

A Perspective on Corrections Health Care

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I want to thank the Commission on Safety and Abuse in America's Prisons for inviting me to testify. I must admit that I have some reservations about the direction of this commission. Your stated mission, press releases, and even the name of your commission all would lead one to believe that our prisons and jails are abusive places and that neither staff nor inmates are safe. While I have no doubt that there are prisons and jails that may meet such descriptions, I do not believe that most do; and in many cases where they do meet this description the conditions are beyond their control. There are thousands upon thousands of fine men and women who work hard each day to provide for secure, safe, and humane facilities and to provide for the public's safety. The excellent work that they do, sometimes under difficult conditions, should not be hidden from the public's view because of the words or deeds of the few.

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We must also be careful not to further distort the public's perception of what goes on in our prisons and jails—a perception that is largely shaped by television and movies which use sex, violence, and corruption to sell their wares. The mundane experience of watching inmates in a classroom working toward their general education diplomas, learning a trade, or in a group discussing drug and alcohol abuse is not something that the public would watch. Yet, scenes of the latter would more truly represent what is occurring in many of our prisons and jails today.

I am also concerned about the methodology that is to be used to determine the presence of abuse and lack of safety in prisons. A review of the commission's public hearings reflects an over-reliance on anecdotal statements, some of which may have occurred over a ten- or fifteen-year time period. Even where an attempt is made to give concrete statistics about the problem the numbers noted are questionable in many ways. We must be careful when using anecdotal statements because they can make people believe that one or several events that took place over time and in certain systems are representative of the daily happenings in all systems. Statistics must also be used in context and cautiously, as different ways of collecting data or a failure to adjust numbers for population growth can make things seem much worse than they may actually be. While I am sure I could find a few people to say bad things about the Pennsylvania prison system, and while bad things have occurred within the system, this is not a true representation of what goes on each day within our system.

I believe that objective criteria are needed to measure the safety of our systems and facilities. In addition, a critical component of any evaluation needs to be actual visits to the facilities that are being evaluated. If this does not occur, and if we rely on anecdotal statements and reports as well as questionable statistical information, I am concerned that we may miss an opportunity to really make a difference by failing to focus on issues that can improve our system.

Those of us who are in the corrections business are seriously concerned about the safety of our facilities; we also know that it is important to be able to objectively measure our performance in different areas of prison life. That is why the Association of State Correctional Administrators (ASCA) has a committee known as the

Performance Based Measures Committee, of which I am the chair, which is actively working on developing these objective performance measures.¹ Key indicators for public safety, institutional safety, substance abuse, mental health, and justice have been developed.² Key indicators for health standards are in final development. A website has been established to allow states to submit data, in accordance with specific elements and counting rules, and then to compare the accumulated data both across a system and between systems.³ Specific contextual information is also collected so that similar facilities and systems can be easily compared. A pilot, consisting of six states, of this system has been operating since 2004⁴ and ASCA is now prepared to open this system to other states. We will also expand the number of measures upon which data is being collected.

ASCA's move toward collecting objective performance data is certainly not the first time such a project has been undertaken. In Pennsylvania, we have been collecting critical performance data for more than fifteen years so that we can analyze the performance of our facilities. Our state correctional analysis network (SCAN) allows us to track all kinds of information—from assaults to grievances to “misconducts” to drug finds (and much more)—so we can monitor ongoing performance. Many other states have similar systems in place. The Criminal Justice Institute's Yearbook and the Bureau of Justice Statistics have also collected and reported on a variety of performance measures over the years.⁵ Where the ASCA effort, which is part of an evolving process, differs is that it focuses on

1. See PBMS Training bulletin, <http://www.asca.net/pbmstraining/> (last visited June 6, 2006), for updates and resources provided by the Performance Based Measures Committee.

