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Pandemics, Prisons, and Policy: An Overview of Criminal Justice and Public Health in Tennessee

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Executive Summary

The COVID-19 pandemic and its disproportionate impact on Tennessee's incarcerated population have exposed gaping deficiencies in access to healthcare within our state's criminal justice system. Incarcerated individuals experience higher rates of chronic and mental health conditions than the general population, and time spent incarcerated is associated with a significant decline in overall health. Those entering the criminal justice system encounter many barriers to adequate healthcare access, including fragmentation and lack of coordination of care, burdensome copays, privatization of correctional health, and lack of insurance prior to incarceration and after reentry. Reform is necessary to protect the health of one of our state's most under-resourced populations.

Introduction

Half of a person's health is determined by the social and economic conditions that influence health, commonly referred to as social determinants. Incarceration is a crucial and often overlooked determinant of health for an increasing percentage of our state's population. Time spent in prisons and jails can profoundly alter an individual's health, and the policies that lead to mass incarceration can impact the health of entire populations.

Tennessee has an incarceration rate of 853 per 100,000 people, which includes prisons, jails, immigration detention, and juvenile justice facilities.¹ This puts Tennessee's incarceration rate at the 10th highest in the United States, and higher than any other national incarceration rate in the world, including developed countries like Canada and the United Kingdom, authoritarian governments like Turkmenistan, and military dictatorships like Sudan.²

Between 1983 and 2015, the total number of people incarcerated in Tennessee nearly quadrupled, from 13,944 people to 47,697.³ However, during the past fifty years of rising incarceration rates, actual crime rates stayed relatively the same, and are similar today to rates in the 1960s, when the incarceration rate was a seventh of its current size.⁴ For most crimes in

Tennessee, sentences and time served has increased, leading to an aging prison population. In the past five years, the number of Tennessee inmates over the age of 65 has increased by 20%.⁵

Tennessee's state prison population is disproportionately Black. Though Black Tennesseans are 17% of the state's population, 40% of the state's prisoners are Black.⁶ As such, the health of Black communities, as well as low-income rural White communities, is disproportionately impacted by incarceration.⁷

The Tennessee Department of Corrections (TDOC) consists of 14 prisons across the state; four prisons are managed privately by CoreCivic, and ten are run by the TDOC.⁸ More than \$2 billion is spent annually on healthcare in the Tennessee public corrections system.⁹ Though 15% of prison costs in Tennessee are payments to healthcare providers, Tennessee faces rising costs in prison healthcare spending due to an increasing number of incarcerated people and an aging incarcerated population.

COVID-19

The disproportionate impact of COVID-19 on Tennessee's incarcerated population reveals deeper failings of our state's correctional healthcare system. COVID-19 case rates have been higher and escalating more rapidly in prisons than in the US population.¹⁰ The national infection rate for the incarcerated is more than 5 times higher than in the general population.¹¹ The death rate of inmates (39 deaths per 100,000) is also higher than the general population (29 deaths per 100,000).¹² For these reasons, the CDC has included the US incarcerated population as a priority group in public plans for mass distribution of a COVID-19 vaccine.¹³

Currently, jails (which house people before trial and serving short sentences) and prisons (which confine people long-term) are unfit for containing a pandemic.¹⁴ COVID-19 presents a unique challenge to prisons because of conditions of close confinement, restricted access to personal protective equipment (PPE), overstretched health services, and increased burden of cardiac and respiratory conditions that exacerbate COVID-19 risk and fatality.¹⁵ Lack of proper containment of COVID-19 is not only damaging to the incarcerated population, but also to staff and the local community.

