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Inmates as Public Health Sentinels

Robert B. Greifinger*

It has been nineteen years since I began working in correctional health care. During that time I have managed the health services at Rikers Island (New York City's jail); supervised the health services for New York State's prison system; and, for the past eleven years, had a consulting practice focused on public policy, public health, and the quality of health services in United States jails, prisons, and juvenile facilities. I have examined the conditions of confinement and health services in more than 100 correctional facilities located in thirty-five states. My work is about assuring access to high quality health care for the 2.2 million people in United States prisons and jails,¹ protecting the public health through prevention and early intervention, and assuring vital health services for the 95% of inmates who return home to their communities.²

The conditions in United States prisons, jails, and juvenile facilities vary considerably. Many facilities are modern and humane, and provide work opportunities, high quality medical and mental health care, and attention to community reintegration. Within these realms, the matter of reentry and the consequent impact on the inevitably returning inmates, their families, and their communities have received the least attention. To face the challenges of prisoner reentry is a large undertaking, but it has enormous potential.³

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1. PAIGE M. HARRISON & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 205335, PRISONERS IN 2003, at 1 (2004).

2. JEREMY TRAVIS, BUT THEY ALL COME BACK: FACING THE CHALLENGES OF PRISONER REENTRY, at xvii (2005).

3. *See id.*

As recently as May 2004 the Fulton County jail in Georgia housed more than 3000 inmates in a facility built for half that number;⁴ 500 were sleeping upon mats on the floor of the day rooms because there were not enough bunks in the cells at the time.⁵ In 2003, the Julia Tutwiler Prison for Women in Alabama housed more than 1000 women in a facility built for 364, without air-conditioning.⁶

Other facilities across the nation fail miserably in providing conditions that are conducive to physical and mental health. Many inmates are isolated for long periods of time. Other inmates are in cells packed tightly with sweaty bodies, milling aimlessly; hungry folks; rank odors and clamor; and air that is still and dank. These conditions are all the more disagreeable considering the prevalence of communicable diseases among inmates, which can range from tuberculosis to drug-resistant skin infections to viral hepatitis to human immunodeficiency virus (HIV) and sexually transmitted diseases. That some American correctional facilities house detainees and prisoners in this way is more than just unsanitary, it endangers the public health. Staff, inmates, and visitors return to their communities daily, carrying with them the conditions to which they were exposed to at the correctional facility.

The conditions in some correctional facilities are redolent of conditions in prisons in the United States a century ago. In 1894, Dr. Julius Ransom, a prison physician, reported that 25% of the 1000 inmates at the prison in Dannemora, New York had active tuberculosis.⁷ In his report to Congress in 1907 the rates were unchanged and half of the prison mortalities were attributed to tuberculosis.⁸ One hundred years later (and despite the widespread availability of modern diagnostics, knowledge about containment, and multi-drug regimens for communicable disease) some American

4. ROBERT B. GREIFINGER, REPORT TO THE FULTON COUNTY ATTORNEY (2004).

5. Observed by the author during a tour in May 2004 as consultant to Fulton County, Georgia.

6. Observed by the author during a tour in May 2003 as a plaintiff's expert in *Laube v. Haley*, 234 F. Supp. 2d 1227 (M.D. Ala. 2002); see also Letter from Tim Roche, to Tamara Serwer & Lisa Kung (Sept. 19, 2003), available at http://www.schr.org/prisonsjails/press_releases/RocheReportFinal.rtf.

7. J.B. Ransom, *250 Convicts Stricken*, ALBANY ARGUS, Mar. 25, 1894.

8. J.B. Ransom, *Tuberculosis in Penal Institutions*, 17 BULL. JOHNS HOPKINS HOSP. 144 (1906).

prisons remain incubators of this same scourge.⁹ Too little attention is being paid to inmates as public health sentinels. Too little attention is paid to preventing, diagnosing, and treating conditions that can poison life for families and members of the free-world society.

A WINDOW TO OUR SOCIETY: INMATES AS PUBLIC HEALTH SENTINELS

A view of the health status of inmates is a view through a window to our society at large. Because of whom we incarcerate, especially drug-users and the mentally ill, inmate morbidity is highly concentrated among people who suffer from either mental illness, communicable disease, or the consequences of alcohol and substance abuse, and, occasionally, a combination thereof.¹⁰

The view through this window to our society is a clear one. It is a window of vast opportunity to protect public health in a cost-effective manner. By focusing on seven areas, public policy-makers can harness this opportunity and achieve the substantial benefit it can provide.