2. PERFORMANCE BASED MEASURES COMM., ASS'N OF STATE CORR. ADM'RS, ASCA PERFORMANCE STANDARDS, MEASURES, AND KEY INDICATORS (2006); <http://www.asca.net/pbmstraining/> (follow “Key Indicators 5-24-06.pdf” hyperlink)

3. PBMS Training Bulletin, *supra* note 1.

4. States involved in this pilot are: Iowa, Louisiana, Ohio, Pennsylvania, South Carolina, and Washington. PERFORMANCE BASED MEASURES COMM., ASS'N OF STATE CORR. ADM'RS, ASCA PERFORMANCE-BASED MEASURES RESOURCE MANUAL 12 (2005), <http://www.asca.net/public/PBMSresourcemanual.pdf>.

5. See, e.g., CRIMINAL JUSTICE INST., INC., THE CORRECTIONS YEARBOOK: ADULT CORRECTIONS 2002 (Camille Graham Camp ed., 2002); BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 143505, PERFORMANCE MEASURES OF THE CRIMINAL JUSTICE SYSTEM (1993).

getting everyone to count and define the problems in the same way. These types of objective processes can help us get a better handle on just how safe and humane our facilities are, and pinpoint which areas need further work. I hope that this commission can help us as we move forward in this important area.

We know that we have some employees who are not the best, as does any organization, and we know that problems will occasionally occur. In short, we know we can always improve. But, I believe that as a profession we want and we strive to do our best. We actively root out problem employees (our internal affairs department's main job is to investigate allegations of employee abuse), we learn from our mistakes, and we seek positive change. When facilities throughout our country are troubled, in the vast majority of cases, it is because that is the way staff want things to be, or because we, as a society, misuse the facility through overcrowding and fail to provide the necessary resources.

In Pennsylvania, the Department of Corrections is responsible for inspecting county jails to ensure they meet certain minimum standards. Some jails do an excellent job and many do quite well, but a handful do a very poor job. When we look at the reasons for this it is not because those who run the jail or work in the jail want to do a poor job, it stems from such things as overcrowding, lack of maintenance, understaffing, inadequate training, and the like. These issues arise as a result of inadequate funding and a shortage of resources for the number of offenders housed in a specific facility. In fact, it is this lack of resources that can generally be pointed to when facilities have problems or fail to appropriately address certain areas. This is true from both a historical and modern perspective.

In the 1980s the Pennsylvania Department of Corrections was seriously understaffed and lacked adequate resources to deal with a rapidly expanding inmate population. This decade ended with a serious riot and several disturbances in our system. The 1990s began with a class action lawsuit on health care and mental health care issues.⁶ As the 1990s progressed and the economy grew, funding became less of an issue for most jurisdictions and we experienced

6. *Austin v. Pa. Dep't of Corr.*, 876 F. Supp. 1437 (E.D. Pa. 1995).

fewer problems. But the economy began to erode as we entered a new decade and around the country we saw an increasing number of jurisdictions cutting resources to corrections. This resulted in reduced staffing in some states; others severely cut back on programs and staff training or gave up their American Correctional Association accreditation. In some areas overcrowding became more of an issue. It is not surprising that several years after this funding squeeze began we now see a commission wondering why things do not go more smoothly within our prisons and jails.

Our prisons and jails are also frequently criticized for failing to effectively deal with those in our care. Recidivism rates in the range of 60% or more illustrate this point.⁷ Yet, the fact is that our society was responsible for these individuals for fifteen years or more during a critical period of their development and those of us in corrections are now supposed to be able to make them responsible members of our society in just a few years. When prisoners are released society does not welcome their return or provide the assistance that they need to succeed. In fact, their chances of succeeding in life are lower than before they were incarcerated as families have drifted away and the stigma of incarceration now hangs over them.

We know that many of our inmates come from a few poor inner-city neighborhoods. Also working against our typical inmate is the fact that, in Pennsylvania, approximately 22% of all high school freshmen do not graduate with their class.⁸ In the urban areas almost 45% fail to graduate in four years.⁹ We have learned that those who pursue an education during incarceration, as well as those who can obtain meaningful employment upon release, are more likely to succeed. However, we also know that over 80% of our inmates did not have a job at the time of their arrest.¹⁰ Based on this information

7. See, e.g., PATRICK A. LANGAN & DAVID J. LEVIN, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 193427, RECIDIVISM OF PRISONERS RELEASED IN 1994 (2002).

