No. 09-1233

IN THE

# Supreme Court of the United States

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GOVERNOR ARNOLD SCHWARZENEGGER, *et al.*,
*Appellants,*

v.

MARCIANO PLATA and RALPH COLEMAN, *et al.*,
*Appellees.*

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**On Appeal from the United States District Courts for the Eastern District and Northern District of California**

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**BRIEF OF *AMICI CURIAE* AMERICAN PUBLIC HEALTH ASSOCIATION, AMERICAN NURSES ASSOCIATION, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, ACADEMY OF CORRECTIONAL HEALTH PROFESSIONALS, AND SOCIETY OF CORRECTIONAL PHYSICIANS IN SUPPORT OF APPELLEES**

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## INTEREST OF *AMICI CURIAE*[1]

*Amici* represent a broad array of health care professionals and researchers dedicated to improving public health. Many of *amici*'s members work in California's correctional facilities and therefore share a direct stake in the outcome of this litigation and its implications for the medical well-being and physical safety of correctional staff, prisoner-patients, and the public at large.

Founded in 1872, the American Public Health Association (APHA) is the oldest and most diverse organization of public health professionals in the world, with over 50,000 individual and affiliate members. APHA aims to protect all Americans and their communities from preventable, serious health threats. It seeks to ensure that community-based health promotion, disease prevention activities, and preventive health services are universally accessible in the United States. Through its two flagship publications, the peer-reviewed *American Journal of Public Health* and the award-winning newspaper *The Nation's Health*, APHA promotes the latest public health science.

The American Nurses Association (ANA) is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses. Founded in 1896, ANA develops the Code of

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[1] Pursuant to S. Ct. R. 37.6, counsel for *amici curiae* affirm that no counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity other than *amici curiae*, their members, or their counsel made a monetary contribution to this brief's preparation or submission. The parties have consented to the filing of this brief in letters submitted to the Court.

Ethics for Nurses and the standards of nursing practice, and it actively promotes patient safety, workplace rights, appropriate staffing, workplace and environmental health and safety, and the public health. With members in every state, ANA advances the nursing profession and public health through its constituent member associations. ANA and its affiliates collectively represent nearly 500,000 registered nurses.

The American Association of Public Health Physicians (AAPHP) was founded in 1954 to serve as the national voice of physician directors of state and local health departments. AAPHP represents physicians in all aspects of population medicine and advocates on their behalf to improve the public's health. AAPHP is noted for its expertise in broad areas of population and public health medicine, including correctional health care, disease control, policy and management training, and issues pertinent to health care access. As a recognized specialty, AAPHP represents physicians and their public health agenda in the American Medical Association House of Delegates.

The Academy of Correctional Health Professionals (ACHP) is a national organization founded in 2000 to provide educational and professional development tools to correctional health care professionals. ACHP works to promote education and information exchange within the correctional health care community, advance the science and ethical practice of correctional health care, and advocate for correctional health care excellence.

Formed in 1992, the Society of Correctional Physicians (SCP) is the nation's largest membership organization of doctors specializing in correctional health care. As the foremost physicians' professional

society in this field, SCP works with other correctional and non-correctional leaders in science, education, and policy to review, promote, and establish the highest ethical ideals and service standards in correctional medicine; to promote evidence-based clinical practice through continuing physician education; to encourage research in correctional health care issues; and to enhance the value of health care delivered to our incarcerated population.

For decades *amici* have developed, implemented, and promoted specific standards on the proper administration of prison health care to help correctional staff, governments, and courts understand the clinical needs of the prison setting. These standards are reflected in several published texts, including:

- The American Correctional Association's *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* (2002 & Supp. 2010) ("ACA Standards");
- The National Commission on Correctional Health Care's *Standards for Health Services in Prisons* (2008) ("NCCHC Standards");
- ANA's *Corrections Nursing: Scope and Standards of Practice* (2007); and
- APHA's *Standards for Health Services in Correctional Institutions* (3d ed. 2003) ("APHA Standards").

Originally published in 1976, the APHA Standards was the first set of professional health care guidelines for prisons and jails. Over the years, leaders in the field of correctional care—including penal medical directors, legal experts, educators, researchers, advocates, and correctional consultants—have periodically updated these standards to reflect current health care practices.

*Amici* believe that an understanding of these standards in the context of California's prison system will assist the Court's resolution of this case.