As of August 2020, the ten largest COVID-19 outbreaks in the country have been linked to correctional facilities, with the 7th largest occurring at Trousdale Turner Correctional Center in Hartsville, TN.¹⁶ At Trousdale, 53% of inmates, or 1,299 people, tested positive for coronavirus.¹⁷ Another major outbreak occurred at South Central Correctional Facility in Clifton, where 81% of all inmates, or 1,144 people, tested positive for COVID-19. After the first incarcerated person tested positive on March 23, 2020, Tennessee implemented mass COVID-19 testing for Tennessee Department of Correction (TDOC) staff and inmates in April.¹⁸

As of January 8, 8,788 COVID-19 tests have been administered to Tennessee prisoners, or four per every ten prisoners.¹⁹ This rate of COVID-19 testing is 51% lower than Tennessee overall. Among TDOC staff, 1,338 individuals have been infected, and three have died.²⁰ Among the 50 states, Tennessee ranks 20th for the highest number of state prisoners infected with coronavirus per capita, with 6,353 total cases as of January 11, 2021.²¹ Significantly, this means there are

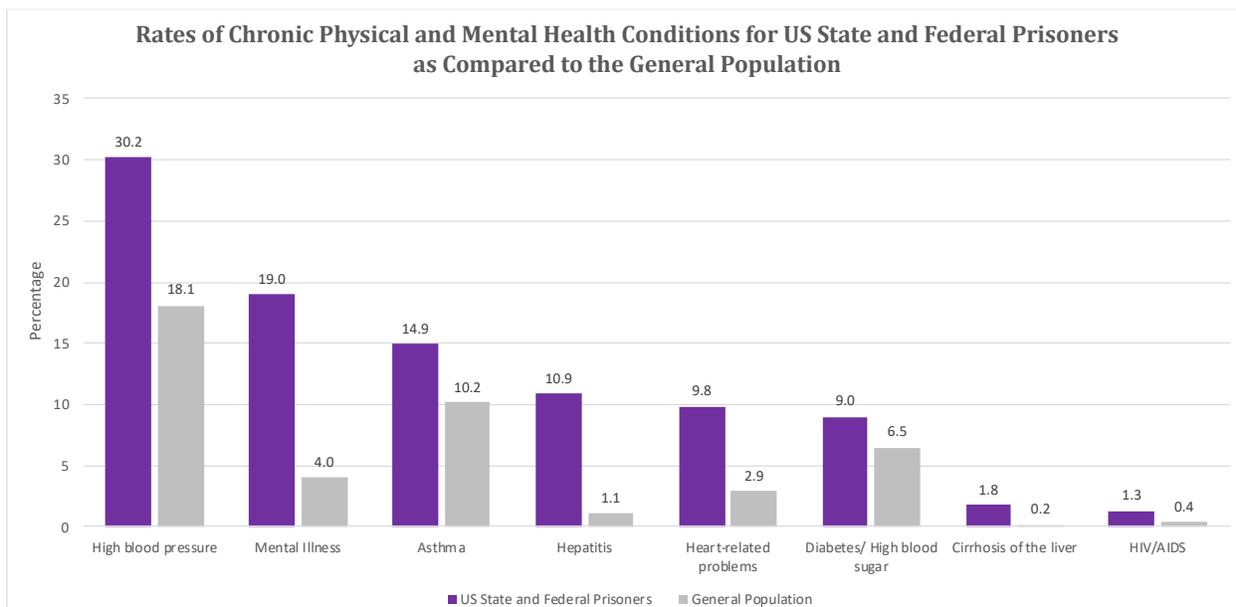
three known cases per every ten prisoners, which is 225% higher than Tennessee overall.²² There have been 34 total deaths, or 1 death out of every 640 prisoners, which is 48% higher than the state mortality rate.²³

These COVID-19 outbreaks in Tennessee prisons are symptomatic of a greater problem of public health in our state’s criminal justice system.

