There is a tension in jail health services, because of the ways we are bound to the risks experienced by the incarcerated. In some instances, we’re the ones who care for patients after these risks lead to harm. In other circumstances, we’re actually part of the risk that incarceration brings. When someone is sent to solitary, or when dual loyalty pressures make us complicit with abuse, we can be part of directly harming our own patients. We’ve already seen that patients in jail often don’t receive the health care they deserve. Now I’ll look back at some of the stories we’ve already examined to focus on how correctional health services in jails can be restructured to reduce health risks to our patients. Because most correctional health services are designed to cut costs and reduce perceived litigation risks, transparency and quality of care are not top priorities. Transforming correctional health is required to reduce the health risks of incarceration, but it is also critical to mitigating our American experience with mass incarceration.

Before diving into the shortcomings of correctional health in this nation, it is important to lay out how correctional health can make a positive difference in the lives of patients. The jail health systems with the best quality and most resources have traditionally been the few that were part of a local public health or hospital system. In these settings, health administrators could make the case that the jail health system was part of the larger community and provide care that addressed chronic medical and behavioral health issues, not just emergencies. With this larger sense of mission, it makes sense to screen and treat for HIV, sexually transmitted diseases like chlamydia and gonorrhea, and also hepatitis C. In our system in New York City,
this approach has allowed us to be one of the largest screening/treatment points for asymptomatic men with chlamydia. About 6 out of 100 people screened for chlamydia during jail intake test positive. This sexually transmitted infection often exists without any symptoms in men and is easily treatable with antibiotics. Unfortunately, when left untreated, it can be transmitted to sexual partners rather easily and can cause life-threatening problems such as pelvic inflammatory disease for women and serious eye and lung infections for their newborns. Because unprotected sex is especially common right after leaving jail, we have always been committed to this type of screening and treatment of health problems that other jails avoid based on costs. This approach doesn’t reduce mortality in jail and is expensive, but it is critical to protecting partners from infection after jail and reducing the rates of high-risk pregnancy in NYC. This approach to correctional health is often called the public health model and leverages incarceration as an opportunity to improve the health of the incarcerated, as well as that of their families and neighbors. When Dr. Ram Raju was commissioner of health in Chicago, he dramatically expanded Medicaid coverage in Chicago by finding and enrolling people in jail without coverage. Later, as president of NYC Health and Hospitals, he helped us strike a landmark deal with the pharmaceutical company Merck to expand hepatitis C treatment in jail. For the past few years, incredibly effective but expensive medications have been on the market that can cure hepatitis C, which is very common among the incarcerated. Hepatitis C is highly prevalent among intravenous drug users, and as the United States has criminalized drug use, we have driven this cohort of people away from public health settings and toward jails and prisons. This treatment is cost-effective and will reduce the national scourge of cirrhosis and liver cancer, but virtually every jail and most state prisons are resisting this life-saving treatment because of the expense. Taking advantage of the public health opportunities to identify and treat illness among the incarcerated can bring great benefits but is often overlooked because of cost. Unfortunately, this public health approach to jail health care also has a pretty clear limit. It seeks to deliver care to those who often don’t receive it, but it doesn’t contemplate the harm that jail brings to these same people. In fact, the core assumption in this approach is that we might as well do something worthwhile with people while they’re locked up, “turning a negative into a positive,” as so many have said. The truth is that these are valuable efforts,
but they don’t erase the harms of incarceration. And participating in ethical care on one front doesn’t excuse ignoring patients on another.

