

## NEW PERSPECTIVES: PART I

### Welcome to the Correctional Health Theme Issue

This month we bring you a series of articles on the complexities and challenges of correctional health. This comprehensive view on the subject is due in large part to the work of Associate Editor Tanu Pandey. Her dedication, enthusiasm, and leadership have brought this important issue of *Forum* to fruition.

—Karen R. Horowitz, *Forum* Editor

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Supplemental content on correctional health available at <http://www.sgim.org/publications/sgim-forum/current-issue>

## Operationalizing a Human Rights Agenda in Correctional Health

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The Bureau of Correctional Health Services of the New York City (NYC) Department of Health and Mental Hygiene is responsible for all aspects of health and mental health care for those incarcerated in the NYC jail system. In 2012, the Bureau adopted a human rights framework as one of the key tenets necessary for the provision of health care in the jail setting. Along with patient safety and population health, we declared human rights to be one of the “triple aims” of correctional health.<sup>1</sup> Although the provision of health care as a fundamental human right is accepted in the language of the United Nations’ “Universal Declaration of Human Rights,” the concept of a right to health care has a more complex history in this country and is not universally accepted. However, it is within the framework of our own laws and constitution that the courts have clearly mandated a right to health care among the incarcerated.<sup>2</sup>

The legal mandate to provide health services to the incarcerated reflects the loss of autonomy that occurs in jail and prison. Incarcerated patients experience a limited ability to seek and participate in their own care. Mechanisms such as intake examinations and daily sick call are designed to identify the needs of each incarcerated patient, but when these services are displaced or interrupted, patients inside jails and prisons cannot reschedule their care as one would in the community. A related concern is that the very nature of correctional settings places a premium on security and relegates medical and mental health services to a secondary level of priority. The pressure exerted on clinical staff and patients by the security needs of these settings has led us to identify human rights as an essential component to our health mission. Although the concepts and methods of human rights suit themselves very well to correctional health, they remain foreign to most US health systems, especially those within the walls of jails and prisons. One basic approach of human rights—documenting abuse—provides a good example of this disconnect. Human rights workers often document abuse and other concerns with the knowledge that their efforts may not quickly lead to change. Health systems, by comparison, are designed to find and fix all manner of problems—from patient diagnoses to infection control to staffing ratios—in a very expeditious manner. Common features of health systems, such as infection control, quality assurance and improvement, and morbidity and mortality reviews, are all geared to identify and address sys-

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**When Justice Fails**

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“I was in prison for 30 years for a crime I did not commit...like any other black man in America,” said my 70-year-old patient with multiple complex medical problems that eventually took his life.

I felt sick to my stomach.

Did it really happen? Does it happen often in America? We hear about it once in a while on TV. How many innocent black men get incarcerated? Imagine one day in prison for a crime you did not commit. Imagine 30 years living with that truth yet unable to prove your innocence!

It has been well documented that crime and incarceration rates are historically high in blacks. The literature is replete with reports of high imprisonment rates for men from poor black neighborhoods that gravely impact the family and community.<sup>1,2</sup> In 2013, the US Department of Justice described trends of state prisoner admissions and releases between 1991 and 2011. There has been a decline in the year-end prison population every year since 2009 due to an increase in releases compared to admissions.<sup>3</sup> In 2012, the prisoner population at year end was 1,570,400 compared to 1,599,000 in 2011.

However, there has been an increase in new court commitments for violent offenses by blacks during this period: 47% in 2011, 44% in 2006, and 41% in 2001. In 2011, 25% of all new white offenders, 34% of black offenders, and 36% of Hispanic offenders were sentenced for violent crimes. For blacks, this was an increase since 2006 when less than 30% of new admissions were for violent crimes. New admissions for murder and non-negligent manslaughter between 2001 and 2011 showed a similar pattern with a reduction in whites from 29% to 24% and an increase in blacks from 46% to 51%.

The imprisonment rate is defined as the number of prisoners under state or federal jurisdiction sentenced to more than one year per 100,000 US residents of all ages in a given year. In December 2012, imprisonment rates based on race and ethnicity revealed that 2.8% of black, 1.2% of Hispanic, and 0.5% of white males were in state or federal prison. Compared to white men, black men were six times more likely to be imprisoned, and the imprisonment rates for black men were at least four times those of white men in all age groups. For black men younger than age 39, the imprisonment rate was six times greater than that for white men of the same age. The biggest disparity was seen in male inmates age 18 to 19; black men in this age group were 9.5 times more likely to be in prison than white men of the same age. Black women age 18 to 19 were three times more likely to be imprisoned than white women.

How many of these were innocent people who were wrongly convicted and suffered for a crime they did not commit?

Historically high numbers of young African-American men are continued on page 7

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## Putting the Patient Before the Prisoner

Emily Thomas, MS, and Emily Wang, MD, MAS

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Last week in clinic, we saw a 57-year-old-homeless man, Abe, with hepatitis C and a rapidly growing liver mass. At face value, this patient seems fairly typical. But he had a unique experience—Abe was returning home from prison.

Criminal justice exposure is an experience that is common in the United States yet entirely hidden from view. Close to 13 million patients return home from correctional facilities in the United States each year, and most primary care providers and trainees are not equipped to understand the challenges that these patients face. Only 22 US primary care residency programs offer training in how to care for prisoners or people who have been through the correctional system.<sup>1</sup>

This lack of training contributes to knowledge deficits that undermine providers' capacity to assess the risks associated with criminal justice exposure and to take action to mitigate those risks. Patients returning home from prison experience exceptionally high rates of psychiatric illness and substance use disorders. Engagement in care upon release is critical yet rarely happens. Few patients have a primary care provider prior to going to prison, and many states systematically strip prisoners of their Medicaid coverage while in prison.<sup>2</sup> Upon release, patients must re-apply for their insurance, delaying needed access to care for these chronic conditions. Most of these patients will not have seen a primary care provider even one year after release.<sup>3</sup>

While these issues are commonplace in the US health care system, the consequences of these structural barriers and health risks are striking. Patients returning home from prison are 2.5 times more likely to be hospitalized within the first seven days of

release compared with matched controls.<sup>4</sup> Within the first two weeks of release from prison, these patients face a mortality risk that is 12 times greater than the general population even after controlling for patient age, race, and sex.<sup>5</sup>

Primary care providers may not be able to alter the conditions of the criminal justice system that predispose our patients to these risks, but they can mitigate these risks in the critical post-release period. At Transitions Clinic-New Haven, where we practice primary care, our goal is to build long-term relationships with patients who have recently returned home from prison. We teach providers and trainees how to tactfully and empathically discuss exposure to the criminal justice system in the context of their patients' health.