Incarceration-associated health disparities

Incarcerated people and non-incarcerated people have among the starkest health disparities of any population in the US. Due to a variety of factors—including the prevalence of adverse childhood experiences and adverse community environments, which are linked to poorer health outcomes in adulthood—incarcerated individuals experience significantly higher rates of chronic and behavioral health problems than the general population. Both prisoners and jail inmates are more likely than the general population to report ever having a chronic or infectious disease, a finding that holds true for every chronic condition and infectious disease measured.²⁴

A nationwide study found higher rates of many chronic medical conditions, including hypertension, diabetes, asthma, arthritis, and cervical cancer, among the incarcerated compared to the rest of the population, despite controlling for age, sex, race, and education.²⁵ Rates of infectious diseases, including COVID-19, tuberculosis, hepatitis B and C, HIV, and sexually transmitted diseases are higher among the incarcerated population than among the general US population.²⁶ In particular, HIV prevalence in correctional facilities is more than three times higher than in the general population.²⁷



Data source: The Commonwealth Fund

14.5% of men and 31% of women in jail have serious mental illness, compared to 5% in the general population.²⁸ Suicide is the leading cause of death in jails and prisons, accounting for nearly half of deaths during incarceration from 2000-2016.²⁹ 40% of jail deaths occur within the first week of incarceration, revealing the need for jails to accurately evaluate mental health during admission and provide adequate care in a timely manner.³⁰

67% of the prison population have a substance use disorder (SUD), compared to 38% in the general population.³¹ Despite such high rates of substance use in the criminal justice system and substantial evidence that treatment significantly reduces drug use and drug-related crime, only 15% of those who need treatment receive it while incarcerated.³²

What is the impact of incarceration on health outcomes?

Not only do those entering the criminal justice system have greater health needs, but the negative health consequence of incarceration is bleak. Mass incarceration decreases life expectancy, with one study suggesting that each year in prison corresponds with a two-year reduction in life expectancy.³³

Research shows that the prison environment itself can lead to serious mental health crises. A U.S. Department of Justice report on jail suicide stated that certain dehumanizing aspects of the jail environment can exacerbate suicidal behavior, including high cost of phone calls, restricted contact to family and friends, conditions of solitary confinement, and denial of access to proper medical care.³⁴

To better understand the health effects of the prison environment, numerous studies have examined change in individual health status during incarceration. The National Longitudinal Survey of Youth revealed individuals with a history of incarceration report more chronic health problems after their period of incarceration than before, even after accounting for these chronic health problems prior to prison. This demonstrates that time spent in incarceration is associated with a decline in health status and increased chronic health conditions.³⁵

Incarceration's effects on health outcomes extend beyond the individual, destabilizing the health of children. In Tennessee, about 1 in 10 children has had an incarcerated parent.³⁶ Currently, Tennessee has the third highest prevalence of incarcerated parents, with 19,198 children separated from a parent due to incarceration.³⁷ Parental incarceration increases their children's risk of substance use and future involvement in crime, which contributes to health problems later in life.³⁸ The loss of care, companionship, and stability can influence children's risk of numerous health conditions, including heart disease, obesity, diabetes, and early death, revealing a generational health impact of incarceration.³⁹

Despite such serious needs in the incarcerated population and the consequences of incarceration, prisoners rarely have access to adequate healthcare.

What are barriers to healthcare access for incarcerated individuals?

Prisoners have a constitutional right to healthcare while incarcerated through the Eighth Amendment’s prohibition on “cruel and unusual punishment.” This list of barriers, while not exhaustive, provides a glimpse into challenges that individuals face to access healthcare in the criminal justice system.

Insurance access before incarceration

Individuals in the criminal justice system are generally low-income and uninsured. Nearly six out of ten jail inmates reported a monthly income of less than \$1,000 prior to arrest.⁴⁰ Though data on uninsurance in the incarcerated population is limited, one survey from jails in San Francisco found that 90% of individuals who entered county jails have no health insurance.⁴¹ Officials from New York and Colorado, two Medicaid expansion states, estimate that between 80 to 90 percent of their prison populations would be eligible for Medicaid.⁴² Like Tennessee, North Carolina has not expanded Medicaid, and one study revealed only 2% of prison inmates were eligible for Medicaid.⁴³ Since the COVID-19 pandemic, unemployment has risen sharply, driving a new rise in the uninsured rate.