The preceding chapters give a good sense of the ways in which correctional health systems are pressured and manipulated to keep critical information from making its way to outside parties. The most benign view is that correctional health services are innocent but mute bystanders to the health risks of jail. The beating death of young Christopher Robinson in 2008 was the type of case where correctional health might be considered a bystander. His death involved correctional officers who conspired with a group of inmates to open their cell doors and that of Christopher Robinson so they could administer a beating in his cell. This death was ruled a homicide and resulted in criminal prosecutions. For the doctors and nurses in that violent adolescent jail, they reacted to the medical emergency that presented itself and spoke with investigators afterward. Responding to trauma from violence was pretty routine at this time in the adolescent jail. Dr. Tom Freiden, then commissioner of health, pushed us to develop an injury surveillance system that would track and elevate these outcomes to a more senior level. He wanted us to know when our doctors were seeing more patients with broken bones and lacerations so that the leadership in the health service could report back to him and to other leaders in the city about these trends.

We built that proactive surveillance system over the course of five years, and slowly, with the help of the US Department of Justice investigation, the entire city government came to see the value (or necessity) of this aggregate reporting of adverse outcomes. This type of reporting necessarily relies on the health service staff, who know when injuries occur and when those injuries are serious. The same goes for missed medications, self-harm, or sexual assaults. All of this information exists in virtually every jail setting and could be aggregated into rates of outcome for every jail in the nation to report, allowing a real apples-to-apples benchmarking of facility performance. An electronic medical record makes it easier, but either way, it’s an embarrassment that we don’t have a standardized, transparent, and mandated approach to these health outcomes. We know more about risks from ATV accidents than we do about critical health outcomes that occur during 12 million incarcerations every year in the United States. Creating this type of reporting doesn’t eliminate the possibility that security staff might keep
patients away from care altogether. In fact, many of the cases in this book reflect this problem. But the lack of transparency in jails about health outcomes is much more consistently tied to losing track of information than actively hiding it. This bureaucratic ineptitude isn’t an accident; it’s just as intentional as an officer telling a patient to “hold it down” and not go to sick call for a broken nose. But the scale is larger, and it reflects how we have designed jails to operate.

We’ve seen how the Department of Correction can subvert the health service and how individual correctional officers can use caps in the system to hide abuse. But there’s another factor that stands in the way of truly reforming the system. Most of the 3,000 jails in the United States deliver health care through contracts with for-profit vendors. This model exists because we’ve left the funding and oversight of this care to local cities and counties. Thus, the groups that decide how much money to spend, what services should be provided, and how to promote quality are sheriffs and commissioners of correction. There are national jail health standards from groups such as the National Commission of Correctional Health Care, and even guidelines from professional organizations such as the American Public Health Association and the American Medical Association, but these are all voluntary. They are not linked to reimbursement, and there is no consequence to the decision maker for ignoring them. Unfortunately, we’ve come to accept as a society that community health systems should be mandated to follow evidence-based protocols and reporting, but once patients move into a jail, we are content with unenforceable recommendations that leave health care at the whim of sheriffs and corrections commissioners. The paramilitary organizations that run the jails are focused on security, and their view of health care is extremely narrow and usually limited to preventing death and defending against lawsuits. There are good reasons for security authorities to concentrate on security, but there needs to be someone whose primary concern is to ensure proper delivery of high-quality health care. In Nassau County, New York, the jail moved from having services provided by the local public hospital to a for-profit vendor. One goal of this transition was to reduce hospital transfers and try to manage sick patients more often in the jail. As one might predict, this worked extremely well as a cost-cutting
measure and very poorly as a model of care. Several years into this transition, the rate of deaths started to rise, but the sheriff stood by the model, pointing to the millions of dollars saved. By the time this contract was terminated, the rate of death in this jail was several times higher than the national average and the rate in the rest of the NYC jail system.1