A conversation with Abe revealed that he was diagnosed with hepatocellular carcinoma (HCC) prior to his last incarceration. His frequent yet brief prison stays created breaks in health care, insurance, and community plans for housing. Without routine monitoring, his HCC had metastasized to his colon, causing a life-threatening GI bleed. Without insurance, he often would go months and weeks without medications and never could make the list for housing.

Unfortunately, most primary care providers will overlook their patients' incarceration history for the simple reason that they were not trained to ask. However, asking about incarceration history, focusing on transitions of care, and framing medical histories in relation to correctional experiences provides critical information in developing effective plans of care. Notably, we are able to address individual and structural factors in the post-incarceration period. These complex factors critically influence illness manage-

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**Errata:** The December 2014 *Forum* article by the Research on Careers Interest Group incorrectly credited Mark Linzer as the SGIM president who initiated the focus on physician satisfaction. That SGIM President was Mack Lipkin. Additionally, co-author Linda Baier Manwell's name was misspelled.

ment, disease course, and even the risk of re-incarceration for our patients. And as Abe demonstrates, the cycle of incarceration may gravely worsen one's health prospects.

How can we train providers and trainees to delve into these tough issues while remaining sensitive to the ways in which these stories may make our patients feel more vulnerable and us more fearful?

First, we must acknowledge the scope of mass incarceration. One in 31 adults in the United States is cur-

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## Opioid Addiction and Criminal Justice Systems: Opportunities to Break the Cycle of Incarceration

Aaron D. Fox, MD, MS

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**M**r. Robinson is a 60-year-old man with HIV infection who came to see me several days after his release from state prison where he had served a five-year sentence for crimes related to heroin addiction. He was healthy, stable, on combination anti-retroviral therapy for HIV, and had completed an abstinence-based substance abuse treatment program in prison. Having maintained abstinence while incarcerated, Mr. Robinson was confident that he would avoid heroin relapse after release. He was getting older and was tired of the stressful lifestyle that using heroin demanded. He planned to move in with his sister who lived out of town and distance himself from the triggers and temptations of New York City. Knowing the high rates of relapse to heroin use following release from incarceration, I offered him buprenorphine maintenance treatment, but he respectfully declined.

For the growing number of Americans with opioid use disorder—2.3 million in 2010—the cycle of incarceration and recidivism is far too common. In a typical scenario, chronic opioid use leads to physical tolerance, which increases demand for opioids, which often leads to petty crime or drug sales to acquire money to buy more opioids. Annually, it is estimated that one third of heroin users, or 250,000 Americans, pass through correctional facilities. More than half of prisoners with substance use disorders have prior incarcerations, which highlights the urgent need for interventions during and following incarceration to prevent relapse and recidivism.

During incarceration, few opioid users receive opioid agonist treat-

ment, such as methadone or buprenorphine, which is the most effective treatment for opioid use disorder. Although 28 state prison systems offer methadone maintenance treatment in some settings, methadone is rarely offered except with concomitant pregnancy or chronic pain. Less than 0.1% of incarcerated Americans with opioid use disorder are estimated to receive agonist treatments. Consequently, opioid abuse often continues during incarceration, with prisoners (or staff) smuggling opioids into facilities. In New York between 1996 and 2005, at least 27 prisoners died of drug overdoses while in custody, but the greatest risk of overdose occurs following release. Within three months of release from prison, rates of opioid relapse can be as high as 75%, and many opioid users report cravings and relapse immediately upon release. Because opioid tolerance decreases with less frequent opioid use during incarceration, resumption of opioid use in amounts similar to those used before incarceration can lead to overdose. The mortality rate in the two-week period following prison release is 12 times higher among former prisoners than the general population, with the leading cause being drug overdose. Between 1999 and 2010 in Washington state, 15% of deaths among former prisoners were attributable to opioid overdose.

My research has focused on understanding why opioid users do or do not seek treatment, including opioid agonists, following release from incarceration. In a qualitative study of formerly incarcerated individuals with opioid use disorder, we asked about barriers and facilitators of post-incarceration addiction treat-

ment, and several common themes emerged. Nearly all participants had experienced adverse conditions following release, which often contributed to relapse, including housing instability, challenges with employment, and constant exposure to substance use. Regarding opioid agonist treatments, participants feared becoming physically dependent on medications, which they often perceived as a step backward in recovery. Interestingly, participants feared physical dependence because it would result in a painful withdrawal if medications were withheld in the future (i.e. during incarceration). Overall, participants believed that willpower was most important for recovery and were confident that they would maintain abstinence. These findings have implications for treatments offered during incarceration and following release.

Correctional facilities need to do more to prepare inmates with opioid use disorder for release. Current treatment paradigms during incarceration only focus on medication-free approaches, but programs should educate inmates about agonist treatments and link them to treatment sites following release. Several randomized controlled trials have demonstrated that, prior to release from prison, initiating methadone or buprenorphine increases entrance into addiction treatment and reduces opioid use following release. Therefore, pre-release opioid agonist treatment should be offered, even if some opioid users would prefer to remain medication free. Because of the high rate of overdose soon after release, distribution of naloxone rescue kits could save lives,

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## How Do We Meet the Unique Medical Needs of Justice-involved Women in our Communities?

Diane S. Morse, MD, and John L. Wilson

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**W**omen face steadily increasing involvement in the justice system and have myriad unmet needs.<sup>1</sup> They are now the fastest growing segment of the US incarcerated population, increasing 646% from 1980 to 2010 or 1.5 times the rate of men.<sup>2,3</sup> Related to this rapid increase, services are primarily designed for men with justice involvement and have not yet caught up to the needs of women.<sup>4</sup> It is important for medical providers to understand these trends and the basic steps in arrest and incarceration in order to best treat justice-involved women.