Seven Areas of Focus

Initially, public policy-makers must recognize that large numbers of inmates tax the resources of states and localities.¹¹ Consequently,

9. See, e.g., Sarah E. Valway et al., *Outbreak of Multi-Drug-Resistant Tuberculosis in a New York State Prison*, 1991, AM. J. EPIDEMIOLOGY, July 1994, at 113.

10. Nat'l Comm'n on Corr. Health Care, *Executive Summary*, in 2 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES, A REPORT TO CONGRESS, at x (Apr. 2002) (unpublished report, on file with the National Commission of Correctional Health Care), available at http://www.ncchc.org/pubs/pubs_stbr.vol2.html (follow "Executive Summary" hyperlink).

11. Only three countries in the world have incarceration rates that exceed 139 prisoners per 100,000 people in their country. In 2003 the United States led the pack with a rate of 715 prisoners per 100,000 people. PAIGE M. HARRISON & JENNIFER C. KARBERG, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 203947, PRISON AND JAIL INMATES AT MIDYEAR 2003, at 2 (2004). Russia followed closely behind at 628 prisoners per 100,000 people, as did South Africa with 400 prisoners per 100,000 people. Mark Mauer, *Comparative International Rates of Incarceration: An Examination of Causes and Trends* 2 fig. (June 20, 2003) (unpublished report, on file with the United States Commission on Civil Rights), available at http://www.sentencingproject.org/pubs_06.cfm (follow "Comparative International Rates of Incarceration" hyperlink). This is in contrast to countries such as Italy, the Netherlands, Germany, France, Sweden, and Japan, whose incarceration rates are all less than

there is limited funding for access to constitutionally mandated medical care. There is even less attention to the public health effects of mass incarceration because these effects are less discernible to public policy-makers and correctional administrators. Therefore, steps must be taken to ensure the adequacy of funding for all correctional facilities.

Second, the social and economic characteristics of inmates must be taken into consideration. The United States predominantly incarcerates young men who are poor and undereducated. We disproportionately imprison minorities. Although current incarceration rates indicate that 6.6% of United States residents born in 2001 will go to prison at some time in their lifetime, roughly 33% of African American males and 17% of Hispanic males will go to prison during their lifetime.¹² Currently, 12.5% of African American males between the ages of twenty-five and twenty-nine are currently behind bars.¹³

Third, the morbidity of American prisoners is higher than virtually any other group of Americans, in large part because of poverty and drug abuse.¹⁴ Not only are rates of diabetes, asthma, hypertension, and heart disease disproportionate to age-adjusted cohorts in the free world, but the rates of alcohol and drug use, communicable disease, and mental illness are even higher in comparison.¹⁵ These latter conditions, when untreated, can have profound effects on others in the public health, social, and economic arenas.¹⁶

or equal to 100 prisoners per 100,000 people. *Id.* In the case of the United States the excess incarceration is not due to more violent crime. Rather, it is due to higher incarceration rates and longer sentences for property crimes and drug offenses. *Id.* at 8.

12. THOMAS P. BONCZAR, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 197976, PREVALENCE OF IMPRISONMENT IN THE U.S. POPULATION, 1974–2001, at 1 (2003).

13. See Mauer, *supra* note 11, at 3.

14. Jordan B. Glaser & Robert B. Greifinger, *Correctional Health Care: A Public Health Opportunity*, ANNALS INTERNAL MED., Jan. 1993, at 139, 139.

15. Carlton A. Hornung et al., *A Projection Model of the Prevalence of Selected Chronic Diseases in the Inmate Population*, in 2 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES, A REPORT TO CONGRESS 46 (Apr. 2002) (unpublished report, on file with the National Commission of Correctional Health Care), available at http://www.ncchc.org/pubs/pubs_stbr.vol2.html (follow “A Projection Model of the Prevalence of Selected Chronic Diseases in the Inmate Population” hyperlink).

16. Carlton A. Hornung et al., *Health Care for Soon-to-be-Released Inmates: A Survey of State Prison Systems*, in 2 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES, A REPORT TO CONGRESS 5 (Apr. 2002) (unpublished report, on file with the National Commission

Fourth, the concentration of mental illnesses and communicable diseases in prisoners is remarkable. In the United States one out of every seven inmates has a major mental illness such as schizophrenia, bipolar disorder, major depression, or post-traumatic stress disorder. Most are decompensated when they arrive behind bars.¹⁷ In 1996, 17% of HIV-infected Americans passed through a correctional facility; 12–15% of those with hepatitis B and 30% with a hepatitis C infection were released; and an estimated 35% of Americans with active tuberculosis were released.¹⁸

Fifth, whatever protection prison may afford, there are other less visible consequences of excess incarceration on a personal level. There is the anger, loss of self-esteem, and isolation from family and community. At the same time there are other risks, such as violence, behind bars. In 1997, 22% of inmates reported that they were injured while in prison.¹⁹

Sixth, overcrowding causes psychological trauma. Though the data is scant, there is some compelling research on crowding. Crowding, such as double and triple cell occupancy or dormitory housing, is associated with increased rates of death, suicide, disciplinary infraction, and psychiatric commitment.²⁰

of Correctional Health Care), available at http://www.ncchc.org/pubs/pubs_stbr.vol2.html (follow “Health Care for Soon-to-be-Released Inmates: A Survey of State Prison Systems” hyperlink).