## INTRODUCTION AND SUMMARY OF ARGUMENT

In California's prisons, bathrooms and closets are being used for clinical examinations, JS1-App. 19a (findings of the three-judge court below); understaffed health care workers fear for their personal safety, *id*. at 107a; and inmates continue to die while they wait months or years to receive urgent medical care and medications. *Id*. at 112a, 115a. "As of mid-2005, a California inmate was dying needlessly *every six or seven days*" because the State failed to provide minimally adequate health care in its correctional facilities. *Id*. at 9a. By 2009, the death rate had barely improved, with one prisoner dying unnecessarily every eight days. *See infra* p. 23. Appellees filed this lawsuit to remedy these constitutional crises, among others.

California does not dispute the woeful health care conditions in its prisons or that its prison system is dangerously overcrowded. Indeed, Governor Schwarzenegger recognized the crisis caused by these deplorable conditions and declared a State of Emergency due to prison overcrowding on October 4, 2006. Four years later, that State of Emergency remains in effect.

Nevertheless, California accuses the court below of "[u]sing the guise of providing healthcare that complies with the Eighth Amendment . . . to undertake comprehensive institutional reform directed at prison crowding." Appellants' Br. 10. But prison overcrowding and systemic health care failures go hand-in-hand.

The Court need look no further than the factual findings below to determine that this case *is* about health care, and by any measure, the health care conditions in California's prisons are deplorable. They fail to meet even the bare minimum standards developed by *amici* to guarantee the possibility of adequate health care in prisons. Alleviation of overcrowding—the remedy ordered by the three-judge court—is necessary to improve health care in California's prisons because systemic structural limitations cannot otherwise be resolved.

The public health consequences are alarming if these problems remain unaddressed. In 2009 alone, California's prisons experienced over 300 extreme lapses in clinical care, resulting in 46 likely- or possibly-preventable deaths. Kent Imai, MD, *Analysis of Year 2009 Death Reviews* (Sept. 2010), p. 9 ("Year 2009 Death Reviews"), *available at* http://www.cphcs.ca.gov/docs/resources/OTRES_DeathReviewAnalysisYear2009_20100907.pdf (last accessed Oct. 29, 2010). And the conditions have consequences beyond prison walls. Infectious diseases are rampant within prisons. As they spread due to cramped living quarters and risky behavior among inmates, communicable diseases present health risks to prison workers, visitors, and the community at large.

*Amici* offer this brief to explain the severity and immediacy of the public health crisis caused by prison overcrowding and to elaborate on the appropriate health care standards for correctional facilities. The published standards of *amici* are nationally-recognized as required care, and many of the benchmarks set forth in this brief have been adopted

in consent decrees and endorsed by courts.[2] This Court previously has found such model rules helpful in understanding the proper administration of prison care. *See Estelle v. Gamble*, 429 U.S. 97, 103-104 n.8 (1976) (citing various prison standards).

*Amici* recognize the political challenges here. Prisoner rights are often low on governmental priority lists, perhaps even more so during challenging fiscal periods. But we are not suggesting the need for state-of-the-art care or even average facilities, staffing, and access to care. California lacks the *bare minimum* needed to treat those patients who suffer from serious medical conditions. Tellingly, although California's *amici* questioned the utility of professional standards, Br. of *Amici* Louisiana et al. 18-21, they did not propose alternative benchmarks or even attempt to defend the conditions in California's prisons.

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[2] *See, e.g.*, *Harris v. City of Philadelphia*, 35 F.3d 840, 843 (3d Cir. 1994) (APHA and ACA standards incorporated into consent decree); *Williams v. Cearlock*, 993 F. Supp. 1192, 1196 (C.D. Ill. 1998) (prison system accredited by ACA found to be constitutionally adequate); *Tumath v. County of Alameda*, No. C 95-3289, 1996 WL 660611, at *3 (N.D. Cal. Nov. 6, 1996) (prison system accredited by NCCHC found to be constitutionally adequate); *Palmigiano v. DiPrete*, 737 F. Supp. 1257, 1261 (D.R.I. 1990) (accepting expert testimony based on APHA medical standards); *Cody v. Hillard*, 599 F. Supp. 1025, 1028 (D.S.D. 1984), *aff'd*, 799 F.2d 447 (8th Cir. 1986), *on reh'g*, 830 F.2d 912 (8th Cir. 1987) (evaluating prison conditions "based in part on the degree of compliance with the 'most important' correctional standards promulgated by two nationally-recognized associations of experts in the field of corrections: the American Correctional Association (ACA) and the American Public Health Association (APHA)"); *Nobles v. Duncil*, 505 S.E.2d 442, 451 (W. Va. 1998) (prison system accredited by NCCHC found to be constitutionally adequate).

