What is the Physician’s Responsibility in an era of Mass Incarceration?

‘Public Health is Contagious’
Public health perspectives across the offender pathway

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My Experience

• Cook County Jail – 1975 Intern
• Illinois Prison Epidemiology 1979-81
• 1981 Plasmapheresis Cook County Jail Expose’
• Montefiore Rikers Island Health Service 1981-86
• NYC Health and Hospitals Corporation 1986-88
• Director AIDS Center – St. Vincent’s Hospital 89-90
• American Public Health Association Representative on the National Commission for Correctional Health Care
• 2009 -- Appointed Member NYC Board of Correction 2009
What’s Wrong with U.S.?
Quantitative Change Causes Qualitative Change

United States is the World's Leading Jailer

Prisoners per 100,000 Population - 2006

Jail incarceration rates by race and ethnicity, 1990-2008

Number of jail inmates per 100,000 U.S. residents

- Black
- Hispanic
- White
The War on Drugs

Thus, by 2003, African Americans were arrested for drug offenses at a rate that was 238% higher than whites, which translates into African Americans being 3.4 times more likely to be arrested for a drug offense than whites.

Table 3: Drug Arrests per 100,000 by Race, 1980-2003

<table>
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<th>RACE</th>
<th>1980</th>
<th>2003</th>
<th>GROWTH</th>
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<td>658</td>
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<td>BLACK</td>
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<td>2221</td>
<td>225%</td>
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ADDICTION

The United States approach to drug possession and use is one of prohibition, with the exception of alcohol, and restricted use of marijuana in some states.

These policies are implemented in a racially biased manner

These policies fuel mass incarceration, and the epidemics of AIDS and Hepatitis C
Mass Incarceration in the U.S.

1. Began in the 1970’s
2. Racially Biased
3. War on Drugs
4. Three Strikes and You’re Out
## WATCH OUT!!

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</table>
What are the Clinical Consequences of Mass Incarceration in U.S. Prisons?

Milwaukee Wisconsin 2006

How do we treat a thirty five year old women pregnant woman with diabetes, hypertension, asthma, and psychosis?

She requests psychiatric care

She requests an abortion

She becomes increasingly short of breath and complains of severe chest pain
What are the Clinical Consequences of Mass Incarceration in U.S. Prisons?

Milwaukee Wisconsin 2006

1. We deny her access to psychiatric care because she is pregnant and thus can’t take medications;

2. Deny her request for an abortion because she is indigent and lacks sufficient funds;

3. Ignore her increasing shortness of breath, chest pain, and tachycardia, until she dies from an untreated pulmonary embolism.
What are the Clinical Consequences of Mass Incarceration in U.S. Prisons?

AIDS IN MISSISSIPPI 1999
In 1999 all prisoners in Mississippi HIV tested
• Positives were segregated
• AZT and DDC started but no protease inhibitor
• After six months, indinivir was added.
• By this time prisoners were predictably resistant to the two drugs, and quickly became resistant to the protease inhibitor.
What are the Clinical Consequences of Mass Incarceration in U.S. Prisons?

• In 1999, the medical care in the Mississippi Prisons was being provided by the University of Mississippi Medical School, under the direct supervision of the Chief of Infectious Diseases.

• Federal Court Hearing
  – Witness – had been undetectable before for inprisonment
  – Called his doctor no response
  – Doctor was the Head of ID.
SUPERMAX PRISON IN OHIO

• OHIO STATE PENITENTIARY 2004
• 23 hours a day locked up, no contact visits, no programs
• “Outdoor Exercise” in doors
• No Treatment of Pain
• INSULIN ADMINISTRATION – Same location in abdomen, because only administered through the food slot
Mentally Ill In Punitive Segregation

Seriously mentally ill prisoners decompensate into severe psychotic states when placed in Punitive segregation.

Physicians have a professional obligation not to support this practice by refusing to transfer psychotic patients, or patients with history of psychosis into Segregation Units.
Use of Punitive Segregation

• The seriously mentally ill disproportionately represented in punitive segregation (23 hour)
• In New York State, 11% of prisoners are on the mental health caseload, while 23% of those in segregation are on the mental health caseload
• In the United States 4.5 to 6.5 % (approximate 112,000 are in segregation.
Mental Illness and Segregation

- Number and percentage of prisoners in segregation status may be 10 times that in Western European Prisons (Andrew Coyle)
- More than 20,000 prisoners are housed in SuperMaxprisons – designed specifically to be bleak, locked down, for the “worst of the worst”
- Seriously Mentally Ill selectively tracked towards punitive segregation (problems with rules!) with predictable decompensation into psychosis
What are the Clinical Consequences of Mass Incarceration in U.S. Prisons?

TS, a 21 year old man with a history of severe mental illness was tied down on a concrete slab in four point leather restraints as punishment for flooding his cell in segregation.

He was psychotic, hypertensive, and hypothyroid. He lay there continuously for four days, during the hottest week of the year. He did not drink fluids regularly. Medical staff saw him regularly and approved his restraints
Tortured to Death in Michigan - 2006

“Say a prayer for TS and the others who have passed. Any earthly help comes far too late for them.”

Judge Robert Allen Enslen
Hadix II, 461 Supp.2d 574, 576 (Western District of Michigan, 2006)
Mental Illness and Segregation

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Why did Abu Ghraib Happen?

It is apparent that United States physicians participated in the interrogation process, and “stood by silently when humiliation, degrading treatment and physical abuses (took place) in Abu Ghraib and Guantanamo.

