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Clinical Associate Professor, NYU College of Global Public Health

United States Senate Judiciary Committee

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Mr. Chairman and Members of the Committee, thank you for the opportunity to submit this statement. My name is Homer Venters. I'm a physician and epidemiologist who has spent the past year performing inspections of jails, prisons and immigration detention facilities across the county to assess the adequacy of COVID-19 responses. I also serve as a member of the Biden-Harris COVID-19 Health Equity Task Force and have spent my entire career providing and improving health care in places of detention. I have previously served as the Medical Director and Chief Medical Officer of the NYC Correctional Health Services, one of the few jail or prison health services in the United States that is an independent health authority and not part of the correctional department. During my career, I have led teams that created alternatives to solitary confinement for people with serious mental illness, innovations that increased safety and health for detained patients and staff alike.[1] I have also devoted significant portions of my career to creating mechanisms and tools to monitor and improve correctional health quality. At the core of this work is the basic assumption that incarcerated people have a right to ethical, evidence-based care and that a correctional health services must be subject to oversight and transparency, just as with community health systems. My recent COVID-19 related work has included conducting court-ordered inspections of the health services provided to people held by the Federal Bureau of Prisons (BOP) in New York, Maryland, Pennsylvania and California. Facilities that I have physically inspected in the past year for their COVID-19 response include;

- MDC Brooklyn (BOP), NY
- MCC Manhattan (BOP), NY
- FCI Danbury (BOP), CT
- Cook County Jail, IL
- Broome County Jail, NY
- Sullivan County Jail, NY
- Shelby County Jail, TN
- Farmville Detention Center (ICE), VA
- Lompoc Prison (BOP), CA
- Southern Mississippi Correctional Facility, MS
- Central Mississippi Correctional Facility, MS
- FDC Philadelphia (BOP), PA
- Osborn Correctional Institution, CT
- Robinson Correctional Institution, CT

[1] From Punishment to Treatment: The "Clinical Alternative to Punitive Segregation" (CAPS) Program in New York City Jails. https://pubmed.ncbi.nlm.nih.gov/26848667/

- Hartford Correctional Center, CT
- Dallas County Jail, TX
- Cheshire Correctional Institution, CT
- Calhoun County Jail, MI
- York Correctional Institution, CT
- Pender Correctional Institution, NC
- Craven Correctional Institution, NC
- Central Prison, NC
- North Carolina Correctional Institution for Women, NC
- Chesapeake Detention Facility, MD

The BOP is at a crucial juncture regarding health care for detained people, and I fear that many critical lessons from the COVID-19 pandemic may be ignored or left unaddressed by the BOP. My greatest area of concern is that pre-existing deficiencies in the health services provided to people in BOP custody, which contributed to the spread and lethality of COVID-19, remain unaddressed. Core areas of health services, including sick call, chronic care and behavioral health services remain substandard across many of the BOP settings. Without a fundamental shift in how BOP approaches these health services, people in BOP custody will continue to suffer from preventable illness and death, including the inevitable and subsequent infectious disease outbreaks. Each of these three areas of care, sick call, chronic care and behavioral health can be substantially improved by the BOP, but this will require not only resources and leadership but creating more formal and lasting partnerships with the Centers for Disease Control and other federal partners.

My investigations into COVID-19 response in BOP facilities has revealed a disturbing lack of access to care when a new medical problem is encountered. This process, called 'sick call' in most carceral settings, relies on the ability of incarcerated people to submit a written or electronic concern and then be seen in a face-to-face encounter with a day or two. In the first BOP facility I inspected, the Metropolitan detention Center in Brooklyn NY, it quickly became apparent that not only were many people reporting that their sick call requests (including COVID-19 symptoms) were being ignored, but that the facility was actually destroying their original requests, which violates basic correctional standards.[2] As a result of such a system, a facility could claim that most people they scheduled for a sick call appointment ultimately received one, but there was no actual record of the original requests, including what symptoms were being reported. This theme, of undocumented or ignored sick call requests, including COVID-19 symptoms, was common throughout my COVID-19 inspections and represented a significant source of mistrust and acrimony between BOP health staff and their patients. At the root of this problem was often a lack of appreciation for the critical role of sick call, as well as chronic understaffing for the number of sick call requests.[3] As a result, when COVID-19 arrived, incarcerated people relied on broken systems of sick call to seek care. Many of the public

[2] https://theintercept.com/2020/05/01/mdc-brooklyn-jail-coronavirus-medical-records/ and https://www.clearinghouse.net/chDocs/public/PC-NY-0082-0026.pdf pp 3,4.

