility for correctional agencies. A revised scope often means a revised budget. With increasing attention to reentry among public policy makers and correctional system leaders, social conditions are favorable for personal health care and public health practitioners to make a real difference here. This is a time and place where their advantage to our communities can shine. It is a place where correctional and public health practitioners can honor their moral duty to provide continuity of care for their patients (AMA, 2001).

Among many other risks, recently released inmates are at higher risk of death after release than people in the community, matched for age, sex, and race (Binswanger et al., 2007). The reentry process contributes to excess mortality relative to incarceration itself, which might have a small protective effect, especially among blacks (Mumola, 2007). In the Binswanger study, conducted in the State of Washington, the relative risk of death within 2 weeks of release was 12.7 times expected and the overall risk of death in the several years following release was 3.5 times expected, and higher among women. In the studied cohort, the most frequent causes of death were overdose, cardiovascular disease, homicide, suicide, cancer, motor vehicle accidents, and liver disease. Surely, some of this risk could be reduced by thoughtful reentry planning.

From a medical perspective, a successful reentry program has seven tasks (Mellow & Greifinger, 2006):

1. *Define the target population*. This includes patients with incompletely treated communicable disease and patients with acute medical conditions. There are other questions for correctional programs:

- Will the program target patients at risk of serious illness?
- Will the program target patients with well-compensated chronic mental illness or any mental illness being treated with medication?
- How about patients with severe chronic diseases? Or all patients with chronic diseases?
- For a larger target, could facilities target patients with nonemergent dental disease, or a history of substance abuse?
- What are the limitations on distributing certain medications at the time of release, for example, antipsychotics, narcotics, benzodiazepines, and TB meds?

2. *Develop formal linkages with commonly accessed community providers including public health departments, community health centers, and hospitals*.
3. *Determine an individual patient's risk and eligibility for reentry services as early as the intake process.*
4. *Summarize essential information for the patient and the subsequent provider of care.*
5. *Provide medication or a combination of medication and written prescriptions.*
6. *Enable access to care on release with community providers, including an appointment and information for access to community-based organizations*.
7. *Designate staff with a clearly defined discharge planning function*.

Improving Public Health Through Correctional Health Care

With our high rates of incarceration and high burden of illness, there are social policy conundrums that go beyond the authority of correctional administrators and correctional health practitioners. Public policy makers will be dealing with increasing costs for medical care, not just because of health care inflation, but because the inmate population is aging. What is the effect of our current policies on communities? Inmates are returning to their home communities without treatment, education, skills, housing, jobs, and self-confidence. Each of these topics is covered in this book. How do we make the expense of incarceration into an investment in our communities? Who do we lock up and who can we safely divert, perhaps in a more constructive manner? How to think about the potential effect of reentry for healthier communities? And, how do we improve the health literacy of public policy makers so as to improve the public health?

Inmates are beacons of public health opportunity. It is my hope that this book will provide a sound basis for a public health perspective on criminal justice policy and operations. It should provide information for policy analysis and direction for correctional medical care programs. Beyond the introductory materials, the book is divided into five sections. Within a section, each chapter is intended to provide both scholarly analysis and practical advice for public health interventions through the criminal justice system. Although I did distinguish communicable disease prevention with its own section, readers may note that I did not separate the psychiatric chapters in their own sectional cocoon. I did this to make the point that we need to reduce the barriers created by mind-body distinctions. Illness is illness. Illness can cause functional disabilities, whether it is somatic or psychiatric.

Part I of this book is about the impact of law and public policy on correctional populations, addressing the following questions: What is the impact of criminal justice policies on communities? What are inmates' constitutional rights to timely and appropriate medical care and how has litigation driven the standard of care? What are the rights of disabled inmates and who are disabled? How do we compare to other countries, especially with public health policies and programs to minimize harm? What are the special needs of aging inmates and has anyone considered the cost of reasonable accommodation for a rapidly aging prison population? How does the medicalization of lethal injection contribute to a moral dilemma for physicians and pain and suffering for the condemned inmates? And with regard to

contracted (or directly provided, for that matter) services, how do we improve accountability toward timely access to an appropriate level of care?

Part II is about categorical public health. From a prevention point of view, we address how to reduce morbidity, mortality, and transmission of diseases that are highly prevalent in inmate populations: tuberculosis, viral hepatitis, HIV, and sexually transmitted disease. We also address, in rudimentary terms because of the recent onset of the pandemic, matters relating to intramural transmission of COVID-19.

Part III is about primary and secondary prevention. How can we use root cause analysis to improve services? What are exemplary nursing practices? How can attention to environmental health reduce risk of intramural transmission of disease? What can we do to prevent disease in the first place and how can we devise programs for early detection (screening) and treatment, using evidence-based protocols? How do we prevent suicides? How can we improve the diagnosis of mental illness? How do we work to prevent prisoners from being punished for behaviors that are outside their control? Why is oral health care important? How are women's health issues different from men's health issues? How are youth different from adults behind bars?

Part IV is about tertiary prevention and access to appropriate care. Care for transgender patients, use and misuse of segregation, and European models for independent monitoring of prisons are timely topics for discussion and thought. How do we use medication-assisted therapy to its best effect?

Finally, Part V is about developing a better infrastructure for reentry. How can we improve communication, especially with electronic information systems and written information for our patients? What research needs to be done? And, how can we manage reentering patients with chronic disease and mental illness so as to provide smooth continuity and coordination of care?

Public Health Behind Bars: From Prisons to Communities, Second Edition, should be a provocative guide to developing the next evolutionary steps in public policy and clinical practices for a better future for our communities.

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