All major clinical organizations, now including psychologists, are now officially opposed to torture. As they were before the events at Abu Ghraib and Guantanamo were revealed.
Physicians and Prison Violence

Need to Report and Protection of Reporter
Need to Document
Need to Make Copies of Documents
Need to Speak out Publically
Need to Demand Sanction of
Physicians who tolerate and fail to report
Corrections Staff who abuse prisoners
In my view, a use of force that causes only insignificant harm to a prisoner may be immoral, it may be tortious, it may be criminal, and it may even be remediable under other provisions of the Federal Constitution, but it is not "cruel and unusual punishment." In concluding to the contrary, the Court today goes far beyond our precedents.

A doctor speaks out

Dear Mr. Brzeczek:

I examined Mr. Andrew Wilson on February 15 & 16, 1982. He had multiple bruises, swellings, and abrasions on his face and head. His right eye was battered and had a superficial laceration. Andrew Wilson had several linear blisters on his right thigh, right cheek and anterior chest which were consistent with radiator burns. He stated that he had been cuffed to a radiator and pushed into it.

He also stated that electrical shocks had been administered to his gums, lips, and genitals.

All these injuries occurred prior to his arrival at the Jail. There must a thorough investigation of this alleged brutality.

Sincerely,

John M. Rabe, M.D.
Medical Director
Cermak (Prison) Health Services

cc: Mr. William M. Doyle
   Mr. Leonard R. Bersky, Director
   Sheriff Richard J. Elrod
   Mr. Phillip T. Kardiman, Executive Director
   Department of Corrections
What are the Clinical Consequences of Mass Incarceration in U.S. Prisons?

California Department of Correction
Capacity 55,000
Number of Prisoners – 165,000
50% of Doctors – Beyond Redemption
One preventable Death per week
The California Experience

• In 2005 there were 165,000 prisoners in the State of California

• In 2006 Governor Schwarzenegger proposed increasing the prison population by 83,000 over the next ten years.

• Of the 110,000 to 120,000 inmates paroled from California prisons each year, 55 percent are returned to prison within two years, where they serve an average of five months (for parole violation).
Dr. Shansky (Expert Consultant for the State of California) testified in 2005 that historically the CDCR (California Department of Correction and Rehabilitation) would hire any doctor who had "a license, a pulse and a pair of shoes."
The California Experience

Dr. Puisis: 20-50% of physicians at the prisons provide poor quality of care. Many of the CDCR physicians have prior criminal charges, have had privileges revoked from hospitals, or have mental health related problems.

An August 2004 survey by CDCR's Health Care Services Division showed that approximately 20 percent of the CDCR physicians had a record of an adverse report on the National Practitioner Databank, had a malpractice settlement, had their license restricted, or had been put on probation by the Medical Board of California.
In an Order to Show Cause issued in May 2005, the federal district court judge who oversees the Plata case described medical treatment in the prisons as "horrifying" and "shocking," and discussed expert reports revealing continued widespread medical malpractice and neglect.
Mass Incarceration:  
The Case of California

Subsequently, in October 2005, the judge issued Findings of Fact and Conclusions of Law, finding that the system is "broken beyond repair," causing an "unconscionable degree of suffering and death." Among the shocking findings are that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to grossly deficient medical care.
Reduce avoidable morbidity and mortality and protect public health by providing patient-inmates timely access to safe, effective and efficient medical care, and integrate the delivery of medical care with mental health, dental and disability programs.
1. Ensure Timely Access to Care
2. Improve the Medical Program
3. Strengthen the Health Care Workforce,
4. Implement QA and CI
5. Establish Medical Support Infrastructure
6. Provide Health Care (HC-Related) Facilities.
TRAGEDY OF PLATA

The Major Recommendation of the Receiver was to build 10,000 medical and mental health beds within the prison system
Mass Incarceration: 
The Case of California 

In 2008, a panel of three federal judges in California ruled that it was not possible to provide constitutionally adequate medical care in the California Prisons because of overcrowding. They ordered the State of California to release 55,000 prisoners. That order is currently pending appeal.
Absence of National Health Care

The absence of a national health care program with universal access to all who live in the United States makes it extremely unlikely that prisoners will achieve access to adequate health care. Hopefully, this is a temporary condition.
Quality Improvement

There is a fundamental divergence of interest between the functioning of the correctional Institution and health care needs of prisoners. Therefore, some approaches to Quality Assurance/Quality Improvement will not improve prisoner health.

The unit of Quality Assurance in correctional health should be the prisoner’s health, not the prison health care system’s functioning.
Possible Strategic Intervention

Decrease the number of people who are in prison;

Avoid Reliance on:
- Alternatives to Incarceration
- Re-Entry Initiatives
- Drug Courts, Mental Health Courts

Achieve the Decrease by:
- Release (retroactive sentencing change)
- Decriminalization of drug use, decriminalization of mental illness.
Suggestions for a Research Agenda

Investigate the iatrogenic Effect of Incarceration, by examining:

Epidemiology of Mental Illness
Does Incarceration cause Mental Illness?
Does Punitive Segregation Aggravate Pre-existing Mental Illness?

Mental Illness in Medical Staff
Mental Illness in Correctional Staff
Mental Illness in Prisoners

Research on Harm Reduction treatment of methamphetamine and cocaine
Homilies

At the present time, correctional health administrators and physicians seek to maintain and improve the quality of health care for prisoners within the boundaries, disruptions, and culture of the prison. We must work within boundaries, while always pushing against them.
We must work with constant disruptions, but we must resist them, and overrule them whenever possible.

The culture of the prison, however, is not consistent with the goals of decent prison health care.

The task is to help practitioners resist the deformation of prisons, and to place the welfare of our patients above all else.
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