Our standards constitute the *minimum* conditions necessary to provide required health care in prisons. They do not reflect, for example, best practices at community hospitals. As professionals who have dedicated our careers to the study of correctional health care and public health, we appreciate the challenges and unique features of prisons. That understanding is reflected in our recommendations and conclusions here.

## ARGUMENT

Following a month-long trial, the three-judge court below found that California has failed to provide minimally adequate health care due to the deplorable conditions in California's correctional facilities. Based on the findings of fact in this lawsuit, we agree. California prisons do not meet our nationally-recognized standards for required medical care. *Amici* designed these standards not only to protect prisoner-patients, but also to ensure the health and safety of health care practitioners, correctional staff, and the community at large. California's failure to comply with these minimally adequate standards creates public health problems that reach beyond the prison walls.

### I. HEALTH CARE IN CALIFORNIA'S PRISONS FALLS WOEFULLY SHORT OF MINIMALLY ADEQUATE STANDARDS

Inmates have no choice in their health care provider. "[H]aving stripped them of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course." *Farmer v. Brennan*, 511 U.S. 825, 833 (1994). Our Constitution does not tolerate a government official's

deliberate indifference to the serious medical needs of prisoners. As the Court recognized in *Estelle v. Gamble*, "[a]n inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met." 429 U.S. at 103.

Prison overcrowding can jeopardize, and often prevents, the delivery of adequate health care to prisoner-patients. Although overcrowding can adversely impact all aspects of health care in prisons, it directly inhibits the system's ability to provide sufficient facilities, staffing, and access to care.

### A. California's Prison Facilities Impede the Delivery of Proper Care in Violation of National Standards

In California's prisons, "available clinical space is less than half of what is necessary for daily operations." JS1-App. 93a. At Avenal State Prison, for instance, "staff must attempt to provide care for 7,525 inmates in space designed for less than one-third of that number." *Id.* The lack of adequate office and treatment space is "endemic in the CDCR [California Department of Corrections and Rehabilitation]." *Id.* Corrections experts uncovered a shortage of clinical space at nearly every facility, including California Institution for Men, Valley State Prison for Women, San Quentin, North Kern State Prison, Pleasant Valley State Prison, California State Prison-Solano, the Substance Abuse and Treatment Facility at Corcoran, the Correctional Training Facility, and California State Prison-Los Angeles County. *Id.* at 93a-95a. The space shortage is a direct result of the overcrowded population. As the Receiver appointed to oversee prison operations in California concluded, "[t]here is a dire need for additional clinical space . . . in the prisons because the existing capacity has been

swamped by the number of inmates in the system." *Id*. at 95a.

Similarly, none of the CDCR's designated reception centers were "designed or constructed with adequate clinical space." JS1-App. 87a. "To make matters worse, as the original prisons designated for reception became overwhelmed by the influx of parole violators, the CDCR was forced to 'convert' general population prisons into reception centers. These 'conversions,' however, were not accompanied by adequate additions to clinical staff or clinical space." *Id*. As a result, rooms are "so small that it would be difficult if not impossible to perform an actual physical examination in them." *Id*. at 88a.

Even where available clinical space—albeit limited—exists, the conditions of those facilities are deplorable. In San Quentin, a nursing expert described the treatment setting:

> [T]he area used for nursing triage [was] a small room at the end of the tier that the nurse accesses by walking through a gate and into the men's showers. . . . Because of a clogged shower drain, standing water was present outside the clinic door. Inside, the room was filthy. The furniture was old and in disrepair. There was no examination table, medical equipment or supplies, or handwashing facilities. According to staff, equipment (otoscope [an instrument used to examine the ear]) requested for this area had been denied. As well, there was no telephone or computer access. Prior to this room being used, a broom closet on the fourth tier was used for nurse triage.

JS1-App. 19a. In short, the nursing expert concluded, the "conditions are deplorable and have no resemblance to a medical setting whatsoever." *Id.* at 20a.

San Quentin is not an isolated example. "Many clinics [did] not meet basic sanitation standards. Exam tables and counter tops, where prisoners with infections such as Methicillin-Resistant Staph Aureus (MRSA) and other communicable diseases are treated, [were] not routinely disinfected or sanitized." JS1-App. 27a. And other "facilities require[d] fundamental repairs, installation of adequate lighting and such basic sanitary facilities as sinks for hand-washing." *Id.* Indeed, "lack of adequate hygiene ha[d] forced the closure of some operating rooms." *Id*. At the time of trial in late 2008, these dreadful conditions remained the status quo. *See id*. at 85a-95a.