Breaking the cycle of low-cost and low-quality care in jails is tough, but there are several ways to pursue this goal. The most tried-and-true model is for oversight groups to investigate and mandate improvements, combined with ongoing monitoring by experts. Most jails have experience with this, and the effectiveness of legal sanction and monitoring can range from mild and fleeting to substantial and lasting. In my work in NYC, we have been under settlement agreements ranging from discharge planning for mentally ill patients to access to air conditioning for sick patients to reporting of abuse. These settlements stem from class action lawsuits or investigations by state or federal investigators. Although brutality is a common reason for these suits and settlements, other areas include mandating air conditioning in jails that experience high heat, delivering reentry services to patients with serious mental illness, improving visitation, and improving bathroom facilities. A good friend of mine, Dr. Susi Vassalo, is an emergency medicine physician at NYU/Bellevue and also an expert in a long-standing lawsuit against NYC regarding the lack of air conditioning throughout many of the jails, including most of the solitary confinement areas. This case is similar to many in corrections in that it has dragged on for over a decade and has seen many bureaucratic twists and turns. Part of one phase of agreement was that officers might put trays of ice in front of fans pointed generally toward the cells of inmates instead of NYC simply investing in air conditioning. Eventually, the decrease in solitary use allowed for most people to be transferred to air-conditioned housing areas. I’ve been inside the solitary cells that lacked air conditioning on warm days, and even for healthy people who may not face risk of heat-related illness, the experience is stifling and maddening. In previous chapters, I have detailed the very welcome investigation by Legal Aid and the DOJ into brutality against our patients. One of the newer examples of this approach is occurring in New York, where the attorney general’s health unit has taken individual reports about deaths written by the State Commission on Correction and aggregated systemic concerns about medical care to take actions against
substandard correctional health providers. When the attorney general’s health unit dives into the health care provided, they often find problems with staffing, quality control, and basic functions like provision of medications. The remedies they have imposed range from traditional monitoring, to fines, to even excluding a vendor from continuing to provide services, as was the case in Nassau County. Unfortunately, none of these measures create a new model of care that isn’t profit driven and where the sheriff or DOC is no longer in control of the scope of services and the approach to transparency and quality.

The hope of this strategy is that it pressures the for-profit companies and the various county leaders into providing a more competent level of care. But it has a major weak point. In community hospitals, clinics, and even pharmacies that administer flu shots, there are accrediting bodies that monitor care based on evidence-based measurements, like the Joint Commission, the Center for Medicare and Medicaid Services, and state departments of health. One of the central weaknesses of the oversight that we get, however, is the perpetual reliance on nonmedical entities to improve medical care. Leaving oversight to purely nonmedical entities ensures that only the most egregious failures will be identified, often after systems have declined for years. The difference in approach can be highlighted if we consider the cases of Bradley Ballard and Angel Ramirez, who both died because they became ill and the jail system responded with punishment instead of treatment. In the rest of US medical settings, these types of failures would result in dramatic financial penalties and possible prohibition from further provision of some types of care. In jails, complex patients with alcohol withdrawal, serious mental illness, advanced cirrhosis, or active seizures are routinely held in units that would never pass muster in the community. Somehow, we need to use our success with transparency to advocate for national standards where performance is public and consequences are clear. If every county jail were forced to seek a certificate of approval to house these types of complex patients, or pay for hospitalization, I am quite sure that correctional health competence would increase very quickly—as would diversion of some patients into more suitable settings.

A second, more costly way to improve correctional health is to transfer the health service to a local health department or hospital. This option is usually limited to fairly large cities like New York, Chicago, Dallas, and
Seattle. It can bring more resources and a true sense of quality assurance and improvement, but it’s quite a bit more expensive. The single biggest part of this cost is transferring staff from a private vendor with few benefits and no union representation to full civil service titles and benefits. Also, these hospitals rarely want anything to do with correctional health, and once involved, they may turn around and subcontract actual services to the same for-profit vendors they initially replaced. That doesn’t seem likely to pass the sniff test, but it is exactly what happened with correctional health the last time it was put into the NYC public hospital system. This model of oversight by a city health agency and care by a for-profit vendor continued when the responsibility went to the NYC Department of Health, but since we’ve returned to the public hospital system, we have been able to jettison the for-profit vendor and create an entire unified division, much like a new public hospital. This hospital model generally improves the ability to recruit staff and focus on quality assurance and improvement. But the absence of correctional perspective in these institutions can make it difficult to raise issues like dual loyalty, solitary confinement, and brutality. The lack of appetite to discuss critical issues of correctional health can be amplified in public hospitals, where decreasing funding has left most of these institutions on the verge of financial ruin, dependent on local handouts to survive. My central concern for the future of the NYC Correctional Health System is that it will experience a slow erosion of the human rights perspective that was so critical to being an effective advocate for our patients.