17. Bonita M. Veysey & Gisela Bichler-Robertson, *Prevalence Estimates of Psychiatric Disorders in Correctional Settings*, in 2 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES, A REPORT TO CONGRESS 5 (Apr. 2002) (unpublished report, on file with the National Commission of Correctional Health Care), available at http://www.ncchc.org/pubs/pubs_stbr.vol2.html (follow “Prevalence Estimates of Psychiatric Disorders in Correctional Settings” hyperlink).

18. Nat’l Comm’n on Corr. Health Care, *Executive Summary*, in 2 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES, A REPORT TO CONGRESS, at xi (Apr. 2002) (unpublished report, on file with the National Commission of Correctional Health Care), available at http://www.ncchc.org/pubs/pubs_stbr.vol2.html (follow “Executive Summary” hyperlink).

19. LAURA M. MARUSCHEK & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, NCJ 181644, MEDICAL PROBLEMS OF INMATES, 1997, at 6 (2001). Nearly half of state inmates who had served six or more years reported that they had been injured after admission. *Id.*

20. Verne C. Cox et al., *Prison Crowding Research: The Relevance for Prison Housing Standards and a General Approach Regarding Crowding Phenomena*, 39 AM. PSYCHOLOGIST 1148, 1148–60 (1984).

Seventh, inadequate surveillance and research has deprived corrections professionals of valid and reliable data on the health status of inmates.²¹

SEIZING OPPORTUNITIES

There are clear opportunities to improve the health status of inmates through focused attention to primary prevention, early detection, and evidence-based clinical interventions.²² Seizing these opportunities will not only be to the benefit of the inmates themselves, but also to the benefit of the public health. Of course, acting on these clear opportunities takes political will and resources.

The released inmate also faces serious difficulties with housing, employability and workforce participation, substance abuse, and health care.²³ Depending on the state, a person convicted of a felony drug offense may be barred for life from receiving welfare benefits, prohibited from living in public housing, permanently lose the right to vote, and be denied access to financial aid for higher education.²⁴ Because of low workforce participation, released inmates are unlikely to have health insurance. Due to tight eligibility standards most released inmates are also not entitled to Medicaid coverage. Without health insurance they are more likely than those with health insurance to receive too little medical care and receive it too late. They tend to be sicker, die sooner, and receive poorer care when they are in the hospital, even for acute situations like a motor vehicle crash.²⁵ The Institute of Medicine estimates that 18,000 Americans die prematurely each year due to the effects of lack of health insurance coverage.²⁶ The uninsured are almost four times more likely than the

21. *Id.* at 1159.

22. *Id.* at 1154–59.

23. JEREMY TRAVIS ET AL., FROM PRISON TO HOME: THE DIMENSIONS AND CONSEQUENCES OF PRISONER REENTRY 25–36 (2001), available at http://www.urban.org/uploadedPDF/from_prison_to_home.pdf.

24. Mauer, *supra* note 11, at 14.

25. COMM. ON THE CONSEQUENCES OF UNINSURANCE, INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 46–89 (2002).

26. COMM. ON THE CONSEQUENCES OF UNINSURANCE, INST. OF MED., INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS 46 (2004).

insured to experience an expensive, unavoidable hospitalization, or require emergency care.²⁷

LESSONS LEARNED

There is inadequate treatment planning and prerelease planning for inmates with chronic diseases, communicable diseases, and mental illnesses. This compromises opportunities for successful community reintegration.²⁸

Excess incarceration has a profound social impact on families, given the 1.5 million children who have a parent in prison,²⁹ and neighborhoods. There is an uneven gender ratio in some black communities as a consequence of high incarceration rates of young black men.³⁰

Recently, the political will has continued to be tough on crime. This tough-on-crime policy has, arguably, hurt urban communities because the cost of corrections competes directly with the provision of vital public health services.

