

## ETHICS CASE

### What Does Health Justice Look Like for People Returning from Incarceration?

Case and Commentary by Lisa Puglisi, MD, Joseph P. Calderon, CHW, and Emily A. Wang, MD, MAS

#### Abstract

Access to health care is a constitutional right in the United States correctional system, and many incarcerated adults are newly diagnosed with chronic diseases in prison. Despite this right, the quality of correctional health care is variable, largely unmeasured and unregulated, and characterized by patients' widespread distrust of a health system that is intimately tied to a punitive criminal justice system. Upon release, discontinuity of care is the norm, and when continuity is established, it is often hindered by distrust, discrimination, poor communication, and racism in the health system. In this paper, we will propose best practices in transitioning from correctional- to community-based health care and argue that achieving health equity for people with criminal justice involvement in the United States is not possible without ethical provision of health care.

#### Case

Mr. C was released two months ago after a four-year prison sentence, shortly after having coronary artery bypass surgery for early onset atherosclerotic heart disease. At 42 years old, he was surprised and scared when his chest pain was diagnosed as a heart attack, necessitating major surgery while he was incarcerated. He was also told that there might be some problems with his kidneys, although he is unclear as to the specifics and does not have a copy of his medical records or his medications. Upon release he was homeless and has been staying with his mother in subsidized housing. This is a source of stress for her; because her son has a felony record, she worries that she is violating housing authority policy and could be evicted.

During his first visit to the community clinic, Mr. C shares with Joe, his community health worker, and subsequently with the health care practitioner that he is fearful of being reincarcerated. He feels weak and has not followed through with cardiac rehabilitation because he doesn't have transportation. His parole officer tells him that if he remains unemployed he will be in violation of his parole. Mr. C's stress has brought on cravings for heroin, which he has not used since being incarcerated. Mr. C's clinician and community health worker wonder if there is anything they can do to help him.

## Commentary

This clinical vignette represents a common scenario people find themselves in after release from prison and demonstrates the very difficult decisions they are faced with: Where will I live? Who will hire me if I have a felony record? How do I get my medications refilled? Can I trust my doctor? My doctor recommended buprenorphine to treat my cravings, but will I violate my parole by taking it?

As health care practitioners, we are largely untrained to even ask people about their incarceration history, so would it be reasonable to expect that we have the skills to help patients recently released from prison address their concerns and prioritize and consider their health goals? And, more broadly, what are the duties of the health system at large to interface effectively between patients who are returning to our communities and the criminal justice system from which they came? Before addressing these questions, we will first describe the burden of incarceration and associated illnesses in the United States and describe current norms of transitioning patients from the correctional health system to a community-based health care system.

### **Incarceration and Health in the United States**

Worldwide, the nation that is the largest jailer of its citizens is the United States [1]. As of 2014, there were approximately 2.2 million people in the United States behind bars [2], and in the 15 years prior to 2014 over 11 million people were admitted to jails annually [3]. The number of incarcerated people in the United States has risen dramatically since the mid-1970s to a point at which US incarceration rates dwarf the incarceration rates of any other Western democratic nation [1]. Black and Hispanic men, especially the young and noncollege educated, are incarcerated at relative rates that far exceed their white counterparts [4].

Incarcerated people suffer a greater burden of illness than the general population due to the widespread prevalence of communicable diseases (e.g., HIV, hepatitis C, syphilis), noncommunicable diseases (e.g., hypertension, cancers, asthma), and mental health and substance use disorders [5]. For example, at least 10 percent of incarcerated people are infected with [hepatitis C](#), which has a 1 percent prevalence in the general population [6]. Compounding the problem, an estimated 40 percent of incarcerated people with chronic conditions, like Mr. C, are diagnosed while in prison [7], where acquiring the skills to self-manage chronic disease is difficult given the punitive and restrictive policies of the penal system.

Ultimately, prison health care becomes a critical issue for community health systems, as 95 percent of the incarcerated population is released back to the community [8]. Incarcerated people face serious barriers caring for themselves upon release, such as poor health literacy, limited access to housing and employment, and difficulties

continuing their medications and accessing primary care [9]. Even in the 26 states that expanded Medicaid services by 2014 as part of the Affordable Care Act (ACA), many people have their Medicaid enrollment terminated upon incarceration, such that most are released without Medicaid and need to reapply [10]. That said, a growing number of states do enroll certain people in Medicaid upon incarceration or suspend their coverage as opposed to terminating the benefit [11].