Another way to bring in higher-quality care is to create nonprofit correctional health organizations that specialize in this work, like the current for-profits do, but are mission driven and can seek external funding and other benefits of nonprofit health organizations. This model hasn’t really taken hold in the United States, but it holds great promise. A great organization in Delaware, Connections CSP, has taken a high-quality community health and social service nonprofit organization and started to provide health services behind bars. In Washington, DC, a collection of local health clinics have come together to provide health services in the district jail. The difficulty with scaling up this nonprofit model is that every local county jail picks their next health vendor based primarily on cost. Still, I believe that this model can work, and it will get a real boost if/when we can crack open the door to Medicaid reimbursement for care inside jail.
An important goal is to connect the funding and quality oversight of jail health care to the rest of the nation. With the opportunity for Medicaid reimbursement, jails could expand their scope of services without new financial investment. Most of the nation’s 5,000 jails and prisons have some aspect of health services that they think is important but don’t implement, purely because of costs. The availability of outside funding would spur many of them to expand their scope of services as advocates and policy makers apply pressure. But it’s the quality oversight that comes with this funding that is the real upside for patients. This idea was proposed to Medicaid officials in 2016, and we were hopeful for results, but the election of President Trump appears to have stalled this effort. Another example of backtracking by the Trump administration relates to the use of private, for-profit prisons. In 2016, President Obama announced a federal ban on for-profit prisons in the federal prison system. Unfortunately, this ban was quickly undone by President Trump, and his comments on criminal justice and immigration foreshadow a return to expanding the number of incarcerated people and utilizing the cheapest means possible to achieve this aim. These recent setbacks paint a bleak picture for the national landscape, but many states have recognized the folly and costs of mass incarceration and are moving to develop drug and mental health courts as pathways toward treatment rather than incarceration. These improvements bode well for correctional health services, since they generally fail to provide anything close to community standards of care for these issues. A more fundamental step, however, would be for states and counties to demand that nonprofit correctional health providers be included in all correctional health contracts. Pressure from the agencies that solicit and pay for these services is needed before community health providers will willingly wade into these troubled waters.

Whatever the model, one feature of community health systems that we can incorporate immediately into correctional health is feedback from our patients. Virtually every clinic and hospital in the United States uses patient surveys about the quality and timeliness of care to guide their operations. These tools were originally called satisfaction surveys but more recently have been thought of as patient experience surveys. Patient experience surveys ask questions about whether health staff listened to patients or explained things clearly to them. In 2015, we conducted the nation’s first patient experience survey in a jail, getting the opinions of about 3,000 patients on
paper forms. The results confirmed some fears and showed us new areas to concentrate on. For example, when asked about being treated with respect, listened to, or communicated with clearly, about 60 percent of patients fell into the “usually” or “always” categories, with only 10 percent in the “never” groups. But when it came to keeping health information confidential, the “never” category grew to 20 percent, and only half of respondents felt like we usually or always did so. Also, more than half of patients we surveyed said that they kept health problems from us because they didn’t think we would keep them confidential, and more than half also said that they think we (health staff) discuss their health problems with security staff without their permission. Almost one-third of respondents reported not getting the access to sick call that they are guaranteed. In this same survey, we asked about community health engagement and found that over one-quarter of respondents said that time in solitary in jail made them trust doctors outside jail less. This information has helped us to focus on increasing the clarity about what staff can and can’t share with security staff, as well renewing our insistence that the security staff should not have access to our EMR, something they often lobby for. The questions we used were standard ones, taken from community surveys used by hospitals and clinics; they could easily be applied to every American jail health service.