Lack of health insurance can have detrimental consequences for individual health. Uninsured individuals are less likely to practice preventative care, less likely to see a physician when ill, and more likely to delay care due to cost.⁴⁴ Uninsured individuals are also more likely to have chronic medical illness, receive cancer diagnoses at more advanced stages, and have a higher mortality rate.⁴⁵

Lack of coordination of care

The prison health system lacks the coordination necessary for local health providers to continue care for inmates after release. Physicians and medical providers in correctional facilities rarely coordinate care with community health providers.⁴⁶ This can be particularly detrimental for people transitioning from incarceration to community settings, as the first week in community following release is associated with a higher risk of injury or death.⁴⁷ The lack of coordination can also be a threat to those entering the criminal justice system. Clinicians who perform medical intake of prisoners rarely have protocols to gain access to patient history from community providers, which increases risk of clinical error or discontinuation of crucial medication, leading to overall poor health outcomes.

Fragmentation of care

Individuals moving in and out of the criminal justice system face a variety of challenges that contribute to fragmented care. As demonstrated, prisoners often have complex medical problems with complicated histories. Issues of poverty, unemployment, transportation, lower education levels, housing instability, and homelessness are prevalent among incarcerated people and persist after their reentry into the community.⁴⁸ Even with the availability of health services, it is often difficult for newly released individuals to access these services consistently, leading to lack of continuity that can cause inefficient allocation of health resources or harm to patients.

Copays

Charging inmates for health services contributes to lack of access to healthcare. In Tennessee, inmates are charged a \$3.00 medical copay for physician visits, medication, and other health needs.⁴⁹ Though not expensive at face value, these copays are paid by inmates who earn 17 cents an hour, meaning a Tennessee inmate would have to work for nearly 18 hours to afford a medical visit.⁵⁰ In an Illinois survey on the state's \$5 copay, 60% of prisoners reported that they avoided seeking healthcare because of the fee. A report also revealed that the amount of money earned by the state through charging copays was likely not enough to offset the expense of administering collection of the fees.⁵¹

Prison administrators have claimed that copays discourage inmates from abusing sick-call triage and encourages fiscal responsibility. As demonstrated above, the Tennessee prison population is largely poor, and copays can be a significant deterrent to seeking healthcare. Thus, copays deter inmates from receiving necessary medical attention, leading to prolonged spreading of infectious diseases and more aggressive and expensive treatments when medical attention is finally received.

Privatization of prisons and prison health care

Four of Tennessee's 14 prisons are operated by CoreCivic, which is the nation's largest for-profit prison company. CoreCivic has faced multiple lawsuits for denial of necessary medical care, including access to insulin for diabetic inmates.⁵² A federal lawsuit published recently alleges a mental health worker at a Tennessee CoreCivic facility falsified health records of treatment for an inmate who committed suicide in August 2019.⁵³ In Tennessee, prisons operated by CoreCivic have twice as many murders and a homicide rate more than four times higher than public state facilities.⁵⁴ These privately-run prisons have a particularly poor record of compromising inmate health and safety to lower costs, which is described in greater detail in the Policy Recommendations section.

Recent Tennessee Initiatives in Correctional Health

In March 2019, Republican Governor Bill Lee launched the Criminal Justice Investment Task Force, aimed at investigating challenges involving the criminal justice system and recommending data-driven state policies to address deficiencies.⁵⁵ One recommendation involved expanding community-based treatment options to prevent correctional facilities from being the primary providers of behavioral health care.⁵⁶ Another recommendation was to increase the use of methods for early identification of behavioral health needs to divert those who could be better served outside the criminal justice system.⁵⁷ While these recommendations have yet to be implemented, this bipartisan effort in improving correctional healthcare is a step in the right direction.