8. Press Release, Pa. P'ships for Children, One Out of Five Pennsylvania High School Students Fails to Graduate Every Year (June 22, 2005), available at <http://www.papartnerships.org/dropouts/index.asp> (follow "Press Release" hyperlink).

9. *Id.*

10. This statistic is derived from internal Department of Corrections information that is compiled on new inmates.

we know that poor inner-city neighborhoods, poor school systems, and a lack of employment create many of our inmates.

We also know that only about 10% of those who need substance abuse treatment are actually able to receive that treatment in our communities.¹¹ And we know that the closure of state mental hospitals, coupled with inadequate community resources, has led to an increase in prisoners with mental illnesses.¹² In Pennsylvania, we have seen the mentally ill portion of our inmate population grow from 14% to 19% in four years.¹³

In many jurisdictions there exists a propensity to lock up more and more people, but, in some of those, there is simultaneously, an unwillingness to provide correctional facilities with the necessary funding to care for those inmates. I believe that where problems do exist in our prisons or jails, it is largely related to the misuse of our correctional system by our society. We are simply locking up too many people, sometimes even the wrong people, instead of dealing with the systemic issues that have created the problems in the first place. If we truly want to make our correctional systems safer and reduce the abuse that may exist we must begin dealing with the root causes.

How did we get in this position? I believe it began in the late 1970s and early 1980s, when there was increased public concern about violent crime. At the same time a researcher by the name of Robert Martinson published an article which many perceived as saying that rehabilitation did not work.¹⁴ So we began locking up greater numbers of violent offenders for an even longer period of time. We also locked up greater numbers of less-serious offenders since the ideology of the time was “nothing works.” The

11. CHRISTOPHER J. MUMOLA, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 172871, SUBSTANCE ABUSE AND TREATMENT, STATE AND FEDERAL PRISONERS, 1997, at 1 (1997).

12. James W. Jordan, Jr., Executive Director, Nat'l Alliance for the Mentally Ill, Pa. Chapter, Testimony to the Pennsylvania House Judiciary Committee (Feb. 5, 2003), available at <http://namipa.nami.org/executivedirectionsr1448testimony.htm>.

13. This statistic is derived from internal Department of Corrections information that is compiled on all inmates.

14. See Robert Martinson, *What Works? Questions and Answers About Prison Reform*, 10 PUB. INT. 22 (1974).

Dukakis/Horton event in 1988¹⁵ solidified and further boosted the “tough on crime” approach which is pervasive to this day.

Today we know much more about the root causes of criminal behavior. We know that there are rehabilitative programs that *do* work,¹⁶ and we know where many of our offenders come from. I believe that this commission can increase safety in prisons by focusing on the causes of criminal behavior while looking for alternatives to incarceration that can reduce such behavior in the first place; because, when criminal activity does occur, it is necessary to ensure that incarceration is, in fact, the best punishment. We failed, as a society, to seek alternatives to incarceration twenty-five years ago and we continue that failure to this day.

This hearing focuses on the public health implications of correctional health care. While the preceding comments did not directly address this issue, I felt it necessary to provide some perspective as to why, in some jurisdictions, we may be seeing problems, and how I believe the commission can focus on these issues for the betterment of our correctional systems. It is also particularly critical in the health care area that we have an objective basis upon which to measure the adequacy of health care in prisons. Without this structure, it would be easy to allow a handful of emotionally charged, anecdotal stories to distort reality. One must also decide what we will be measuring. Do we want to know about access to and the adequacy of health care in relation to judicially defined minimum standards of care? Or do we want to focus on how we can improve correctional health care to maximize the impact on the public’s health? Once we decide what we want to accomplish we need to define objective measures to help us reach our goals.

15. Dukakis was the Governor of Massachusetts at the time, and Horton was an inmate sentenced for first-degree murder. Dukakis believed that temporary releases or furloughs would help rehabilitate inmates. Horton was released on a forty-eight hour furlough and did not return. While he was free he raped one person and murdered two people. Many believe that Dukakis lost his bid to become President of the United States because of this event.