There’s a third aspect to improving correctional health: the staff. Working in correctional health can be rewarding work, but most correctional health staff toil without the support and training that they need to provide adequate care. Doctors, nurses, and other health staff in jail are very familiar with the brutality, arbitrariness, and unfairness of jail conditions. In most jails and prisons, there is pressure to get along with security staff and little or no effort expended to talk with staff about the real challenges that they and their patients face in promoting health. Like any other profession, when management neglects to acknowledge the real experiences of the staff, they quickly become embittered and start to develop their own approach to their jobs, with a focus on survival and safety. In correctional health, this problem is exacerbated when difficult patients or security staff create a toxic setting that health staff can’t address. I recently heard from a physician who had just started working in one of the NYC jails that almost every day correctional officers referred to patients using the “N” word. We’ve developed forums to discuss these problems in NYC, and while they may not resolve the issues,
at least our health staff and their leadership are on the same page about the realities of the work. Around the nation, correctional health staff routinely observe beatings and other physical and verbal abuse of patients. Their reluctance to report these incidents may stem from worry about their own safety, but it also results from years of working in a setting where they soak up the security perspective on their patients and don’t get any other message from their leadership.

Journalist Eyal Press published an article in the *New Yorker* in 2015 that focused on abuse of mentally ill patients in the Florida prison system. He homed in on the silence and complicity of health staff, one of whom witnessed a terrible beating of a handcuffed patient by numerous guards. The mental health staffer reported that the lookout of this assault spotted her, and “in the days that followed, the guards involved in the beating dropped by [her] office to tell her that they had ‘taken care’ of everything. Their tone was polite, but the message was clear, she said: ‘We’re running this place, this is our house—you’re just visiting.’”

This staffer was warned by colleagues not to report anything, and ultimately, she quit the job. Imagine the staff who stay in these jobs for years. To last, they don’t report anything, and any discomfort they feel is bottled up. Acknowledging these problems is difficult when the health authority is independent from the security service, reporting to a separate authority, but it’s basically impossible in a for-profit staffing company that earned their contract by being the cheapest bid. It may be that correctional health staff should work in both the community and the jails. That is the way it works in the United Kingdom and several other nations, where there’s much less distinction between care inside and on the outside of jails.

In Washington, DC, city officials went through their normal contracting process and selected a for-profit jail health vendor, only to have the city council take the unprecedented step of rejecting the contract. This left the provision of health services in limbo because there wasn’t an acceptable alternative. An independent nonprofit could compete with the for-profit vendors and show that better health outcomes are also in the interest of county and security leadership. But creating a new approach to correctional health can do more than reduce the health risks of incarceration; it can also help reduce incarceration. This could be a great time for recruitment to mission-driven correctional health programs, in light of the growing interest in social
justice and mass incarceration in the United States. Our correctional health service has been fortunate to recruit newly trained residents and fellows from some of the nation’s top programs, including Mount Sinai, Montefiore, and NYU in NYC and the University of California, San Francisco.

Once the independence of correctional health services is assured, then a more community-facing scope of services can be developed. In NYC, we’ve moved from only providing basic health services inside jail to also doing the brief health screen in Manhattan central booking, which happens hours before decisions about bail or going to jail occur. Pushing into this space with our EMR allows us to do a better job of triaging the people who end up going to jail. But the real benefit for the city is that it allows us to provide some critical information to the patient and their defense lawyer that can lead to treatment for mental health or addiction rather than going to Rikers. Many of our patients have their most reliable health records in the jail EMR, and with their informed consent, we can share that with other social service agencies. On the inside, we have sought and received federal funding to build a large discharge planning service that doubles as a diversion program. The staff who arrange the health services, housing, Medicaid, or food stamps for our patients leaving jail are invaluable assets in helping them avoid jail altogether in the future. Most people in American jails are there because they can’t pay for bail and because of the nation’s criminalization of drug use and mental illness; most of them cycle in and out of jail as these problems lead them into minor misdemeanor charges and perpetual lack of treatment. Both pre-arraignment screening and in-jail discharge planning programs serve essential functions for people who go to jail, by identifying risk factors for decompensation in the early hours of incarceration and ensuring continuity of care after release. But these programs also represent a key to decarceration. With the involvement of the correctional health program, diversion or alternative-to-incarceration programs can quickly come up with an alternative to bail/jail that involves meaningful treatment.