These findings demonstrate that California's prison facilities are wholly unsuitable to meet the health needs of inmates. "We are dealing not with deferred maintenance, but with some facilities that are literally falling apart." JS1-App. 93a. It is unrealistic to expect clinical physicians and nurses—whom *amici* represent and support—to perform their jobs adequately in such conditions, which fall far short of *amici*'s standards for prison facilities. To provide basic care, clinics, infirmaries, and other medical care facilities must include at the very least: examination, treatment, and isolation rooms; toilets and sinks; nursing stations; adequate lighting; central and general storage; and medical records storage. APHA Standard II.E.1; *see also* NCCHC Standard P-D-03. Health care staff must have office space to maintain files and have access to telephones, facsimile machines, copiers, and properly-equipped computers with appropriate software. APHA Standard II.E.1.

And while it should go without saying, medical areas must meet basic sanitary requirements, must be adequately disinfected and sterilized, and must include necessary equipment to treat and care for patients. *Id*. California's prison facilities, as noted, fail to meet these basic requirements.

Moreover, California does not have sufficient clinical space to ensure, much less foster, confidential patient communication. "Exams are conducted in areas separated only by a thin white fabric folding screen that is approximately five to six feet tall[,] and conversations between physicians and inmates can be overheard on the other side of the screen." JS1-App. 88a. At North Kern State Prison, inmate health interviews "are conducted in a small office, with prisoners sitting back to back, separated only by a shoulder-high divider." *Id*. As a result, "fundamental medical confidentiality rights are routinely ignored." *Id*. at 94a.

This is unacceptable. Health care services must be provided in private settings to ensure patient-provider confidentiality and encourage the patient's subsequent use of medical care. *See* American Medical Association, Code of Medical Ethics Opinion 5.05—Confidentiality (2007), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/ code-medical-ethics/opinion505.shtml (last accessed Oct. 29, 2010). This core requirement applies in the prison setting as well. APHA Standards II.E & III.B.4; NCCHC Standard P-A-09; ACA Standard 1-HC-3A-10. Indeed, the need for a private setting is heightened in prison where the patient lives in crowded quarters with other prisoners who could use and abuse medical information about the prisoner. Prisoners forced to convey their health information in

front of other prisoners, therefore, are particularly unlikely to communicate frankly about the nature or extent of their medical needs, thereby thwarting the clinician's ability to diagnose and provide appropriate care.

### B. California's Prison Clinical Staffing Prevents Even Basic Medical Care in Violation of National Standards

California's clinical staffing record is similarly poor and a direct consequence of overcrowding. The three-judge court found a chronic shortage of medical personnel. Existing employees were insufficiently credentialed and not equipped to handle their basic responsibilities.

"Defendants' own data demonstrates significant vacancy rates for medical staff. As of August 2008, 20 percent of chief physician and surgeon positions, 25 percent of physician positions, 19 percent of physician assistant positions, 39 percent of nurse practitioner positions, 10 percent of registered nurse positions, and 18 percent of licensed vocational nurse positions remained vacant." JS1-App. 105a. These staffing shortages led to predictable "significant appointment delays," *id*. at 106a, and an inability "to develop required medical programs, including the chronic and preventive care programs." *Id*. Even if California could mount a successful recruitment campaign, prisons "would not have sufficient space for clinical staff if all of the clinical positions currently budgeted were filled, let alone if new positions were created and filled." *Id*. at 107a.

The court also found that prison health care workers were ill-equipped to perform their duties. "According to one court expert, 20-50% of physicians at the prisons provide[d] poor quality of care." JS1-App. 28a.

"CDCR nurses often fail[ed] to perform basic functions, such as taking vital signs, conducting examinations, and identifying urgent medical issues requiring immediate referral to a physician." *Id.* at 26a. Prison administrators share the fault for these lapses because "the CDCR's lack of a medical credentialing policy resulted in many CDCR clinicians' practicing outside of their areas of medical expertise." *Id.* at 28a.

These staffing deficiencies stem from California's prison overcrowding. The court concluded: "[c]rowding [] makes it impossible for the CDCR to hire the additional staff necessary to provide constitutionally adequate medical and mental health care to the current population." JS1-App. 105a. "[M]any newly-hired clinicians will be unwilling to risk their professional credentials and reputations by practicing in an environment where their patients are at risk of harm because among other things adequate clinical space is scarce, appointments are not scheduled, complete medical records are unavailable, and medications are not delivered." *Id.* at 107a.