16. See, e.g., EVIDENCE-BASED CRIME PREVENTION (Lawrence W. Sherman et al. eds., 2002).

HEALTH CARE

The provision of appropriate health care to our inmate population is important to our staff and inmates, but it is also essential for the public's health, as over 90% of inmates will return to society.¹⁷ Some believe that we do not do a very good job in this area and that, as a result, our prisons and jails are incubators for disease. I, however, believe that most medical issues, and there are many, arrive at our prisons and jails with the inmates when they enter prison.

Many of the serious, contagious diseases present in prisons were acquired due to intravenous drug use and unsafe sex practices in the community. Other medical illnesses are frequently found only upon admission to our correctional system, due to a lack of access to community health care and the inmate's unwillingness to seek care.

If our prisons and jails were incubators we would see evidence of transmissions to staff and we would see a general increase in infections among inmates not previously affected by these diseases. However, this phenomenon has not been observed in Pennsylvania or elsewhere. I am only aware of one case where a staff member may have acquired hepatitis C within our system, and there is no known case of human immunodeficiency virus (HIV) being transmitted to staff.

In Pennsylvania, we have tested our entire inmate population for hepatitis C. We have found that 23% of our new admissions were positive for hepatitis C, but we also found the same rate for those already in our population.¹⁸ The only published study of prison transmission of HIV, hepatitis B, and hepatitis C (done in a Rhode Island prison) found no instance of HIV transmission, rare transmission of hepatitis C, and less than three transmissions per one hundred susceptible inmates of hepatitis B per year of incarceration.¹⁹ We do not see a surge of sexually transmitted diseases within our

17. JOAN PETERSILIA, WHEN PRISONERS COME HOME: PAROLE AND PRISONER REENTRY 3 (2003).

18. This statistic is derived from internal information compiled by the Pennsylvania Department of Corrections on new inmates.

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

system and we have also been able to isolate and control the spread of both tuberculosis and methicillin-resistant staphylococcus aureus (MRSA) cases that have been brought into our facilities. While these few reports should not be over-interpreted, they are based on the kind of objective research which is needed in correctional systems.

In order to be successful in providing quality health care that meets the community standard of care and maximizes the positive impact on the public's health it is important to remember that the health care program must be comprehensive. It must include assessment, education, prevention, and treatment protocols and it must focus on both staff and inmates. It must also be a dynamic program that is continually revised to keep pace with treatment advances and our growing knowledge of medical issues.

There are a number of reasons why an aggressive approach to correctional health care is important. First, we have an obligation to our staff to do what we can to protect them from disease. Education and training should be provided so they are aware of potential diseases and how they are transmitted. Isolation and treatment of cases, where appropriate, and immunization due to increased risk of exposure should also be considered. We must remember that by not doing so we pose a threat to staff *and* the general public, as the staff returns to the community daily.

Second, we must remember that the majority of our inmates will return home someday. Over 600,000 inmates nationwide²⁰ and 15,000 in Pennsylvania²¹ do so each year. Prevention, education, and treatment can all reduce the potential of public exposure.

Third, if we deal aggressively with contagious diseases today we will have fewer complications, reduced costs, and fewer deaths in the future. We, in corrections, have a unique opportunity to make a substantial and positive impact on the public's health because we have a captive audience. While it is important to treat the diseases, when possible, it is critical that we take this opportunity to educate the inmates about their afflictions.

20. PETERSILIA, *supra* note 17, at 3.

21. This statistic is derived from the internal information compiled by the Pennsylvania Department of Corrections on new inmates.

As with other issues, there are a few jurisdictions that do a poor job of providing even basic health care, let alone taking a more aggressive “education and prevention” approach. A lack of resources is frequently the culprit in these cases. Other jurisdictions may meet the judicially defined minimum standards for health care and believe that this is sufficient, or they may not believe that their resources permit a more aggressive approach. Irrespective of the reasons, we miss out on an opportunity to make major improvements within the public health system in situations such as these.

There are things that we can do to change these facts. First, in many cases, those in corrections may not be aware of the unique opportunity that they have to make a difference in promoting safe public health practices. Second, those outside corrections, especially those responsible for funding, may also not be aware of the potential impact of aggressive correctional health care on our communities. They also may not be aware, in some cases, of the potential liability for inadequate health care. Awareness of these facts must be raised specifically with regard to legislators. The focus of this enlightenment needs to be on the threat to society and the consequence and cost of not maximizing our correctional health care programs.