A highly critical audit, published in January 2020 by the Tennessee comptroller's office, revealed severe deficiencies in the administration of healthcare services within the Tennessee Department of Corrections. During the audit, the comptroller's office evaluated samples of prisoners' medical files, only to find that vital and necessary medical information, including

medication, mental health evaluations, and history of medical care, was missing in medical records of several inmates.⁵⁸ The office also determined that two state-managed facilities impeded inmates' access to forms and healthcare instructions.⁵⁹

While well-intentioned, these reports alone are insufficient to address the overwhelming deficiencies in our state's prison healthcare system. The passage of state-level policy that specifically targets improving healthcare for Tennessee's incarcerated population is necessary and long overdue.

Policy Recommendations

Stringent data collection and transparency

In light of COVID-19 outbreaks in American jails and prisons, Senator Elizabeth Warren (D-Mass) and Senator Cory Booker (D-NJ) cosponsored a bill that would require federal, state, and local correctional facilities to collect and publish COVID-19 case data, specified by gender, race, and other categories.⁶⁰ While other states have already implemented similar policies and disclosed the racial breakdown of positive cases in correctional facilities, Tennessee has not provided this information for its incarcerated population. Experts say this lack of data makes it difficult to plan an equitable response to COVID-19.⁶¹ To determine whether COVID-19 has been a disproportionate burden on certain racial or ethnic groups within the criminal justice system, rigorous data collection with release to the public must be implemented as state-level policy.

Meaningful continuous quality improvement (CQI)

Improving quality of care in correctional health begins with implementing a robust, independently evaluated quality monitoring system. Experts agree that establishing a quality monitoring system is necessary to achieve at least an adequate level of quality, improves quality of care provided, and informs states' understanding on efficacy of correctional health spending.⁶²

Tennessee, along with 34 other states, has a system of prison healthcare quality monitoring, where departments of correction monitor several clinical domains, including access to care, utilization of services, screening and prevention services, infectious disease, chronic disease, behavioral health conditions, and geriatric conditions.⁶³ However, unlike other states, Tennessee has not yet implemented a formal process to integrate findings from quality monitoring into decision-making and legislative and administrative oversight.⁶⁴

To fully benefit from the system of prison healthcare quality monitoring, the TDOC should be required by law to report on the results of CQI findings and proposed action plans to the Tennessee House Criminal Justice Committee and to the public, as a method of accountability. Additionally, the state should pass legislation making the data and statistics of the monitoring publicly available to inform the public, nonprofits, and legislators on the most beneficial practices in correctional health and areas with potential for improvement.

Employment of corrections medical director in every prison

In 2017, a judge in Tennessee released prisoners from Silverdale Detention Center after ruling that prisoners were not receiving proper treatment from Correct Care Solutions, now known as Wellpath.⁶⁵ The judge's order involved an inmate who had an "undisputed need" for cancer treatment, and that treatment had not been provided to the defendant. A January 2020 audit by the Tennessee Comptroller's Office determined two state-run prisons, Northwest Correctional Complex and Turney Center Industrial Complex, impeded inmates' access to information relating to healthcare, including access to grievance and sick call forms.⁶⁶ Correctional facility staff, operating under the assumption that the inmate is malingering or feigning illness, often dismiss prisoners' requests for healthcare services to detrimental effect.

Prison personnel without formal medical training should not serve as gatekeepers to healthcare. To ensure access to care, each prison in Tennessee should be required by law to hire a full-time medical director with clinical credentials and experience delivering services in correctional settings to ensure that medical needs of inmates are being met. Considering the destructive consequences of neglecting critical care, the policy should impose strict and severe penalties for noncompliance.