The increasing rate of arrests for women is attributed to many causes, including the mandatory minimum sentencing for drug convictions.<sup>5</sup> Many of these women will recidivate in and out of large county jails for short stays of days to months. Smaller numbers of women commit violent crimes; thus, women are less likely than men to be incarcerated long term in federal settings. These numbers are growing, however.<sup>6</sup> When a woman commits a violent crime, it is not unusual for it to be in the context of intimate partner violence (IPV) or self-defense. The man often is not arrested because women's safety concerns prevent them from pressing charges and testifying.<sup>7</sup> Women reentering the community from incarceration are plagued by comorbid health conditions and face barriers to care on both intrapsychic and systemic levels.<sup>8</sup> Short-term incarceration in jail with frequent recidivism results in more interruption of medical care than longer-term incarceration in prison.<sup>9</sup> Short stays create multiple problems: inadequate time to establish needed care due in part to records not being received, appointments being missed, social instability engendered by recidivism, release

without medication, interruption of Medicaid (which then must be reactivated), and breaks in substance abuse and mental health treatment.<sup>9,10</sup> Upon enacting recent legislation aimed at increasing health care utilization in the United States, Cuelar and Cheema<sup>10</sup> found that 10% of potential Medicaid expansion beneficiaries under the 2010 Patient Protection and Affordable Care Act (ACA) were recently incarcerated individuals. While thousands reenter the community every day and are at risk of recidivism, most efforts to date have focused on prison practices rather than those related to reentry. Prison health care is more likely to include treatment for chronic conditions including HIV,<sup>11</sup> hepatitis C,<sup>12</sup> and substance abuse;<sup>13</sup> unfortunately, it has important limitations. In both jail and prison, there are a lack of gender-specific treatments to address women's unique needs.<sup>14</sup> Individuals from prison face a mortality rate in the first two weeks after release that is 12 times higher than that of the general population.<sup>15</sup> This increased risk is due to suicide, homicide, cardiovascular disease, drug overdose, and health behaviors such as cigarette smoking and unprotected sex.<sup>15</sup> Additionally, recently released women are more likely than their male counterparts to experience mental health, substance abuse, and physical health co-morbidities; to have unstable housing related to IPV; and to engage in high-risk behavior including sex work.<sup>16-18</sup> These are all undertreated conditions that medical providers can and should address.

Stigma and a lack of understanding of the needs of individuals reentering the community from incarceration interfere with subsequent linkage to care.<sup>19</sup> It is typical to label these patients according to their history of incarceration with terms such as

"former inmate" and "parolee." These terms tie them to that experience for a lifetime and invite judgment. While it is important for medical providers to routinely inquire about a history of justice involvement in order to address associated risks, documentation and speech should instead utilize phrasing such as "justice involvement." Similarly, it is generally inappropriate to inquire about specifics of any crime or conviction. Doing so will cause shame and not impact health or inform the medical care needs of the individual. In the medical setting, justice-involved women report that feeling judged by providers is a barrier to seeking and obtaining treatment, including prenatal care.<sup>1</sup> Women striving to overcome drug and alcohol addiction are in a particular bind: They are judged for temporarily giving up their children in order to focus on treatment, unlike men who are encouraged to put their recovery first. Childcare is difficult but necessary for women to obtain in order to participate in court appointments, community supervision, and needed social services.<sup>1</sup> One study<sup>20</sup> found that the provision of gender-specific wrap-around services for women relating to childcare and work obligations improved recovery and drug court completion outcomes. Since 75% of justice-involved women are mothers,<sup>21</sup> providers must be cognizant of these challenges. Helping justice-involved women find childcare and other needed social services can prevent stigma by normalizing their difficulties. If a dedicated staff member is not available, it is reasonable to include childcare resources among patient handouts in the office. Stigmatizing language should also be avoided in the medical encounter. Medical providers can appropriately inquire about "sex work" and "sexually transmitted infection" and "continued on page 15

## From Justice to Health: The High Cost of Poor Transitions

Hermione Hurley, MBChB

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Improving medical care during the transition from inpatient to outpatient services has been a focus of broad efforts for many years. The transition from larger systems such as justice to health, however, has been ignored at considerable cost to individuals and health systems alike.

Of the 10 million individuals released from prison or jail each year, the majority will be uninsured as they return to the community.<sup>1,2</sup> This population is aging and increasingly burdened by chronic medical conditions such as cardiac disease, diabetes, chronic obstructive pulmonary disease, and malignancy.<sup>3,7</sup> After release, justice-involved individuals die more frequently<sup>8,12</sup> and use inpatient services for ambulatory conditions more frequently than their peers.<sup>12,13</sup> Access to care for mental health and addiction disorders has improved, but chronic medical conditions have received less attention.

There are many immediate needs after release from incarceration that take precedence over establishing care with a primary care physician. These include obtaining safe housing, food, and income as well as avoiding old enemies, reengaging with family, and maintaining sobriety. As a consequence, the most frequent portal into health systems is the emergency room or urgent care clinic—our most expensive sources of health care. Alternatively, chronic conditions may remain untreated, resulting in hospital admission or death. Historically, hospitals and health care systems have been reluctant to address the needs of released prisoners as new patients because they rarely have health insurance and are often non-paying patients.

Anyone released from a correctional facility will face barriers to accessing health care, but there are predictable differences between

transitions from jail and transitions from prison.

Jails are responsible for those recently arrested or awaiting sentencing. Their jurisdiction can be as short as a few hours or may last many years. Acute health issues in jailed individuals are often untreated and may influence the circumstances prompting arrest. Substance use, addiction, and undertreated psychiatric disorders are prevalent. With rapid turnover of inmates, chronic conditions may not be fully addressed before charges are dropped and the individual leaves the facility.

Prisons hold people who have been convicted and sentenced; prison stays may range anywhere from one year to life. During imprisonment, health care is institutionalized, structured, and managed within a single system. At the moment of release or parole, the prison no longer has any obligation to provide health care for these individuals. People frequently leave prison with only a few weeks of medication (or less) and no plan for health care follow-up.

In both prisons and jails, cessation of care at the time of release is abrupt, and resumption of prior health insurance benefits is not guaranteed. Inmates are not eligible for social security payments while incarcerated. The Social Security Administration offers a \$400 incentive payment for each inmate reported within 30 days of arrest.<sup>14</sup> In many states, this reporting is linked to the Centers for Medicare and Medicaid Services (CMS), which suspends or cancels their insurance. Therefore, prisons and jails are paid to suspend benefits but have no incentive to reinstate them upon release. The patient you enroll in Medicaid during a visit to your emergency room or clinic can be arrested and released only to be uninsured again by the time of the next clinic visit a week later. Thus begins

the revolving door of insurance, incarceration, cancellation, and release.

There must be solutions to these problems. If we act together, efforts to develop partnerships between the health care and justice systems can improve outcomes for patients while reducing costs.

The Affordable Care Act (ACA) has dramatically changed eligibility for criminal-justice populations. This is most notable in states that have accepted Medicaid expansion. By including those with income below 133% of the federal poverty level and eliminating the need for disability or dependent family members, the majority of current inmates are now eligible for Medicaid coverage once released. Seeking out criminal-justice populations is no longer a financially risky proposition for health systems.