Fourth, we have to recognize that, just as with reentry issues in general, we are not going to solve the problem alone. We must continue to interact with and increase awareness among other public agencies. Health and public welfare departments are a critical part of this process.

Finally, we need to recognize that we do not have to do everything at once. We can proceed incrementally. Some things that can be extremely important do not cost that much. Education and training, for instance, can be done for both staff and inmates with minimal cost. We can also look to immunization for things such as hepatitis B, and, to keep costs down, we can start with staff. We can then move to immunizing inmates as we become financially able to do so, focusing initially on those inmates with the greatest risk for complications and the highest likelihood of exposure to the public.

A good example of a comprehensive and aggressive approach to correctional health care is the Pennsylvania Department of Corrections’ handling of hepatitis. We began a number of years ago

by incorporating it into our staff training and we offered hepatitis B vaccinations to all staff. We then put together a more comprehensive program dealing with assessment, education, prevention, and treatment with the focus on both staff and inmates.²² We continue to assess new inmates for hepatitis C. We also provide education on hepatitis for all inmates and staff. This is done through pamphlets, videos, group discussions, and training programs. We also expanded our hepatitis B immunization program for staff to all inmates. Anyone who tests positive for hepatitis C receives additional education about the disease and potential consequences. Initially, we also offered drug therapy to all those who were positive and not excluded from treatment for mental health or medical reasons. Our protocols are dynamic and have evolved to meet the community standard of care as we have learned more and in accordance with recommendations made by the National Institute of Health (NIH) and the Center for Disease Control (CDC).

We have learned several important things regarding our attempts to offer treatment to everyone. First, due to the sheer number of people, it was simply logistically impossible to treat everyone at once, and we had no way to prioritize hepatitis C treatment based upon need. Second, we began to learn that the majority of chronically infected people would have a relatively slow-spreading version of the disease and, therefore, they had a lower risk of progressing to advanced liver disease. These people had little to lose from refusing treatment. We found that over 50% of those that were offered treatment declined, and 25% of those accepting treatment dropped out. Again, at least part of the problem was that we could not educate the person on the likelihood that he or she would develop long-term complications from hepatitis C. We could tell them they were positive; that they had a 20% chance of developing complications; that if the complications did develop it could be in twenty years or more; that the treatment was not pleasant due to its side effects; that it was only effective in about 45% of the cases; and that there would

22. For more information on the Pennsylvania Department of Corrections' efforts see ACA Archives, http://www.aca.org/archives/media_part3.asp (last visited June 6, 2006), and HEALTH CARE SERVS., PA. DEP'T OF CORR., HEPATITIS C (HCV) (2004), available at <http://www.cor.state.pa.us/stats/lib/stats/hepc.pdf>.

likely be more effective treatments in the future. For many inmates, armed with this information, the decision to refuse treatment was an easy one.

To address these issues we decided to increase follow-up testing and began utilizing liver biopsies prior to treating most cases. This allows us to not only prioritize cases but to better inform inmates as to the severity of their hepatitis C and the likelihood of future consequences. We believe such testing will allow us to better address this very real public health concern, and make it more likely that those who really need treatment will get it, accept it, and follow it through to completion.

Again, we must remember that most inmates will be released. If we do not deal with the problems posed by hepatitis C, as well as other health concerns, while we have a chance, we increase the risk to the public and to our staff. If we do not pay attention today we will really pay tomorrow, through substantially increased costs, medical complications, greater amounts of pain and suffering, and an unnecessarily increased rate of death.

In order for us to succeed in improving correctional health care, and other areas of operations within our prisons, we must overcome the legacy which we in corrections inherited as a result of the public's desire to get tough on crime, the further politicizing of that desire, and the failure to examine other courses of action. As what goes on in our prisons is poorly understood by the public it is easy to lay blame for the problems that do exist on the corrections system. In so placing the blame we ignore society's responsibility for that system. It is my hope that this committee can provide the proper focus to this issue—a focus that is based on reality and the facts. Thank you for your attention.