Inmate medical care varies in quality from place to place, but, overall, there are insufficient resources to take full advantage of personal and public health opportunities during the period of incarceration for this high-risk, vulnerable group. Inmates in the United States are released without adequate health care coverage or access to medical care, mental health, and public health services (among other things). With regard to mental illnesses and communicable diseases, these inadequacies linkages pose public

27. AM. SOC'Y OF INTERNAL MED., AM. COLL. OF PHYSICIANS, NO HEALTH INSURANCE? IT'S ENOUGH TO MAKE YOU SICK—SCIENTIFIC RESEARCH LINKING THE LACK OF HEALTH COVERAGE TO POOR HEALTH 4 (1999), available at <http://www.acponline.org/uninsured/lack-contents.html>.

28. See Raymond Patterson & Robert Greifinger, *Insiders as Outsiders: Race, Gender and Cultural Considerations Affecting Health Outcome After Release to the Community*, 1013 J. CORRECTIONAL HEALTH 399 (2003), available at <http://www.correctionalhealth.org/resources/journal/10-3/Patterson.pdf>.

29. CHRISTOPHER J. MUMOLA, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 182335, INCARCERATED PARENTS AND THEIR CHILDREN 1 (2000).

30. Donald Braman, *Families and Incarceration 165* (Nov. 21, 2003) (unpublished Ph.D. dissertation, Yale University), available at <http://www.ncjrs.gov/pdffiles1/nij/grants/202981.pdf>.

health and public safety risks. These inadequacies also have economic consequences for the community.

Seven Areas for Intervention

First, correctional facilities must engage in primary and secondary disease prevention. As a high-risk group, because of poverty and lifestyle, the majority of inmates are susceptible to HIV, viral hepatitis, and other sexually transmitted diseases, if they are uninfected when they arrive. Up to 25% of inmates have a latent tuberculosis infection.³¹ Inmates are prime candidates for cost-effective medical interventions such as counseling, screening, prophylaxis, treatment, and immunization against vaccine-preventable illnesses (such as hepatitis A, hepatitis B, influenza, and pneumococcal pneumonia). *Wouldn't an ounce of communicable disease prevention be worth a pound of cure behind bars?*

Second, sufficient alcohol and drug treatment should be provided in all correctional facilities. Despite its effectiveness and utility in preventing crime and recidivism, there is too little alcohol and drug treatment in prisons and jails in the United States. Roughly 52% of incoming inmates were under the influence of alcohol or drugs at the time of their offense.³² More than 20% of inmates are incarcerated on drug charges.³³ *Doesn't it make sense to intervene behind bars, in a controlled environment, where there is such a high concentration of alcohol and drug addiction?*

Third, correctional health care programs should use evidence-based treatments. Too few correctional health care programs use nationally-accepted guidelines for the diagnosis and treatment of chronic disease and mental illness. Diabetes, hypertension, coronary artery disease, hyperlipidemia, and asthma are examples of diseases for which a consensus agrees that there are clear, cost-effective methods for reducing morbidity and mortality.³⁴ There is no good

31. KAREN WILCOCK ET AL., U.S. DEP'T OF JUSTICE, TUBERCULOSIS IN CORRECTIONAL FACILITIES 1994-95, at 3 (1996).

32. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 177613, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 1997, at 61 (2000).

33. *Id.* at 50.

34. *See, e.g.*, National Commission on Correctional Health Care, <http://www.ncchc.org/>

reason not to implement these methods. Without them there is excess morbidity, mortality, and cost.³⁵ *Why shouldn't correctional clinicians follow nationally accepted methods for diagnosing and treating the most prevalent conditions behind bars, especially when they are cost-effective for society?*

Fourth, inmates need to be prepared for reentry. Community reintegration depends in large part on successful connections with community providers for the treatment of chronic diseases, mental illnesses, and communicable diseases. For communicable diseases, collaboration with public health departments is obligatory. It does not make sense to treat conditions in correctional facilities without a plan for continuity of care once prisoners are released. Continuity of medication is especially critical for those with diseases like tuberculosis and HIV, where medication lapses can cause drug-resistance, and for mental illnesses where medication lapses can lead to mental decompensation and subsequent reincarceration.

Correctional systems, public health departments, and community organizations can redirect energy into building these connections. If they chose to, states could extend Medicaid benefits to reentering inmates to provide continuity of medication and affordable access to health care. *After spending so much money to incarcerate and treat prisoners, wouldn't it be sensible to provide these community connections and health care coverage?*

Fifth, barriers to effective implementation of correctional health care and public health policy must be addressed. We would all benefit from an examination of at least five of these barriers and the implementation of effective programs to reduce the barriers:

- **Leadership:** There is a shortage of people in leadership positions advocating for inmate health care. This could, in part, be due to the belief held by some correctional administrators that inmates are not “entitled” to good health

resources/clinicalguides.html (last visited July 2, 2006).