Again, these prison staffing practices are an affront to *amici*'s minimum standards. The staffing level for prison health care programs must be of sufficient size and composition to provide prisoners with adequate health care. APHA Standard II.C.1; NCCHC Standard P-C-07; ACA Standard 1-HC-4A-05. This requires staff for direct treatment services as well as for consultation, training, administration, evaluation, and quality improvement. APHA Standard II.C.1. Budgetary resources to support recruitment and employment of health care staff must be on par with the cost of care for non-incarcerated populations, APHA Standard II.C.3, and staff must be appro-

priately trained and not be asked to perform health services beyond their training. APHA Standard II.C.10; NCCHC Standard P-C-01; ACA Standard 1-HC-2A-03.

Moreover, adequate staffing is not just about new hires; California must also retain the qualified clinicians already serving the prison population. Service coverage by physician's assistants, nurses, and administrative personnel must be relatively stable to assure that health services are adequately planned, delivered, and monitored. APHA Standard II.C.4. Yet, staff shortages and high turnover persist because "crowding interferes with the ability to recruit, hire and retain competent medical personnel." JS1-App. 107a.

### C. California's Prisons Prevent Needed Access to Care in Violation of National Standards

Overcrowding also has a direct and negative impact on inmates' access to care. Adequate access to care is the rudimentary goal in any health care system. It encompasses a patient's timely access to basic medical services and medication, a provider's access to accurate medical records, and an adequate emergency response system. Incarcerated individuals have the same right as those in the community to access an appropriate level of care in a timely fashion. APHA Standard I.B; *see also Estelle*, 429 U.S. at 103 (recognizing "the government's obligation to provide medical care for those whom it is punishing by incarceration").

But in California's prison system, none of these basic requirements are met. "Inmates are forced to wait months or years for medically necessary appointments and examinations, and many receive

inadequate medical care in substandard facilities that lack the medical equipment required to conduct routine examinations or afford essential medical treatment." JS1-App. 9a. In one instance, "inmates with consultation referrals from early 2004 had yet to be seen in May 2005." *Id.* at 25a. At Avenal State Prison, an expert observed "1,293 pending specialty referrals, 316 urgent and 977 routine. Of the 316 pending urgent referrals, only approximately 105 had an appointment date, with only 2 of the 316 urgent referrals—a dismal 0.6 percent—scheduled to take place within the fourteen-day period . . . ." *Id.* at 115a.

Similarly, inmates must endure extreme lapses in the supply of medication because "the management of prison pharmacy operations was 'unbelievably poor.'" JS1-App. 27a. This, too, is caused by overcrowding. As the three-judge court found, "crowding prevents defendants from achieving an adequate medication delivery system that is marked by the timely delivery of the correct medication to the correct patient . . . ." *Id.* at 112a. "Defendants' medication delivery systems are inadequate for the size of the population they serve, and are plagued by short-staffing at a number of prisons . . . . [Consequently,] prisoners receive their medications late or not at all, and suffer as a result." *Id*.

These shocking delays and lapses in medical access flaunt national standards and deny any meaningful medical care. Prison officials must provide prompt hospitalization and specialty care (e.g., surgery and orthopedics) to patients in need of those services, and inmates are entitled to receive the treatment and diagnostic tests ordered by clinicians. APHA Standards III.D & F; NCCHC Standards P-D-04, D-05, & E-12; ACA Standards 1-HC-1A-05, 09, & 16. Prisons should have prescription-based medication

delivery systems that guarantee prisoners will receive, without interruption, chronic medication in a timely and continuous manner, as directed by the prescribing physician or provider. APHA Standards, Chapter 4: Chronic Care Management; NCCHC Standard P-D-02. To that end, every prison must have a secure pharmacy appropriate to the size of the prisoner population served. APHA Standard VI.G; NCCHC Standard P-D-01; ACA Standard 1-HC-1A-35.