Financial incentives for justice facilities that enroll or screen their populations for Medicaid also exist. Under the ACA, the federal government pays for inpatient admission to hospitals and offers meaningful use payments to justice facilities if they institute an electronic health record (EHR). These incentives are successfully leading prisons and jails to screen and enroll their populations in health care in many states.

The financial “carrot” of payments may, however, soon be followed by a federal “stick.” Just as hospitals dread readmissions, justice facilities loathe recidivism. It is conceivable that future payments will depend on good transitions. To receive the full Medicaid payment, a facility may need to demonstrate plans that avoid return to prison or avert an inpatient admission soon after release. Cooperation across disciplines is therefore necessary.

Transition clinics offer a bridge from justice to health. They can be implemented in a variety of ways.

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One model imbeds specialized transition clinics within the justice facility. Medical teams can be incorporated into probation offices, and justice staff can be encouraged to collaborate with community clinics. A patient navigator for health care can be included in release planning teams for those with chronic medical conditions. Responsible health systems can fund the first month of medications and initiate the first outpatient appointment rather than bear the cost of an emergency visit or inpatient admission.

We can share our medical knowledge of patients. Compatible EHRs will shorten length of stay, improve the quality of justice intake screening, and maintain uninterrupted specialty services from the correctional setting to the community.

Some of the most challenging patients are often those affected by the criminal justice system. Those most vulnerable patients—the emergency department “frequent flyers”—may be well known to the local jail as well. Incarceration may provide a period of opportunity for health interventions for these patients.

Management of conditions such as hepatitis C, drug addiction, mental illness, and diabetes can be facilitated by institutional collaboration. By ensuring continuity or preventing disruption of treatment, costs and duration of expensive care plans can be appropriately managed.

The delivery of health care and justice are political but bipartisan. Solutions require local and national effort. Partnerships between prisons and health care systems can form a strong voice for change. We can lobby state governments to suspend Medicaid rather than terminate it upon incarceration. We can add our voice to sentencing reform and compassionate release for elderly patients with high health care needs.

The cost of a poor transition from justice to health is high, but the potential for benefit is significant. There are solutions to these problems. We can combine our expertise to affect change for the sake of our patients and the welfare of our communities.

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spending their emerging adulthood in prison.<sup>3</sup> In 2000, Arnett defined emerging adulthood as the period between age 18 and 25 that defines the individual’s foundation for adult life based on choices made in social, occupational, and behavioral domains.<sup>4</sup> Exposure to prison restricts the complete development of the individual with subsequent failure to thrive as a productive member of society. High prevalence of parental imprisonment among blacks is a distinct childhood risk factor for crime and subsequent incarceration, thus feeding a vicious cycle that condemns an already susceptible population to inequality from one generation to the next.<sup>2</sup>

In a recent study that examined false conviction rates for criminal defendants on death row, it was estimated that at least 4.1% of them were innocent.<sup>5</sup> The principal author of this paper is the editor and co-founder of the *National Registry of Exonerations*, a joint project between the University of Michigan and Northwestern University law schools, which has tracked wrongful convictions since 1989.<sup>6</sup> According

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## Confidentiality and the Incarcerated Patient in the Community Setting

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**Hippocratic Oath: “Whatever, in the course of my practice, I may see or hear (even when not invited), whatever I may happen to obtain knowledge of, if it be not proper to repeat it, I will keep sacred and secret within my own breast.”**

It is rare that medical professionals are specifically trained about the ethical, legal, and practical aspects of caring for incarcerated patients despite the fact that it is not an uncommon occurrence. When faced with a patient dressed in a bright orange or red jumpsuit who is shackled in cuffs and chains, I often find that medical providers go about their business trying not to acknowledge that the patient is incarcerated. This is not the best approach as it ignores the role of the correctional officer that is ever present in the room. When people are incarcerated, they lose many rights, including the right to freedom of movement and the right to vote, but they do not lose the right to confidentiality except for certain exceptions mandated by federal and state law.

Disclosure of protected health information (PHI) to the correctional officer can occur in two distinct ways: 1) There can be the direct or active transfer of information to the officer, or 2) the officer can passively overhear the exchange of information. When is it appropriate to tell a non-medical professional PHI? The Health Insurance Portable and Accountability Act (HIPAA) privacy regulation makes allowances for a health care provider to disclose PHI if he/she believes that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the public and the disclosure is to persons reasonably able to prevent or lessen the threat. For example, an emergency room physician can report to law enforcement authorities the extent and location of injuries if a patient has wounds consistent with being stabbed, shot, or involved in a crime in some way. However, it is

important to note that not all disclosure laws create an *obligation* to make such a disclosure; some laws simply *allow* the disclosure without penalty. In most circumstances, a patient's PHI has no relation to the public's safety and therefore cannot be used as a reason to disclose to law enforcement authorities. The American Medical Association (AMA) states that when the law or a court order requires the disclosure of confidential information, physicians generally should notify the patient.

Laws usually also allow a health care provider to disclose PHI about a patient without the patient's consent to the extent the recipient *needs* to know. The difficulty is determining when a law enforcement officer truly *needs* to know PHI. For continuity of care, disclosure can be made to an official of a penal or custodial institution where the patient is detained, but when possible it would be preferable to give the PHI to a medical professional from that facility. When a patient is discharged from a hospital back to a correctional facility, it is important that the receiving medical provider receive a summary of the patient's hospital stay. Similarly, if a patient is sent out to the community for specialist consultation, the recommendations should be given to the correctional medical provider by calling them by phone or giving the officer the written information in a sealed envelope, but they should not be verbally given to the officer to pass on. Although it is appropriate to disclose some PHI to the law enforcement officer who brought the patient to the medical center, disclosure should be limited to demographic information, clinical condition

as opposed to diagnosis, estimated or actual discharge date, and extent and location of injuries when admitted. It can sometimes be necessary to disclose PHI about an inmate to a correctional officer if it impacts the health and safety of the staff at the correctional facility or the persons responsible for transporting the inmate. For example, if a patient is diagnosed with pulmonary tuberculosis, then the need for airborne precautions and a contact investigation is necessary to disclose. For most other diseases, universal precautions would be sufficient, and disclosure would not be necessary. No matter the reason for disclosure of PHI directly to a non-medical professional, only the minimal amount of PHI needed should be shared.

Alternatively, PHI can be passively disclosed to the correctional officer guarding the patient by speaking to or about the patient in his/her presence. Guarded patients can be maintained within line of sight of the officer but do not always need to be within earshot of the officer especially when the patient's medical history is being obtained or the inpatient team is rounding. On the other hand, during an exam, incarcerated patients should be afforded visual privacy by standing behind a curtain or other barrier at which time the officer can be within earshot to maintain safety.

