

**Testimony on Prison Health Care
before the Health and Corrections Committees
of the New York State Assembly**

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I am the director of the Prison Visiting Project of the Correctional Association of New York, a nonprofit research and advocacy organization founded in 1844. The Correctional Association is one of two organizations in the country that has statutory authority to enter state prisons and issue reports on conditions of confinement to the legislature and the public. Our access offers a unique opportunity to observe conditions and learn from inmates, correction officers and civilian staff about the strengths and weaknesses of prison operations and practices. In my five years at the Correctional Association, I have visited 35 of New York's 70 state prisons. My testimony is based on conclusions drawn from these visits.

On monthly monitoring visits and in the hundreds of letters we receive each year from inmates, inadequate medical care ranks as a leading complaint. Annual grievance reports from New York State correctional facilities uniformly list medical care as inmates' first or second most frequently grieved issue. In surveys we conducted with 301 prisoners at nine facilities over the past two years, 64% rated medical care as poor, 26% as average and only 10% as good. Sixty percent of inmates said that they do not have timely access to medical care, and one-fifth of inmates cited better medical care as the single most important improvement they would like to see result from our visit, a particularly telling finding given the many changes that inmates could recommend to improve life behind bars.

From interviews with inmates and staff conducted over the past two years, four key deficiencies in medical care emerged:

1. Understaffing. With the exception of Green Haven, where medical services are overseen by consent decree, staffing vacancies existed at every facility we visited. At Coxsackie, which we visited in June 2002, there was only one physician for over 1,000 inmates. At Queensboro, which we visited this past July, there was no medical coverage-not even a nurse-on site after 10 p.m. at the facility and only 8 hours of medical coverage during weekends. At Southport, a total lockdown facility where over 700 inmates are confined to their cells 23 hours a day, the Nurse Administrator reported that inmates' medical concerns often go unaddressed because of insufficient staff to conduct cellside screenings. In sum, these medical staff vacancies, largely due to noncompetitive state salaries, compromise the delivery of routine health services in many state prisons.

2. Long Waits to See a Physician. Many inmates reported delays of 2 to 4 weeks to see a physician. At Arthur Kill, inmates complained bitterly that medical exams are cursory and that it can take a month or longer to see a doctor. At Woodbourne, which has a high concentration of inmates with mental illness and as well as chronic medical conditions, inmates reported a 3- to 4-week waiting period to see a physician and that Tylenol is the universal form of treatment. At

Otisville, inmates' leading complaint was the up to 2-month delay to see a doctor, and the brusque, often superficial medical exams where medical staff sometimes fail to take inmate vital signs or sometimes even touch the patient.

3. HIV Care. With some 6,000 HIV-infected inmates, the New York State prison system has the highest number and rate of HIV-infected inmates of any state department of corrections in the country. Nevertheless, findings from site visits indicate that the clinical management of inmates with HIV/AIDS is uneven and that wide variations exist among prisons with regard to HIV testing, education and care, and that there are no measures to combat transmission of the HIV virus. Most prisons we visit lack an HIV-specialist to provide vital monitoring and clinical management of HIV-positive inmates and fail to ensure access to infectious disease specialists with the expertise to care for inmates with complex and chronic diseases.

4. Hepatitis C Care. DOCS estimates show that about 14% of incoming male inmates and nearly 25% of incoming female inmates are infected with Hepatitis C, creating what some health care experts say is a prison epidemic and the costliest health crisis since AIDS. Yet, at most prisons we visit, inmates routinely report that testing and treatment for Hepatitis C is discouraged and that little patient education is provided. Facility medical staff reported concern about the growing roster of HCV-infected inmates and the insufficient access to treatment due to cost and insufficient staff training regarding the clinical management of Hepatitis C. At Great Meadow, which we visited in December 2002, only three of the 200 HCV-infected inmates were receiving treatment. Certainly, not all people who test positive for HCV are not at the stage where treatment is appropriate, but the 1% treatment rate at Great Meadow and the similarly low rates at other prisons, is disturbing.

At Woodbourne Correctional Facility, which we visited last March, two inmates with Hepatitis C were told by the facility medical director that they could not receive treatment for HCV unless they agreed to stay in prison past their conditional release date in order to satisfy the Department's requirement that inmates seeking treatment have 12 months left on their sentence. One individual opted to remain incarcerated past his release date; the other did not. It is a serious concern that inmates are being forced to choose between medical care for a potentially fatal disease and their freedom. A more progressive and certainly doable practice, which some other state Departments of Correction carry out, would be to connect inmates with community providers that would continue treatment upon release. The policy of keeping a person in prison at a cost of \$32,000 annually is more expensive than the cost of treatment alone.

These deficiencies observed during prison visits conducted by the Correctional Association over the past two years--specifically, high staffing vacancies, lack of access to physicians and inadequate infectious disease management and care--are similar to those reported in an evaluation study we conducted in 1999-2000 that focused on the quality of inmate medical care. These deficiencies are similar to those documented in an in-depth study conducted by the AIDS Institute's Subcommittee on Criminal Justice in 1999.

These deficiencies persist, I believe, partly because prisons are insulated from public scrutiny and no outside agency or oversight board has consistently reviewed the quality of inmate health care. While the New York State Department of Health reviews the quality of care in hospitals and clinics in the community, its oversight does not extend to prisons, where it is needed the

most. Essentially, the largest HIV practice in the country is being conducted in a place where the state agency responsible for public health is not authorized to intervene or even monitor. The bill introduced by Assemblyman Gottfried requiring DOH assessment of Hepatitis C and HIV policies and practices would provide critical guidance on what is needed to improve care and avoid disease transmission. At a time when fiscal austerity demands careful use of resources, identifying deficiencies and scrutinizing practices are important and intelligent first steps. Requiring the Department of Health to evaluate the care given to a sprawling and disproportionately infected inmate population will not only benefit the inmates involved, but also safeguard the public health of the communities to which they return.