These obstacles, along with poorly coordinated transitions of care between the prison and community systems, are thought to be some of the driving factors behind the high risk of death, hospitalization, and worsening health outcomes (e.g., increasing HIV viral load, relapse to substance use, elevated blood pressure) following release [12–15]. Mr. C, however, appears to have received at least a month supply of medication and been connected to primary care prior to release by the Department of Corrections.

### **Moving the Health System from Blockade to Buttress**

Enhanced methods of communication between the correctional and community health systems are essential for improving the health of this population. In contrast to current community standards for hospital discharge planning, for which the Centers for Medicare and Medicaid Services (CMS) clearly outlines recommended practices as a prerequisite to reimbursement [16], prison discharge practices in coordinating care across the country are inconsistent and underfunded [17]. Prison discharge plans range from nonexistent (i.e., no medications, medical records, or primary care appointments), to some planning by community-based organizations, to well-coordinated planning run by prison-based medical discharge planners who arrange for medications, medical records, and scheduling community appointments. Regrettably, without coordinated assistance, in our experience, health records are routinely not given to patients and the cost of obtaining records can be as high as two weeks of wages garnered behind bars.

Even when medical discharge is well planned, returning home from prison for those with chronic medical conditions is difficult. Most people's first priorities are access to food, finding somewhere to live, obtaining employment, reconnecting with families, and meeting the myriad stipulations of probation or parole. As a result, patients like Mr. C are often forced to make "trade-off decisions" that put their health at risk.

So how can health care practitioners and health systems address the medical and social complexities of caring for people just released from prison? We argue that achieving health equity is critical for the ethical provision of health care for the previously incarcerated. In her Gardener's Tale talk, Camara Jones, the physician and epidemiologist, defines health equity as assurance of the conditions for the optimal health for all people and asserts that achieving health equity requires: (1) viewing all persons and populations equally, (2) recognizing and rectifying historical injustices, and (3) providing resources according to need [18]. If we apply this framework to evaluate the provision of health

care for people who return to the community from correctional facilities, we can create an ethically sound path toward health equity.

### **Assessing the Needs of All Persons and Populations Equally**

Assessing the needs of all persons equally is a basic ethical duty of physicians, but we are not achieving this goal for corrections-involved populations. Viewing the previously incarcerated as equal to others in the health system is possible and requires that clinicians start by acknowledging that they might have implicit or explicit bias against criminals—viewing them as dangerous and deserving of incarceration, for example—and focusing on some of the modalities that show promise in addressing bias: pursuing egalitarian goals, identifying common identities, counterstereotyping, and perspective taking [19]. Hearing that someone has a criminal record can bring out fears and misconceptions of prison life and of those who commit crimes. We clinicians would like to think we are objective, but we are just as susceptible to being discriminatory based on a criminal record as employers, who have been shown to call back fewer than half as many equally qualified applicants with a fictive criminal record [20]. Although there is no consensus, from our personal experience, we believe it is important to [ask patients about their experiences](#) while incarcerated—for instance, their experience with trauma or solitary confinement, which pose individual health risks [21]. But asking details about a patient’s crimes is usually not medically relevant, can be emotionally taxing on the clinician, and might promote bias when documented in the medical record. The electronic health record—while meant to be a living and fluid document—can be one that tarnishes a person’s reputation and labels him or her as a certain “type of patient.” One can instead ask patients how one can best help prevent their reincarceration, which might elicit details about patients’ past substance use, poverty, and trauma, all of which are clinically relevant.

Additionally, why, ethically, would we require normative practices for hospital discharge in the general population and not require the same for people leaving correctional facilities? Not providing transition of care from prison to community is unethical because it relegates formerly incarcerated people to unequal treatment. We should, at the very least, provide patients with medical discharge summaries, a minimum supply of medications prior to discharge, and a primary care follow-up appointment. Furthermore, there should be a state-based oversight body that ensures standardized procedures for quality and safe discharges.

### **Recognize and Rectify Historical Health System Injustices**

Health care practitioners and systems must recognize and then rectify historical health system injustices. To start with, we are not currently educating health professionals to care for the population of incarcerated and formerly incarcerated patients; only 22 primary care residencies have any formal training on the health impacts of incarceration [22]. We must develop [curricula](#) to educate all health professionals in various stages of

training, develop competencies on caring for the previously incarcerated, confront race and racism and its impact on patient and community health, and train clinicians to work within correctional health care systems without becoming an arm of the penal system.