There are several reasons why it is of utmost importance whenever possible to have non-medical professionals out of earshot when discussing PHI to avoid passive disclosure of confidential information. In medical school, we are taught that when taking a history of an adoles-

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## A Call to Understand the Mental Health Needs of Older Prisoners

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An unintended consequence of mass incarceration in the United States has been an exponential increase in the number of aging prisoners. Prisoners are considered “old” in their 50s. This relatively young age is used to reflect the common experience of “accelerated aging” among prisoners, which often results from the stressors of prison life combined with unhealthy lifestyles and inadequate health care experienced in the community outside of the criminal justice system. Older prisoners are now the fastest growing segment of the prison population, and it is estimated that they will comprise one third of the US prison population in the coming decades if current sentencing laws remain unchanged. This changing demographic has a considerable impact on criminal justice health care systems since, given their high rates of multiple chronic illnesses, older prisoners use a disproportionate amount of prison health care services and generate higher health care costs.

In 2012, experts in correctional health care, academic medicine, nursing, and civil rights collaborated to publish a research and policy agenda to address the medical needs of older prisoners.<sup>1</sup> These recommendations called for an improved definition of geriatric functional impairment in the correctional setting, attention to dementia and to the unique needs of aging female prisoners, development of transitional care models designed to meet the needs of older adults following their return to the community, and more evidence-based guidelines for early and compassionate release for prisoners with life-limiting or serious illnesses.

While these guidelines took an important first step toward creating a comprehensive agenda for meeting the health care needs of older

prisoners, the guidelines missed a call to action for geriatric mental health awareness. Distinctions are often made between medical and mental health care. However, given the overrepresentation of mentally ill persons in the US criminal justice system combined with the growing number of aging prisoners with serious mental illness (e.g. schizophrenia, major recurrent depression, and bipolar illness), it is critical that the mental health care needs of older prisoners be added to the policy and research agenda.

Rather than developing a separate set of mental health priority areas, the importance of mental health could be incorporated into several of the priority areas recommended by the expert panel. For example, the panel indicated that older prisoners have a high prevalence of common risk factors for dementia including traumatic brain injury and alcohol abuse. Depression, which is inexorably linked to dementia, is also common among older prisoners. Depression earlier in life—typically defined as depression or depressive symptoms occurring before age 60—has consistently been found to be a risk factor for dementia.<sup>2</sup> Furthermore, it is common for depression in older persons to be mistaken for dementia. Outside of the correctional setting, it is common to find diagnostic errors in detecting both depression and dementia (e.g. assuming symptoms are a “normal” part of aging). In prison, these errors may be compounded as the regimented schedules of prison life make it difficult to discern changes in mood, behavior, or wandering and may also mask symptoms of flat affect. As in the community, clinicians in the criminal justice system need to be actively screening and addressing both depression and dementia in older adults. In addition, older adults with schizo-

phrenia have considerably higher rates of dementia as compared to their age-matched peers.<sup>3</sup> As the prison population continues to age, it will be increasingly important to develop our understanding of the impact of serious mental illness on dementia.

The expert panel also called for more research into the unique health care needs of older female prisoners. As compared with male prisoners, female prisoners have higher rates of mental health problems and comorbid mental illnesses, even after controlling for drug and alcohol abuse.<sup>4</sup> Understanding whether these gender differences persist into older age is an important next step. Female prisoners also report high rates of prior physical and sexual abuse—two risk factors for mental illness, including post-traumatic stress disorder and major depression. Knowledge about the impact of traumatic experiences on the mental health of female prisoners as they age is largely unknown but is critical for developing effective programming and therapeutic interventions for older female prisoners.

The expert panel emphasized that a fundamental goal of correctional systems should be to help prisoners plan for reentry so they can effectively manage their health care needs upon release. Improved understanding of mental illness in older prisoners is important for optimizing their transitions from prison to the outside community, particularly in light of recent legislation that may allow for easier continuity of care after incarceration. These laws include the Medicare Improvements for Patients and Providers Act [H.R. 6331; 110th Congress; July 15, 2008], which created parity in copayments for physical health conditions and outpatient mental health services, and the January 2014 expansion  
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to this registry, most false convictions do not result in exonerations. As of April 2014, this registry had 1,326 exonerations with a record number of 87 in 2013. California (119), Texas (114), and Illinois (112) had the highest exoneration numbers. The average time spent by the exonerees in prison was 10 years, and most spent five to 10 years in prison. Factors contributing to these convictions included perjury or false accusation, official misconduct, mistaken identification, misleading forensic evidence, and false confessions. A study of the basic patterns revealed that of all innocent prisoners, 92% were men, and 46% were black—in a country where African Americans comprise only 15% of the total population. In every category except child sexual abuse—including sexual assault, homicide, and other crimes—more blacks were exonerated than others.

The Innocence Project is a national litigation and public policy organization dedicated to preventing future injustice by exonerating wrongfully convicted individuals through reform of the criminal justice system and use of DNA testing.<sup>7</sup> So far more than 300 wrongful convictions have been overturned, and many more are anticipated. This has been described as a masterful legacy of data on wrongful convictions, yet it only represents the tip of the iceberg. Of these DNA exonerations, 63% of defendants were African Americans.

Who can forget the mind-numbing details of the extreme torture inflicted on more than 100 African-American prisoners by Chicago Police Commander Jon Burge and his officers? Between 1972 and 1991, prisoners were systematically tortured by electric shock and suffocation to obtain coerced confessions leading to wrongful convictions. Andrew Wilson, a prisoner accused of murder, sustained serious injuries after the torture and was examined by John Raba, MD, the medical director of Cook County Jail. The extent of the

injuries and Wilson's claim of innocence convinced Dr. Raba to initiate an investigation with the assistance of then Police Superintendent Richard Breczek that triggered a series of events resulting in Burge's termination from the Chicago Police Department and eventual conviction and imprisonment in 2011. Most of the torture survivors received no compensation or psychological counseling. Twenty remain in prison due to convictions based at least partly on their coerced confessions. A few were freed after languishing for decades in prison. Historical injustices like these due to confessions obtained through violence have been reported for centuries. The Miranda rulings were a result of landmark decisions by the US Supreme Court in the early 20th century against the use of coerced confessions as evidence for conviction. Yet injustices against African-American men and women continue unabated. The recent release of Glenn Ford after conviction by an all-white jury and 30 years on death row for a murder he did not commit forces us to wonder how many more remain unfairly imprisoned.