Increasing availability of chronic medical and mental health treatment during incarceration

One nationwide study found that among inmates with a persistent medical problem, 20% of state inmates and 68% of local jail inmates did not receive a medical examination while incarcerated.⁶⁷ Only 69% of prison inmates and 46% of jail inmates who had previously received psychiatric medication had taken medication for a mental condition since incarceration.⁶⁸

These statistics are unacceptable and reveal many inmates with serious physical or mental illness fail to receive minimal care while incarcerated. Broad improvements are needed in availability of treatment during incarceration that may prevent recidivism, as well as further crime and incarceration.

De-privatization of healthcare services

In Tennessee and across the US, correctional healthcare has become increasingly privatized. In 2017, the TDOC declined to renew the contract of Corizon, a private healthcare company, and instead awarded Centurion Health, another private healthcare company, a \$270 million contract to oversee healthcare in all public Tennessee prisons.⁶⁹ The recent audit by the Tennessee Comptroller's Office determined Centurion and Corizon did not meet contractual medical and mental health staffing levels, increasing the risk that inmates would not receive needed services.⁷⁰ CoreCivic has also faced multiple lawsuits in Tennessee, claiming inmates were denied timely access to insulin, as well as adequate cancer treatment.⁷¹ These prison healthcare providers have faced bipartisan criticism from state legislators for cutting costs at the expense of quality of care.⁷²

However, private prison healthcare can also be more costly than its counterpart. Though the TDOC assessed these private healthcare providers for \$2.1 million in contract noncompliance

issues, the state only collected \$92,020 after allowing them good-faith credits for self-reported areas of good performance or efforts.⁷³ A survey of nearly 70 federal prisons found that the vast majority paid more for medical services than Medicare rates.⁷⁴

In 2016, the Department of Justice announced its intention to de-privatize federal prisons, citing unsafe conditions within private prisons and reduced quality of care.⁷⁵ De-privatizing healthcare in Tennessee will similarly lower significant barriers to healthcare access during incarceration, with the potential to save money for the state.

Medicaid Expansion

Before the passage of the Affordable Care Act in 2010, most adults leaving incarceration were not eligible for Medicaid, despite having significant mental and physical health needs, because coverage did not include low-income adults without children. To date, 39 states (including D.C.) have adopted Medicaid expansion, expanding Medicaid coverage to all adults with incomes below 138% of the federal poverty level.

In Florida and Washington, individuals with severe mental illness who were enrolled in Medicaid before release from jail were more likely to access community mental health and substance abuse services than those without Medicaid.⁷⁶ One year after release, these Medicaid enrollees had 16% fewer detentions and had lower recidivism rates than those who had not been enrolled or had been enrolled for a shorter length of time.⁷⁷

After Medicaid expansion, Tennessee correctional facilities will be able to enroll eligible individuals into coverage through staff or external enrollment assisters. Increased coverage will facilitate improved access to comprehensive health services, including mental health and substance use treatment. This will have broad benefits both for the incarcerated and the general public, by leading to reduced crime and recidivism rates.⁷⁸

Conclusion

Mass incarceration and conditions of incarceration threaten public health and health equity in Tennessee. With an expanding and aging prison population, Tennessee prisons and jails have emerged as institutions in dire need of systemic change, both to ensure efficient use of state funds and to protect the health of those behind bars. Bipartisan calls for prison healthcare reform in Tennessee have been amplifying over the past five years, driven by lawsuits and news reports of incarcerated prisoners denied necessary care and paying the price with their lives.

Inadequate healthcare for individuals in the criminal justice system not only inflicts harm on incarcerated individuals, but their families and the local and state community. Medicaid expansion is an unprecedented opportunity for our state to advance criminal justice reform by ensuring access to healthcare before and after incarceration. Lowering barriers to healthcare access during incarceration involves structural changes and administrative improvements, as well as sweeping legislative reforms. By protecting the health and dignity of prisoners through comprehensive public policy, we can ensure a more humane, just, and equitable Tennessee.

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