[3] https://bloximages.chicago2.vip.townnews.com/lompocrecord.com/content/tncms/assets/v3/editorial/d/f3/df325d91-1e1d-5fc6-b1e4-c6b9c16fd1ed/5f748b8696819.pdf.pdf and https://oig.justice.gov/sites/default/files/reports/20-086_0.pdf.

statements I encountered about nobody having COVID-19 symptoms in a facility reflect a lack of looking, not a lack of illness. While some facilities implemented proactive screening for COVID-19, these approaches were mostly limited to housing areas where there was already a concern and also failed to ask people about their symptoms, simply relying on temperature checks, which can be unreliable. The result of the baseline deficiencies in sick call within BOP facilities was that people reporting illness were not seen in a timely manner, and that without a system to track where symptoms of COVID-19 were being reported via sick call, many facilities were missing a basic epidemiologic tool, symptom surveillance.

Chronic care is another area where pre-existing weakness in the BOP health services worsened the morbidity and mortality of COVID-19. People with chronic health problems have long reported delays in their scheduled care for asthma, diabetes, hypertension and other common health problems in BOP facilities. Unlike community health systems, the approach to chronic care in BOP facilities appears to focus on the process of scheduling and resolving individual encounters, a largely administrative task. Individual medical directors are likely aware of some of the sickest patients, but in the facilities I have inspected, there was not a practice of classifying the chronic care patients based on level of disease control. For example, if 40% of the people in a prison were in the chronic care service, nobody would be able to report what percentage of them were poorly controlled for their specific disease. For example, a common scenario I encountered was to hear that a person needed two asthma inhalers, one for emergencies and one for daily control, but that they had only been given a single ‘rescue’ inhaler. As a result, they used their ‘rescue’ inhaler daily and were rarely, if ever, assessed for their level of asthma control. The clinical approach I encountered over and over again was that individual physicians would have the responsibility to address these issues based on BOP policies, but without any tracking of how well this was occurring. One of the clear lessons of COVID-19 is that we need to think of the subset of people with poorly treated chronic health problems as having higher risk of serious illness or death, and we cannot address their level of disease control if we do not think of them as a cohort so we can measure and intervene.

A third area of health concern that pre-dates COVID-19 inside the BOP system is access to behavioral health care. I utilize the term behavioral health to include mental health as well as treatment for substance use. While this represents a broad range of issues, I will point out just two concerns; solitary confinement of patients with serious mental illness and access to medications for substance use disorders. While the topic of solitary confinement has received significant attention within and concerning the BOP, the use of isolation or solitary confinement among people with serious mental illness has not been well addressed and remains a significant problem. When the Inspector General of the DOJ addressed this issue in 2017, they found that the BOP lacked the same standards present in many state prisons systems to protect people with mental illness from extended solitary confinement. They also found that since the implementation of the new BOP mental health policy in 2014, the number of people receiving mental health services has decreased by 30%. This stands in stark contrast to almost every other carceral system I am aware of, where this share of the incarcerated population has been increasing dramatically. In their report, the DOJ IG detailed an example of this problem;

"This treatment trend was particularly pronounced among SMU inmates at USP Lewisburg, which confined over 1,100 SMU inmates as of June 2016. Based on our sample of SMU inmates, we found that, prior to the new policy, the number of inmates (16) whose mental health care level was increased equaled the number of inmates (16) whose care level was decreased. In contrast, after the new policy was adopted, all 27 inmates whose care level changed had a decrease and therefore ostensibly required less treatment. By May 2015, only about 2.5 percent of SMU inmates at USP Lewisburg were categorized as requiring regular treatment, compared to about 11 percent of ADX inmates and 7 percent of SHU inmates nationwide, which we believe raises treatment concerns for inmates in USP Lewisburg's SMU."[4] One feature of this problem that is largely unaddressed, is the manner by which people who are suicidal or who engage in self-harm may be placed into solitary confinement that is labelled 'mental health watch' or some other given another pseudo-health name. This practice has been identified by the USDOJ as violating constitutional rights of incarcerated people but is often the standard approach in prison settings and has not yet been reviewed comprehensively within the BOP since the DOJ findings letter regarding MA DOC.[5]

The second area of behavioral health deficiencies that pre-date COVID-19 is an almost total lack of access to methadone and suboxone in BOP facilities. Substance use disorder is one of the most common health issues among people in BOP custody and the failure to treat substance use disorders increases in-prison mortality and drives illicit markets. In addition, overdose death after release from prison is a major cause of the increase in post-release death and these medications can and have been safely utilized in carceral settings for decades.[6] Despite public statements acknowledging the need to expand access to these lifesaving medications, a recent GAO report identified that almost none of the people who would qualify to them have received have. In addition, the GAO documented that BOP lacks many of the programmatic and structural infrastructure to meet their stated goals.[7] While the BOP has expanded the number of facilities designated to prescribe these medications, they have not reported on the most critical data point, what percentage of people who are clinically eligible for receiving them are being offered or are engaged in treatment?[8]

These two issues (solitary confinement for people with mental illness, and access to methadone and suboxone) are closely tied to management of COVID-19. Many facilities suspended group therapy and other mental health out of cell treatment options because of COVID-19 concerns, so people with mental health issues who were also locked behind a cell door have experienced the trauma of COVID-19 absent the minimal care their were receiving before the pandemic. In similar fashion, many facilities suspended or slowed their rollout of medications for substance