So what can we do about this?

The Center on Wrongful Convictions at Northwestern University has been a champion for justice in wrongful convictions and has raised public awareness through evidence-based depiction of the current situation. Its ground-breaking legal actions have resulted in a moratorium on state executions, criminal justice reform, expanded DNA testing, increased funding, international reform, and compensation for exonerated prisoners. Many challenges remain, however, including the need to expand electronically recorded interrogation procedures in all criminal cases, implement standard procedures to enhance correct identification of suspects by witnesses, restrict actions that cause suffering from a stigmatizing experience, provide appropriate legal services for all prisoners, and establish structured compensation plans for exonerees.

Thomas Jefferson wrote, "We hold these truths to be self evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." It remains to be seen if United States can truly claim to be a land of freedom and opportunity without discrimination based on color. The racial bias that tarnishes the criminal justice system gets attention in only a handful of prominent convictions. Without a sustained multipronged effort from the public, I daresay such discrimination will persist.

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## COMMENTARY

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cent, it is important to do so without a parent in the room to respect the privacy of the adolescent and increase the likelihood that accurate information is obtained. Similarly, when taking a history from a person in custody, it is equally important to take the history without the watchful eye of the legal system to obtain more accurate and important information that can impact health outcomes. The AMA specifically recommends that physicians avoid “situations in which an outside observer’s presence may negatively influence the medical interaction and compromise care.”

Respecting the patient’s privacy and autonomy works toward earning the patient’s trust, and the relationship between patient and physician is based on trust. Most incarcerated patients have had poor relationships with authority figures, often starting with their parents, then teachers, principals, and police officers. Medical providers are just another authority figure to many inmates—many of whom have never been engaged in regular medical care. Trust is something earned, and asking an officer to stand out of earshot is an important first step in earning trust. Due to the innate unequal nature of the relationship between officer and inmate, asking the patient if it is okay

for the officer to remain in the room is not valid as the inmate is not truly at liberty to make a free decision. It is better to have the default be that the officer step aside when discussing PHI. Although the safety of medical staff trumps the need for confidentiality, when incarcerated patients are seen in the community setting they are either in shackles and chains or cuffed to an inpatient bed. The safety concern is usually minimal in these circumstances, so confidentiality can almost always be honored.

The disclosure of information in a community setting can also have an impact on the patient’s care behind the walls of the correctional facility. Although officers guarding incarcerated patients in the community must legally uphold confidentiality to the same extent that medical professionals do, they are still seen as non-medical correctional staff in the eyes of the incarcerated patient. The concern about confidentiality is often exaggerated when the patient has a stigmatized diagnosis such as HIV. There is a real risk that officers will share information about blood-borne pathogens with their colleagues out of concern for the health and welfare of their co-workers and not appreciate the greater benefit of abiding by universal precautions. The

knowledge within an incarcerated setting that an inmate has HIV can create such an unpleasant environment for the infected individual that he/she may choose to be in solitary confinement for his/her own safety. I have had experiences with inmates returning from community appointments during which their HIV status was revealed to the accompanying correctional officer. To avoid any further unwanted disclosures of PHI to custody staff, some of these inmates refuse to go to any needed specialty follow-up appointments while others outright refuse any further care for HIV until after release back to the community.

Confidentiality laws and policies surrounding incarcerated individuals are laden with subjectivity. The information necessary to disclose directly to non-medical staff should be limited to only PHI that would avoid immediate harm to the individual or the public. It is equally important to avoid passive disclosure of guarded patients’ PHI while balancing confidentiality with safety. The Society of Correctional Physicians encourages “privacy of sight and sound to the degree possible without creating a risk to the provider or other individuals.” In general, the disclosure of PHI without consent should be the exception, not the rule. *SGIM*

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sion of Medicaid under the Patient Protection and Affordable Care Act (ACA) [H.R. 3590; 111th Congress; August 25, 2010].

However, coordination of services at the time of community reentry may be particularly challenging for older prisoners who have a complex interplay of mental and physical health needs. Mental illness has been found to exacerbate chronic medical illness in older adults and to increase the risk of onset and worsening of disability in activities of daily living. Polypharmacy is also of concern when medical and mental health conditions coexist, and coordi-

nating the medications for both mental illness and physical conditions is critically important for the reentry planning of older prisoners. Furthermore, after a long incarceration, prisoners may lose contact with the outside world and become “institutionalized.” Institutionalization, combined with fears regarding safety and lack of social support upon release, may be a significant source of anxiety for older prisoners. Such concerns and anxiety can exacerbate mental health-related symptoms, which may contribute to high rates of homelessness, mortality, and suicide found in older former prisoners.<sup>5,6</sup>

Finally, the panel called for improved compassionate or medical release policies that “reflect the ways that people experience serious medical illness and death.” Older prisoners with serious mental illness should also be considered in these policies. However, as noted by the panel, compassionate or medical release policies are rarely used because skilled nursing facilities (SNFs) often will not accept patients with a history of incarceration. Additionally, the narrow eligibility requirements and cumbersome process of compassionate release (e.g. back-continued on page 13

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tems issues related to care with an emphasis on accountability and timeliness. Within correctional health settings, there is an additional barrier to documenting human rights concerns: Health staff commonly are employed by the security authority, such as the department of corrections or sheriff's office. This arrangement can create a disincentive to report problems, especially those that are difficult to fix. The integration of human rights into our overall mission is an acknowledgement that our health system bears a central responsibility to provide care and document health risks; this is a right that the correctional setting confers to patients.

We have worked to operationalize the human rights framework at several key levels of our health system. At a very high level, we created a quarterly meeting called the Human Rights Collective, where we engage human rights experts, academics, policymakers, and formerly incarcerated persons to discuss human rights issues in our settings. Topics have included dual loyalty, solitary confinement, racial disparities in care, and human trafficking. These discussions then result in recommendations that are delivered to the Human Rights Quality Improvement Committee (HR-QIC), which is one of several committees that make up our overall quality improvement structure. The HR-QIC is composed of leadership from jail, medical, nursing, mental health, and administrative staff and works to develop new policies, procedures, or trainings.

One instructive example is the problem of "dual loyalty"—the conflict between professional obligations to patients and the interest of a third party, such as the security authority of the jails.<sup>3</sup> In the case of health care in jails and prisons, the conflict between the desires and needs of the patients and of the security authority comes to the surface in clinical interactions almost immediately and universally. Health care staff are routinely asked to mediate between patients and the security authority, such as deciding which patients are

authorized to carry a cane, wear their own shoes, or be spared from certain types of restraints. These decisions often put the staff member in conflict with either the patient—their primary loyalty in the healing dyad—or with security staff—colleagues on whom they rely for their safety and security and who also commonly represent their employer.