California's inability to process and store medical records exacerbates its poor delivery of care. "CDCR cannot track and transfer essential health care records, because the record system lacks the capacity to deliver records regarding this many prisoners." JS1-App. 118a. Medical records were "dangerously incomplete" in the opinion of one expert. *Id.* at 119a. "Medical records in most CDCR prisons were either in shambles or non-existent . . . mak[ing] even mediocre care impossible." *Id.* at 27a. As a result, CDCR has "failed to develop or implement a system to track and treat inmates with chronic care needs," *id.* at 25a-26a, even though an accurate and complete health record is an essential instrument for delivery of health services and must be available for every prisoner. APHA Standard II.F; NCCHC Standard P-H-01 & H-04; ACA Standard 1-HS-4A-06; *see also* American Medical Association, Code of Medical Ethics Opinion 7.05—Retention of Medical Records (1994), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion705.shtml (last accessed Oct. 29, 2010).

Overcrowding also prevents correctional staff from adequately responding to medical emergencies. Emergency care and access to urgent medical

treatment must be available at all times, 24 hours per day. APHA Standard III.E; NCCHC Standard P-E-08; ACA Standard 1-HC-1A-08. Emergency requests should be reviewed immediately, and correctional staff with emergency skills must be able to enter any living area within 60 seconds to evacuate or treat prisoners in emergency situations. APHA Standard I.B.3 & B.10; *see also* ACA Standard 1-HC-2A-14 (four-minute emergency response). Patients requesting non-emergency medical assessments should be triaged or seen by independent licensed practitioners within 24 hours of their requests. APHA Standard I.B.3; NCCHC Standard P-E-07.

California's prisons do not have the capacity to achieve these standards. Overcrowding and understaffing seriously inhibit the ability of prison staff to identify and respond to medical emergencies:

> In a housing unit such as San Quentin's H Unit Dorm 2 (one officer for 200 prisoners) or CIM's West Facility Cleveland Hall (two officers for 198 prisoners) or East Facility Gym (two officers for 202 prisoners), staff in an emergency can only sound the alarm, make frantic telephone or radio calls, and hope for backup. An officer alone with several hundred inmates is unlikely, for example, to perform emergency first aid or CPR—it is simply unsafe to do so with no backup, when prisoners could easily simulate an emergency as a diversion. The inability to perform basic lifesaving functions could have potentially devastating consequences on the life and health of a prisoner undergoing a medical or mental health emergency. This situation presents an unacceptable risk of harm to prisoners.

JS1-App. 111a.

At trial, a former California prison official described the assault of one prisoner in a crowded gymnasium that had been converted to overflow housing. Because of overcrowding and understaffing, prison officials did not learn of the assault—much less provide emergency aid—until after the victim had died. *See* Trial Tr. 382:2-383:3.

It is readily apparent why California does not attempt here to defend the conditions of its prisons. Clinical facilities are few and filthy, staffing is low and strained, and access to care is delayed or nonexistent. California's prison system fails almost every benchmark established by *amici* to guarantee the possibility of minimally adequate health care.

## II. CALIFORNIA'S SUBSTANDARD DELIVERY OF HEALTH CARE IN PRISONS THREATENS PUBLIC HEALTH AND RESULTS IN UNNECESSARY, PREVENTABLE DEATHS.

California's inability to provide adequate medical care results in preventable deaths and an increased spread of infectious diseases both within and beyond correctional facilities.

1. Cramped living conditions and risky behavior lead to exceptionally high rates of infectious diseases in prisons. Inmates have a disproportionately greater prevalence of tuberculosis (TB), hepatitis C virus (HCV), and HIV/AIDS, among other diseases. Cindy Weinbaum et al., *Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings*, 52 Morbidity and Mortality Weekly Report 1, 1 (Jan. 24, 2003); *see also* Niyi Awofeso, *Prisons as Social Determinants of Hepatitis C Virus and Tuberculosis Infections*, 125 Pub. Health Reports 25, 31 (Supp. 4

2010) ("As social determinants, prisons exert a particularly strong influence on the epidemiology of HCV and TB infections."). Nationwide, tuberculosis case rates in correctional populations are ten times higher than the general population;[3] hepatitis C rates are 8-20 times higher;[4] and HIV rates are 5-10 times higher.[5]

In California's prisons, elevated infection rates are a direct result of overcrowding. According to Scott Kernan, then-Chief Deputy Secretary of the Division of Adult Institutions for California's prisons, overcrowding "has led to increased numbers of infectious disease outbreaks," including eleven different outbreaks (or possible outbreaks) of tuberculosis at seven California prisons. JS1-App. 102a. Other experts echoed concerns about increased outbreaks of infectious diseases, *id.*, and Dr. Ronald Shansky

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[3] Jessica R. MacNeil et al., *An Unanswered Health Disparity: Tuberculosis Among Correctional Inmates, 1993 Through 2003*, 95 Am. J. of Pub. Health 1800, 1800 (2005).