Rectifying injustices will require long-term, systems-level commitment and change. As part of building trust, facilitating communication, and rectifying historically unequal relationships between universities and hospitals and their surrounding communities, urban health systems—which are often large employers—have opportunities to provide meaningful work to people with a history of incarceration and to develop hiring and workforce development programs directly targeting this population. Realizing these opportunities will require changing current practices in hiring and restrictions in occupational licensing to permit hiring of people with incarceration histories in the health system and the creation of training that will support their success [23]. In the Transitions Clinic Network, of which we are a part, the provision of care for chronically ill people returning home from prison hinges on a team of clinicians led by a community health worker who has a history of incarceration and is specifically trained in the care of recently released people. Employing those with histories of incarceration in health care is critical to building bridges and regaining trust between formerly incarcerated patients and the health care system [24].

### **Advocate for the Provision of Resources According to Patient and Community Needs**

Lastly, we must advocate for the provision of resources according to patient and community needs. We, as community health clinicians, are continually confronted by patients living in extremes of poverty and social deprivation, where the safety-net institutions that exist do not sufficiently support their needs. We bear witness to a host of policies that prohibit people with felony convictions from meeting their basic needs—even after serving the terms of their sentences—and these “collateral consequences” (e.g., bans on food stamp and public housing eligibility, voting restrictions, and criminal record discrimination) have a significant impact on patients’ health and well-being [25]. Despite recent gains through the ACA, the areas of greatest need for this population—health insurance coverage, substance use treatment, [mental health care](#), and civic engagement [26]—must be prioritized, advocated for, and financially supported both within and outside of prisons. These resources are critical to people with a history of incarceration becoming active, healthy citizens.

### **Conclusion**

So what can Mr. C’s health care practitioner and community health worker do both to help him receive health care that is just and addresses the specific health risks he faces and to help him obtain social services? Mr. C’s health care practitioner can develop a plan for early initiation of medication-assisted treatment to [prevent opioid relapse](#) and prescribe naloxone to prevent overdose. Furthermore, the health care practitioner and community health worker can speak to his parole officer, with Mr. C’s permission, to

advocate for the medical necessity and safety of this plan. They can assess Mr. C's health literacy and offer guidance on self-care and medication adherence, with the understanding that he has never had to manage his own medications before. This guidance might involve identifying a convenient pharmacy, reviewing Mr. C's medication labels with him, and teaching him how to take the medication and how to obtain refills. The community health worker can work with the local housing authority (which manages low-rent or rent-free housing) and housing organizations (which assist those who don't otherwise qualify for housing) to advocate for Mr. C, identify housing resources of which he is not likely aware, and help circumvent the barriers and stigma that Mr. C will probably encounter because of his felony record. In each of these circumstances, knowing Mr. C has just returned home from prison provides critical context for understanding how best to create feasible action plans for chronic disease management and obtaining social services.

Until we approach the care of the millions of Americans with a history of incarceration through a health equity lens and acknowledge the role that health systems have in rectifying past and current injustices, we will inadvertently be complicit in perpetuating unethical care, and patients like Mr. C will not be able to achieve the levels of health and well-being they deserve and need to return to the community in a meaningful way.

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**Lisa Puglisi, MD**, is an assistant professor of general internal medicine at the Yale School of Medicine in New Haven, Connecticut. She is also co-director of Transitions Clinic Network-New Haven, a clinical program focused on providing postincarceration primary care in partnership with community health workers.

**Joseph P. Calderon, CHW**, is a community health worker with the Transitions Clinic Network in San Francisco, where he also teaches and trains community health workers. He has a passion for working with diverse and disenfranchised populations, leveraging his personal experience with incarceration to advocate the ideals of social justice and community investment.

**Emily A. Wang, MD, MAS**, is an associate professor at the Yale School of Medicine in New Haven, Connecticut, and co-founder of the Transitions Clinic Network. She has developed expertise in training formerly incarcerated people to become community health workers and researchers through community-based participatory research methods. Dr. Wang's research focuses on promoting health equity for vulnerable populations, especially people with a history of incarceration.

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