Even mediating the most mundane dual loyalty disputes leaves staff feeling that they let down one side or the other. Universally choosing the side of the patient will lead to conflict with the security staff and may also compromise the security of the facility; however, denying even one patient the medical device or permit that he/she needs can destroy the therapeutic alliance between healer and patient. Furthermore, the medical assessment requires the integration of both objective and subjective factors (i.e. the history of present illness). Such arrangements lead health care staff over time to be distrustful of their patients. Without the ability to rely on the subjective component, the decisions they are forced to make are essentially arbitrary. Dual loyalty also applies in more high-stakes decisions, such as in systems where health care staff have authority to remove patients from solitary confinement or are integrated into the punishment process by "clearing" patients for solitary confinement. Though such arrangements are ostensibly established to protect patients, the repeated exposure to this dual loyalty conflict can be traumatic for health care staff, cause burnout, and lead staff to gradually drift toward a primary loyalty to the security staff rather than to their patients.

Dual loyalty was an early topic of the Human Rights Collective, resulting in a formal assessment of the problem by the HR-QIC. Substantial concerns were documented. In response, a dual loyalty training was implemented for all staff in our system. The goal of this intervention was to increase staff awareness of the phenomenon of dual loyalty and

to give them tools to employ in difficult situations. The first component of the training was online and included basic definitions of the dual loyalty concept as well as a presentation of a series of dual loyalty scenarios with multiple options on how health care staff might respond. Scenarios included the role of health care staff in approving the punishment of patients with solitary confinement, providing condoms to a transgender patient, and witnessing physical abuse of a patient by security staff. Staff were asked to respond to discussion questions on each scenario. The training was recognized as important by more than 90% of participants, with staff requesting additional training on this issue in the future (unpublished data). The answers given by staff during these trainings were compiled and presented in multidisciplinary, small-group discussion sessions led by leadership staff.

In addition to dual loyalty, the HR-QIC has identified a wide range of systems-level interventions that can be applied to key areas of intersection between human rights and health care in the jail setting. One of the most important strategies has been to leverage our system-wide electronic health record (EHR) to assist in surveillance. Finding key data elements that might be flags for vulnerable patients and reporting on these data elements has allowed a level of surveillance that was previously impossible.<sup>4</sup> Because injury is such a prevalent problem in our setting and certain patterns of injury may reflect abuse, we implemented flags that allow us to collect data about injuries and patterns of injury to share with our partners in the security authority, including defining the incidence of traumatic brain injury in an incarcerated setting for the first time.<sup>5</sup> Data collection and analysis have also been key strategies for defining the health consequences of solitary confinement, which have led to progress in working with the security authority to establish alterna-

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<b>Human Rights Concern</b>	<b>Interventions Employed or Proposed</b>
Dual Loyalty	Training/Education Workflow Changes
Injury/Abuse	Electronic Health Record Flags/Surveillance Anonymous Reporting Data Analysis
Solitary Confinement	Data Analysis
Sexual Assault	Reporting Mechanisms Training/Education Data Analysis
Mass Incarceration/ Patient Confidentiality	Training/Education Physical Plant Changes Workflow Changes

tive management strategies for vulnerable populations.<sup>6</sup>

Other strategies include rethinking workflows to relieve dual loyalty pressure points and anonymous reporting of human rights concerns through an e-mail system established specifically for this purpose. Examples of interventions employed and considered appear in Table 1. Future directions include exploring ways in which the incarcerated setting influences traditional medical ethics concepts, including patient autonomy, beneficence, informed consent, non-maleficence, and confidentiality.

By leveraging current processes for quality improvement, we have been able to approach human rights

concerns with the same rationale and strategy that we use to address patient safety and medical error. The HR-QIC has had success in taking the abstract concept of human rights and operationalizing interventions to address specific areas of concern. In this way we hope to make attention to human rights part of the daily work of providing health care in the NYC jails. We argue that correctional health care leadership must be devoted to this key component of correctional health in order to adequately serve incarcerated patients.

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ground checks, resident notification, plan for supervision and monitoring by the department of corrections) increases the likelihood of denied admission. Prisoners with serious mental illness and a history of aggressive behaviors or those who experience frequent exacerbations of their illness that require hospitalization may be inappropriate candidates for deinstitutionalization.

Yet the prison setting is often not equipped to provide appropriate SNF-level care for such individuals. In May 2013, the State of Connecticut opened a specialized community-based SNF, known as “60

West,” for individuals transitioning from a correctional or state-run mental health facility. A dedicated facility such as 60 West can offer appropriate care that may not otherwise be available in a prison or state mental health facility. Facilities like 60 West offer an alternative to traditional SNFs and enable prisoners to receive appropriate care for their level of need.

Nearly two decades ago, Koenig et al.<sup>7</sup> described the prevalence of depression and anxiety in 95 male prisoners age 50 and older from one federal correctional facility and found that nearly 54% met one-month crite-

ria for these psychiatric disorders. Since publication of this seminal study, the number of older prisoners has nearly quadrupled, but only a handful of subsequent studies have evaluated mental illness in older prisoners. A policy and research agenda for older prisoners should: 1) incorporate more research on mental health, 2) highlight the challenges associated with releasing older prisoners with co-existing medical and mental health disorders, and 3) encourage the development of specialized facilities to care for older prisoners with SNF-level medical and mental health needs.

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## IN TRAINING

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rently in the prison system; one in 17 white men, one in six Hispanic men, and one in three black men in the United States will have been incarcerated at some point during his lifetime. You don't have to be a physician in prison to take care of patients who have been to prison.

Second, providers should be aware of the health risks associated with incarceration so that they understand the importance of asking. Rates of substance use and mental health disorders in correctional populations are estimated to be at least two to four times that of nonincarcerated populations.<sup>6</sup> These conditions not only compound the impacts of incarceration—suicide accounts for 50% of prison deaths worldwide—but also place patients at greater risk for reincarceration in the future.<sup>7</sup> Prisoners additionally experience higher rates of chronic conditions like asthma, hypertension, and arthritis as well as many infectious diseases. Seventeen percent of prisoners are estimated to have hepatitis C. Understanding a patient's history of incarceration will prompt providers to screen for hepatitis C and HIV and ask about health risks including time in solitary confinement or post-traumatic stress disorder following incarceration.