[4] Amy E. Boutwell et al., *Opportunities to Address the Hepatitis C Epidemic in the Correctional Setting*, 40 Clinical Infectious Diseases S367, S367 (Supp. 5 2005) ("[R]ecent estimates of the magnitude of the HCV epidemic in prisons are staggering. . . . These rates indicate that the prevalence of HCV among prisoners is 8-20 times higher than that of the general US population."); Zulficar G. Restum, *Public Health Implications of Substandard Correctional Health Care*, 95 Am. J. of Pub. Health 1689, 1689 (2005) (hepatitis C infects more than 41% of California inmates, compared with less than 2% of the state's general population).

[5] Lois M. Davis et al., RAND Corporation, *Prisoner Reentry: What Are the Public Health Challenges?* (2003), p. 2 (HIV rates 8-9 times higher; AIDS rates 5 times higher), *available at* http://www.rand.org/pubs/research_briefs/RB6013/ (last accessed Oct. 29, 2010); Restum, *supra* note 4, at 1689 (estimating a prison HIV "rate 10 times higher than among nonprisoners").

concluded, "[u]ntil CDCR reduces its population, it will remain highly vulnerable to outbreaks of communicable diseases, including staph infections, tuberculosis and influenza." *Id*.

High infection rates intensify the need for adequate screening and medical care. As previously noted, California's screening and treatment fall woefully short of nationally-recognized standards. Exacerbating the situation, California's prisons lack protocols to treat hepatitis and HIV, among other chronic illnesses. JS1-App. 15a. Thus, overcrowded conditions in California foster a dangerous escalation of disease transmission: inmates enter prison with high infection rates, overcrowding increases the spread of infectious diseases, and clinicians cannot mitigate transmission risks without adequate prisoner screening and treatment options. As explained above, correctional health care workers lack the resources needed to adequately screen or treat prisoners because of overcrowding.

2. The epidemiological consequences of California's substandard delivery of correctional health care reach beyond the prison walls. Correctional facilities are open, not closed, societies—as visitors, guards, administrators, and clinical staff enter prisons and jails every day and return home to their communities each night. Additionally, 171,556 California prison inmates reentered the general population in 2008. CDCR, *Corrections Moving Forward* (2009), p. 8. The turnover rate in jails is considerably higher; local jails experienced a *weekly* turnover rate of 63.7% nationally in 2009. Bureau of Justice Statistics, *Jail Inmates at Midyear 2009—Statistical Tables* (June 2010), p. 7, *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/jim09st.pdf (last accessed Oct. 29, 2010). Collectively, about 10 million people are released

from incarceration each year in the United States. Timothy P. Flanigan et al., *HIV and Infectious Disease Care in Jails and Prisons*, 120 Transactions Am. Clinical & Climatological Assoc. 73, 74 (2009).

This revolving door of correctional staff, visitors, and prisoner-patients makes it imperative to include incarcerated populations in community-based disease prevention and control strategies. Otherwise, their reentry into society will exacerbate the community's health care issues. Prison intervention and treatment is also fiscally prudent. "Improved access to medical care and prevention services for incarcerated populations can benefit communities by reducing disease transmission and medical costs." Weinbaum, *supra*, at 1. For example, "[l]eft unchecked, chronic liver disease stemming from hepatitis B and hepatitis C is projected to cost our nation's health care system more than $85 billion annually within 15 years and ravage minority populations, including millions within the African-American, Latino and Asian-American communities." Lorren Sandt, Roll Call, *Bipartisan Support Grows for Addressing Nation's Hepatitis Scourge* (Nov. 6, 2009), *available at* http://www.rollcall.com/news/40349-1.html (last accessed Oct. 29, 2010).

Incarceration represents a valuable opportunity to improve public health by treating underserved—and generally inaccessible—individuals. Community public health institutions struggle to provide services to the type of individuals in the prison population. In contrast, correctional health care professionals have direct access to this at-risk group and can address serious public health issues during incarceration, so long as those professionals are equipped with adequate resources.