35. There are nationally accepted performance measures, such as HEDIS, which, when used, improve performance. HEDIS is a widely used tool developed by the National Committee for Quality Assurance to measure and compare the performance of managed care organizations on clinical and access measures. NCQA Programs: HEDIS, <http://www.ncqa.org/programs/hedis> (last visited July 2, 2006).

care. These administrators are not sufficiently educated about the potential benefits to staff and their own communities that can be derived from improved health services for inmates.

- Cynicism: There is far too much cynicism regarding inmates among correctional health care professionals, who work in environments of constant tension. Too often these professionals are skeptical about inmates' concerns and complaints, believing that the inmates (who do often exaggerate) are malingering for secondary gain. Correctional health care staff also frequently incorporate the custody staff's fear that humane responsiveness is coddling that can lead to anarchy.
- Funding: Correctional systems should be sufficiently funded to fulfill a public health agenda. Too often, public health is not on the minds of correctional administrators when they negotiate their budgets.
- Logistics: There are logistical barriers, such as short periods of incarceration, for many inmates in jails. As a result of this turnover, facilities with routine screening policies typically delay comprehensive assessments for up to fourteen days. As a result, for the inmates who will stay longer than fourteen days there are lost opportunities, for example, with the early diagnosis of contagious tuberculosis. Further, the custody division is often short-staffed, causing problems with the timely distribution of medication. Additionally, discharge planning is often compromised because of inadequate communication between courts, parole boards, custody staff, and health care staff.
- Policies: Correctional policies themselves are barriers to care. For example, jurisdictions often fail to specify the minimum levels of health care required in contracts with private health care vendors. Contracts also often fail to explicitly require adherence to evidence-based clinical

guidelines. Moreover, communication with public health agencies is often poor.

- Regulation and Accreditation: Regulations for health care in jails, prisons, and juvenile centers vary by state. Few states have regulations with specific performance expectations, such as those required for hospitals and licensed outpatient health care facilities.³⁶ For the most part, health care in correctional institutions is self-regulating. The National Commission on Correctional Health Care and the American Correctional Association publish health care standards and, on a voluntary basis, assess institutions for accreditation.³⁷ These standards are minimum standards and, for the most part, are structural- and process-oriented, as opposed to performance standards based on nationally accepted clinical guidelines. Nevertheless, meeting these standards provides a sound infrastructure for correctional health care programs. Unfortunately, only 10% of correctional facilities voluntarily seek accreditation, where they are measured against these standards.³⁸ It would be a step forward for all correctional facilities to be required to meet a set of minimum health care standards.

Sixth, greater amounts of research and evaluation of correctional health care issues should be undertaken. Currently, there is a paucity of data on inmate health status and evaluation of program effectiveness. There is insufficient information on what works and what does not work. Necessary questions have gone unanswered: How do correctional systems compare in performance, where intervention is known to improve outcome?; How do they compare

36. Notably, California has accreditation standards for adult detention facilities, published by the Institute for Medical Quality, a subsidiary of the California Medical Association.

37. NAT'L COMM'N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN JAILS (1993) (similar standards for prisons and juvenile facilities are published by the National Commission on Correctional Health Care); AM. CORR. ASS'N, PERFORMANCE-BASED STANDARDS FOR CORRECTIONAL HEALTH CARE (1999).

38. Interview with Edward Harrison, President, Nat'l Comm'n on Corr. Health Care, in New Orleans, La. (Nov. 15, 2004).

where there are cost-effective interventions?; How do they compare in risk-management? Correctional systems should utilize health care surveillance systems and performance measures using nationally accepted measures to accumulate this, as well as other, information.

Seventh, the consequences of incarceration have not been adequately explored. There is too little data on the personal and social consequences of incarceration. What happens to people psychologically and socially when they are incarcerated? What are the adverse or salubrious effects of living in a prison community? And what are the effects on families and communities? Further research in this area might help drive public policy toward reducing unnecessary incarceration and decreasing recidivism.

CONCLUSION

On average, correctional facilities in the United States house more than two million people each day. These prisoners have a high prevalence of illness, especially communicable diseases such as HIV and viral hepatitis, and mental illnesses. Among those uninfected by serious diseases, there is a high degree of risk for future illness, primarily through drug abuse. There are choices in public policy that could lead to an improved health status of prisoners and a reduction in recidivism. Improving the health status of inmates serves a broad public health purpose and benefits the communities to which prisoners ultimately return.