Third, providers should reflect on their personal biases in caring for patients with a history of incarceration. Implicit bias can directly impact the care that we provide to our patients. An incarceration history, in particular, reinforces stereotypes of criminality—black, dangerous, and deserving of punishment.<sup>8</sup> In a survey of patients recently released from prison, 42% perceived discrimination by health care providers related to their criminal records.<sup>9</sup>

Medical residency programs like the one at Yale train their residents in correctional health care by visiting prisons. Our residents often are surprised to learn that prisoners are the only group in the United States who are constitutionally guaranteed access to health care. Many prisoners see a medical provider for the first

time in their adult lives and as a result are diagnosed with a chronic condition while incarcerated. Routine access to care, housing, and food contribute to decreased mortality and decreased racial health disparities while in prison.<sup>10</sup> However these gains are far outstripped by the loss of services and rights on release, including bans on food stamps, public housing, educational grants, and voting. Even as the Affordable Care Act promises to expand Medicaid coverage for patients returning home from prison, patients can face persistent discrimination at the systems and provider level, eroding access to routine care and basic needs.

Primary care providers and trainees can be more attentive to these issues, simply by taking a thorough, yet thoughtful incarceration history. Rather than asking about criminal activity, directed questions about release date, length of incarceration, and probation or parole status can foster collaborative

discussions to reduce recidivism risk. Questions about new diagnoses or medications and about the challenges returning home from prison contextualize our patients' disease processes and management without further stigmatizing or stereotyping them.

When patients are released from correctional facilities, their health care support systems often vanish, leaving many of our sickest and most vulnerable patients without essential resources. Our lack of awareness about the specific needs of the prison population and about our own biases may cause patients to avoid primary care and mental health and substance use treatment. When we do not effectively engage these patients in care, we are left with what the statistics suggest and Abe's story illuminates—patients who disproportionately end up in emergency departments and inpatient wards almost surely are subject to iterative cycles of incarceration.

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and pilot interventions in correctional settings have demonstrated feasibility. Additionally, long-acting naltrexone, an opioid antagonist that does not cause euphoria and only requires monthly injections, is a promising pre-release treatment option. At the very least, identifying inmates at high risk for relapse and providing discharge planning and linkage to aftercare is a high priority.

As general internists, we can also improve medical care for formerly incarcerated individuals in several ways and possibly break the cycle of incarceration. Transitions clinics create a medical home for formerly incarcerated individuals and work with the criminal justice system to facilitate linkage to care following release from incarceration. Using community health workers who were formerly incarcerated can improve engagement in care while serving this population, and community-based organizations can help address competing needs, such as lack of housing, that contribute to relapse. Transitions clinics can offer office-based buprenorphine treatment or naltrexone and screen patients for relapse and referral to addiction specialists. Treating mental health conditions, which are often comorbid with opioid use disorder, may also prevent reincarceration. Physicians can also familiarize themselves with naloxone prescribing for prevention of opioid overdose.

Ultimately, my concern that Mr. Robinson would overdose was unfounded, but unfortunately he did relapse to heroin use. As we discussed his challenges in adjusting to post-prison life, he told me about his heroin use and interest in initiating buprenorphine maintenance treatment. Mr. Robinson has continued follow-up for HIV care and has maintained abstinence from illicit opioids. Although the risks of relapse and overdose remain, he is fully engaged in medical care and doing his best to break the cycle.

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tions," which are less stigmatizing terms than "prostitution" and "STDs."

Justice-involved and substance-abusing women have an increased likelihood of prior trauma that can negatively impact their health outcomes.<sup>22</sup> It has been shown that women in drug court who experience victimization are more likely to have experienced trauma such as child abuse by a personal contact or family member as compared to men, who are more likely to experience random community violence.<sup>23</sup> Such traumagenic factors are likely to be associated with affective disorders.<sup>23</sup> To address such disparities, a variety of gender-specific programs have been developed addressing HIV prevention,<sup>24</sup> hepatitis B and C testing,<sup>25</sup> and trauma-informed interventions.<sup>26,27</sup> There is some evidence that these programs can improve outcomes, but more research is needed. Lack of funding for such programs has limited their accessibility and prevented their widespread implementation.<sup>28</sup> Access to programs such as gender- and trauma-informed addiction treatment interventions varies by treatment organization.<sup>14,29</sup> Medical providers should assume that justice-involved women are likely to have a history of trauma. The medical encounter should include questions about past and ongoing experiences, safety planning, and referral to appropriate mental health and IPV agencies. Trauma-informed provider strategies avoid retraumatization by giving patients more control, being supportive, and avoiding judgment.<sup>30</sup> Emotional dysregulation, missed appointments, relapses, and recidivism can lead to such judgment. Motivational interviewing has been shown to be an effective tool in reinforcing healthy behaviors such as cessation of cigarette smoking<sup>31</sup> in stigmatized populations and can be a helpful way of structuring nonjudgmental interactions. Educating office staff to better manage the behavioral needs of traumatized patients can systemically increase physical and emotional safety for patients in clinical settings. Restructuring of the office to provide

physical comfort can be as simple as arranging the waiting room with enough distance between seats<sup>32</sup> to ensure adequate personal space.

While medical providers do not control justice system factors impacting patients, they should be aware of them in order to understand the context of care, potentially mitigate patient and public health impact, and express empathy. Racial bias in the system has a large impact. Women of color are disproportionately imprisoned at two to three times the rates of white women.<sup>33</sup> For every 100,000 women in the United States, 47 white women, 77 Hispanic women, and 133 black women will be incarcerated.<sup>3</sup> (Rates are even higher for men of color, contributing to racial disparities in opportunities and multi-generational risks.<sup>34</sup>)

Reentry into the community after incarceration can be especially challenging for women. Jobs, job training, housing, and education can be virtually impossible to obtain in many states where laws limit access for those with felony convictions.<sup>35</sup> Many states ban food stamps for people who have committed felonies; as such, 95% of those returning to society after incarceration meet criteria for food insecurity—a condition associated with increased HIV risk behaviors.<sup>36</sup> For women, these challenges can lead to abusive partners and/or sex work, thereby increasing their mental and physical health risks. Innovative projects designed to address these issues include reentry clinics, incorporation of legal assistance in medical settings, and inclusion of on-site social workers in large medical clinics.<sup>37,38</sup> For practices without these options, providers should offer lists of local community resources to patients.

In summary, justice-involved women are steadily increasing in number and face complex multi-dimensional challenges. Medical providers can facilitate care by addressing medical, psychiatric, substance abuse, and social risks. These risks should be addressed using non-stigmatizing and trauma-informed strategies.

References available online

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CA-HI Regional Meeting: January 10, 2015  
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