Even if we succeed in reducing the nation’s appetite for incarceration, we will still have millions of people cycling through jails and prisons every year. It’s likely that these people will continue to suffer from high rates of
physical and mental health problems, as well as addiction. Creating an independent health authority in each of these places will go a long way toward promoting transparency and ensuring that the health services we design on paper are actually delivered. With 5,000 jails and prisons, there are many types of correctional health systems, but one basic element should exist in every one of them: the health authority should be fully independent of the security service, and security leaders should no more evaluate health care quality or scope of services than they should direct the care of an individual patient.

In the middle of all these issues rests correctional health, a vulnerable and largely compromised institution that is more likely to serve security authorities than patients. While the power dynamic between correctional staff and the incarcerated is understood, the weak position of correctional health is critical to the health risks of incarceration. One tangible example of this imbalance is the medical treatment of correctional officers. Like all correctional health services, we provide emergency treatment to officers in addition to the total spectrum of care provided to the incarcerated. When there is a use of force, however, we are often forced to see less injured officers before more seriously injured incarcerated patients. The way this plays out is that a group of 5–10 officers will come into the jail clinic and take over a cubicle or two and tell the doctor or physician assistant that their colleague needs to be seen. Any patients currently in the clinic will be removed from other cubicles and placed in a pen somewhere. Patients who were injured in the same use of force will not be brought to the clinic until the officers have been treated, and they usually remain hidden away in the intake pens or other places so that our staff often aren’t even aware of them until the DOC staff have been cared for. A common scenario will involve DOC staff with hand injuries or muscle strain being seen and treated before an incarcerated patient with facial trauma. The bullying of our staff is so common that when we raise this issue at the highest levels in the city, everyone simply shrugs their shoulders. We haven’t had any deaths related to this practice that I’m aware of, but many patients have had to wait for critical emergency care while our staff were attending to lightly injured security staff. In some jails, we try to do both jobs simultaneously, but few jail clinics have this capacity because the security staff usually demand that no inmates be present in the clinic when they are being seen. After a particularly bad episode
involving adolescents with head trauma who waited hours for care, I asked our staff to go look for injured patients in the jail intakes whenever they found themselves treating officers in the clinic. We’ve found many more seriously injured patients this way, but we still rely on DOC cooperation to bring them to the clinic and also to allow emergency medical services into and out of the building, which is another point of intentional and unintentional delay. To be clear, there have been plenty of serious injuries to officers, and we want to treat them first when their injuries merit it. But in jail, almost every injury to an officer is treated before any injury to an incarcerated patient. An additionally subversive aspect of this dynamic is that in NYC DOC staff receive a cash insurance payment any time they go out on an ambulance from work, so our staff were routinely pressured to send officers out for very minor ailments. When our staff have balked, they receive swift retaliation from security staff and even their union leadership. One physician who made the clinical decision that an officer didn’t need to go out to the hospital received a profane and intimidating visit to his cubicle by the president of the Correctional Officers’ Benevolent Association, Norman Seabrook. Few staff of any type would stick to their clinical judgment with such intimidation, but this provider did. More ominous, though, are the threats to physical safety that can and do ensue when our staff run afoul of the wishes of security staff in these situations. While this is only one example of the power imbalance in jail, it is crucial to understanding how jails harm the incarcerated and then compound those initial harms with barriers to accessing health services.