[4] https://oig.justice.gov/reports/2017/e1705.pdf
[5] https://www.justice.gov/opa/pr/justice-department-alleges-conditions-massachusetts-department-corrections-violate
[6] https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf
[7] https://www.gao.gov/products/gao-20-423#:~:text=In%20fiscal%20year%202019%2C%20it,naltrexone%2C%20buprenorphine%2C%20and%20methadone
[8] https://www.bop.gov/inmates/custody_and_care/docs/rdap_locations_20201001.pdf

use disorder and we have yet to hear from the BOP how those services will be fully expanded to all patients who meet the clinical criteria for treatment.

Recommendations

The BOP cannot address all of these challenges on its own. Some improvements, such as creating a standardized and clinically-driven approach to sick call may be achievable with increased oversight and resources for provision of care. But tackling the longstanding issues with chronic care and behavioral health services will require new and expended partnerships particularly with the CDC and SAMHSA.

There is one critical task that remains undone regarding the BOP and COVID-19, even after all staff and incarcerated people have been offered vaccines; we must have an independent assessment of all COVID-19 deaths, including those that occurred in private facilities. In my work investigating the adequacy of COVID-19 responses in BOP facilities, I have encountered a great many strengths in the overall and local COVID-19 responses. Strengths like effective staff screening, implementing vaccination programs for high-risk patients and creating new inpatient treatment capacity. But I have also encountered significant deficiencies in how or whether basic CDC guidelines and the BOP policies in place at the time were being implemented. These deficiencies include a lack of attention to the role that inmate work crews play in the spread of COVID-19, a lack of attention to symptoms of COVID-19 and lack of sufficient health staff to provide care once outbreaks develop. There is no doubt that many of these strengths saved lives and conversely, that many of these deficiencies led to preventable illness and death. One cannot be true without the other. Yet to date, there has not been any systemic and independent review of deaths from COVID-19 in BOP custody, although a recent call for exactly this type of analysis was sent to the Inspector General of the DOJ.[9] I strongly support this proposal, but it highlights a more significant problem for the BOP, the lack of independent assessment in how deaths are reviewed. In my work, have spoken to scores of detained people, staff, inspected facilities and reviewed tens of thousands of pages of medical records as well as facility polices and records. When I have reviewed the cases of people who died from COVID-19, I have found that both the internal review, and the external review that BOP has paid a consultant for come to the same conclusion, that there were no deficiencies in care. These reviews have not met my or community standards for how deaths should be investigated, in that they have not focused on two important questions; did the patient receive the standard of care and was their death at all caused by conditions inside the facility? These are not always simple questions to answer, but they require both skill and the will to probe beyond simply reporting that a patient had pre-existing illness and then died from COVID-19 related illness. They also require connecting deaths to systemic barriers to care or other health risks that are created inside a prison setting.

[9] https://www.cnn.com/world/live-news/coronavirus-pandemic-vaccine-updates-03-18-21/h_da9af577035e29c42d4024c22840c8dc

In order for the BOP to improve its overall health services, and prepare for the next infectious disease outbreak, I believe the following recommendations are essential;

1. An independent assessment of COVID-19 related deaths among people in BOP and Marshalls custody should occur, with focus on a. whether each person received the standard of care and b. whether delays/denials of care or other environmental issues contributed to their death.
2. All facilities within BOP should standardize their sick call systems and staffing to ensure that sick call requests are retained and that requests result in timely care.
3. The BOP should consider partnering with the CDC to create a population health plan that;
    a. Identifies and tracks chronic disease morbidity mortality and level of control.
    b. Creates an injury surveillance and prevention program, including traumatic brain injury, that both tracks the rates of various injuries and also works to implement injury reduction programs and their effectiveness
    c. Implements a plan for suicide prevention and substance use treatment that is based on evidence from the CDC and SAMHSA and includes a roadmap and regular reporting on the resources required to fully implement access to methadone and suboxone and minimize the use of isolation.
    d. Identifies racial, gender and other disparities in how care is provided or accessed.

Conclusion

The BOP faces an important choice in how they respond to COVID-19 and work to improve their health services. In community health settings, we do not allow a hospital or clinic to be the arbiter of how well they are doing. Instead, we rely on external agencies and authorities with health expertise for this critical work, whether through the state or federal oversight. Currently, the BOP is left to make its own assessments about the quality and scope of its health care, and only sporadic investigations by the Inspector General of the Department of Justice provide any alternative viewpoints. This is wholly insufficient and leaves incarcerated people at a systematic disadvantage because the organizations and structures that measure and promote health for the rest of the nation are excluded from the care they receive. The BOP has an opportunity to start addressing this unequal system of care, and it must start with an honest assessment of COVID-19 deaths and partnership with the CDC and other true health organizations.