California's inability to identify, treat, or mitigate the spread of infectious diseases is a missed opportunity for intervention. *See* Cindy M. Weinbaum et al., *Hepatitis B, Hepatitis C, and HIV in Correctional Populations: A Review of Epidemiology and Prevention*, 19 AIDS S41, S45 (Supp. 3 2005) ("Although correctional facilities are only required to provide adequate, reactive healthcare, entry into the correctional system provides an opportunity for a population at risk of HBV, HCV, and HIV infections to access preventative healthcare, including immunization, health education, substance abuse treatment, and risk reduction."); Awofeso, *supra*, at 30 ("In relation to HCV and TB infections, adequate interventions to limit transmission and to promptly treat infected inmates constitute a public health opportunity to reduce the burden of these diseases."); Centers for Disease Control and Prevention, *HIV Testing Implementation Guidance for Correctional Settings* (Jan. 2009), p. 5 ("The implementation of HIV testing in correctional settings is an important consideration in reducing the annual number of new HIV infections occurring in the United States."), *available at* http://www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings/pdf/Correctional_Settings_Guidelines.pdf (last accessed Oct. 29, 2010). Because 1.3 million individuals who are infected with hepatitis C are released from prison annually, intervention and mitigation "efforts would affect not only the incarcerated population but also the community at large." Grace E. Macalino et al., *A Missed Opportunity: Hepatitis C Screening of Prisoners*, 95 Am. J. of Pub. Health 1739, 1740 (2005).

3. As a result of lapses in clinical care attributable to chronic overcrowding, incarceration too often becomes a death sentence for many California inmates.

"[I]t is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's medical delivery system." JS1-App. 25a (2005 findings). In 2007, "better medical management or a better system of care would likely have or may have prevented the patient's death" in 40 percent of natural, unexpected deaths. *Id*. at 124a-125a. In 2008, that statistic rose to 43 percent. Kent Imai, MD, *Analysis of Year 2008 Death Reviews* (Dec. 14, 2009), p. 9 ("Year 2008 Death Reviews"), *available at* http://www.cphcs.ca.gov/docs/resources/OTRES_DeathReviewAnalysisYear2008_20091214.pdf (last accessed Oct. 29, 2010).

California's prisons have seen little improvement, as catastrophic failures in the past continue today. In 2009, the Receiver observed 101 "severe lapses in care" in the 46 likely- and possibly-preventable deaths—more than two severe medical lapses per death. Year 2009 Death Reviews at 9. Even in deaths determined to be "non-preventable," the Receiver noted 205 severe lapses in medical care. *Id*. Overall, the most common lapse was a failure to recognize, identify, or adequately evaluate important medical symptoms or signs. *Id*. According to the Receiver, "It's not that we've got bad clinicians. It's that they're working in a third world environment." Julie Small, *Report Indicates Rise in Number of Preventable California Prison Deaths Since 2006* (Dec. 14, 2009), *available at* http://www.scpr.org/news/2009/12/14/report-fewer-inmates-dying-california-prisons/ (last accessed Oct. 29, 2010).

Currently, severe medical lapses continue to result in an unnecessary death every eight days in California's prisons. Year 2009 Death Review at 9. Thus,

we reject as absurd the claim by California's *amici* that the "current conditions [of avoidable deaths] were dramatically better" at the time of trial. Br. for *Amici* Louisiana et al. 20. In reality, the death rate had *worsened* in 2008, with an inmate dying unnecessarily every 5.5 days. Year 2008 Death Reviews at 9 (66 likely- or possibly-preventable deaths in 2008). The three-judge court did not rely on outdated information when it considered these statistics and other historic evidence of prison conditions. Appellants' Br. 26-30. That historical evidence, combined with evidence of conditions in 2008, showed the systemic and ongoing nature of California's prison health care crisis.

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"By all accounts, the California prison medical care system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action." JS1-App. 24a. "[U]ntil the problem of overcrowding is overcome it will be impossible to provide constitutionally compliant care to California's prison population." *Id*. at 141a.

As clinicians and public health professionals, *amici* are committed to improving the health and well-being of our patients and the general public. We conclude, based on the factual record in this case, that the appalling conditions of facilities, staffing, and access to care in California's prisons prevent the delivery of minimally adequate health care, creating hazardous public health effects in prisons and surrounding communities. Given California's inability or unwillingness to remedy those violations during the past decade of this litigation, we endorse the

conclusion of the three-judge court below that a reduction of the current level of overcrowding is a necessary precondition to achieving adequate health care in California's prisons.

Where the government can prevent the unnecessary suffering and death of individuals involuntarily committed to its care, it must do so. A mature and decent society tolerates nothing less. *See Estelle*, 429 U.S. at 102.

## CONCLUSION

The "prison release order" issued by the three-judge court should be affirmed.

Respectfully submitted,

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