William & Mary Bill of Rights Journal

Volume 31 (2022-2023)
Issue 2 The Problem of Mass Incarceration: Diagnosis and Reform

Article 4

12-2022

Jail Health and Early Release Practices

Brandon L. Garrett

Deniz Ariturk

Jessica Carda-Auten

David L. Rosen

JAIL HEALTH AND EARLY RELEASE PRACTICES

Brandon L. Garrett,[*] Deniz Ariturk,[**] Jessica Carda-Auten[***] and David L. Rosen[****]

ABSTRACT

Local jails in the United States incarcerate millions of people each year. The COVID-19 pandemic made jail health a pressing public health concern nationally, where releasing individuals from jails occurred across the country in order to prevent pandemic spread. But releases also faced substantial resistance and exposed long-standing challenges in delivering adequate healthcare in jail settings. People in jail have substantially higher levels of medical need than individuals in the general population, with large numbers having serious mental illnesses and substance use disorders. Further, overcrowded conditions and poor healthcare standards and delivery make jails harmful to those already-vulnerable people. What means exist to protect individuals whose health would suffer in jail? Constitutional standards under the Eighth Amendment are highly deferential to jail administrators, nor is there substantial state or local level regulation of jail health. However, more informal mechanisms do exist, and they may be more responsive to health-based needs than constitutional or legal rights. This Article describes insights from qualitative interviews with jail medical staff in four states, to explore what challenges face delivery of healthcare, but more specifically, when health-based needs require counsel releasing individuals from jail. The Article describes widespread informal and unwritten mechanisms for health-based releases from jails. The Article will present the data and how such practices have implications for reforming the legal rules surrounding jail healthcare.

---

* L. Neil Williams Professor of Law & Director, Wilson Center for Science and Justice, Duke University School of Law. We are grateful to the participants at the William and Mary Bill of Rights Symposium for their comments on this Article.

** J.D. Candidate, Yale Law School.

*** University of North Carolina at Chapel Hill.

**** Associate Professor of Medicine, Division of Infectious Diseases, University of North Carolina at Chapel Hill.

Research reported in this publication was supported by the National Institute on Minority Health And Health Disparities of the National Institutes of Health under Award Number R01MD012469. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Health. We thank the interview participants who made this project possible.

INTRODUCTION

Local jails in the United States incarcerate millions of people each year, many of whom have serious healthcare needs. The jail population in the United States has reached a record size and scale, posing substantial public health challenges.[1] Many millions of individuals are detained each year in nearly 3,000 local jails.[2] These stays, on average, are short.[3] About two-thirds of these people are detained pretrial, while about one-third have been sentenced and would require longer-term healthcare in jail.[4] There is strong evidence that jail detention has a range of negative effects

[1] *See* Samuel R. Wiseman, *Bail and Mass Incarceration*, 53 GA. L. REV. 235, 279 (2018).

[2] *See* Zhen Zeng, Bureau of Just. Stat., *Jail Inmates in 2016*, 1, 2, 7 (2018), https://bjs.ojp.gov/content/pub/pdf/ji16.pdf [https://perma.cc/YMH7-RMB4].

[3] The average time served in jail is less than one month. *See id.* at 1, 6.

[4] *See id.* at 4 (indicating that sixty-five percent of these people are detained pretrial).

on health, and also on public safety.[5] The question that this Article explores is what can be done about the problem of carceral health, and whether formal and informal practices, alongside legal and constitutional rights, can respond to long-standing, typical healthcare challenges that jails have.

Healthcare is an urgent challenge in the record-sized jail population in the United States. Jails are overcrowded, which hinders the prevention and mitigation of disease spread within facilities.[6] On average, people incarcerated in jail have substantially higher levels of medical needs than individuals in the general population.[7] Jailed persons are five times more likely to have a serious mental illness and approximately twelve times more likely to have a substance use disorder than those in the general population.[8] Those incarcerated in jails also have higher rates of infectious diseases and other chronic illnesses than the general population.[9] Up to 55,000 pregnant individuals are admitted to jails every year, a substantial number

---

[5] *See* Zoe Guttman et al., *Beyond Cash Bail: Public Health, Risk Assessment, and California Senate Bill 10*, 17 J. SCI. POL'Y & GOVERNANCE 1, 2 (2020); Paul Heaton et al., *The Downstream Consequences of Misdemeanor Pretrial Detention*, 69 STAN. L. REV. 711, 714 (2017); Christopher T. Lowenkamp et al., *The Hidden Costs of Pretrial Detention*, NAT'L INST. OF CORR. 1, 22 (2013).

[6] *See* NAT'L ACADEMIES OF SCIS., ENG'G, AND MED., DECARCERATING CORRECTIONAL FACILITIES DURING COVID-19: ADVANCING HEALTH, EQUITY, AND SAFETY 26–27 (Emily A. Wang et al. eds., 2020) [hereinafter 2020 NRC REPORT] (finding that the average daily incarcerated population exceeds the lowest measure of capacity in all states except for Virginia and West Virginia).

[7] *See id.* at 28–30.

[8] Jennifer Bronson & Marcus Berzofsky, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12*, 1, 4 (2017), https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf [https://perma.cc/74X5-TLC5] (finding in jail inmate survey that twenty-six percent reported experiences that met threshold for serious psychological distress and forty-four percent had been told in the past they had a mental disorder); Jennifer Bronson et al., *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007–2009*, 4 (2020), https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf [https://perma.cc/87ZL-4UV3]; *see also* Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 764 (2009).

[9] Chronic conditions that are more common in the jail population compared to a matched estimate of the general population include diabetes, heart problems, and asthma. *See* Laura M. Maruschak & Marcus Berzofsky, *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12*, 2–4 (2016), https://bjs.ojp.gov/content/pub/pdf/mpsfpji1112.pdf [https://perma.cc/A27K-PK76] (finding that amongst jail inmates, 44.7% report having had a chronic condition (including, most commonly, hypertension, asthma, and heart-related problems) and that 14.3% report having tuberculosis, hepatitis B or C, or other STDs, compared to 26.9% and 4.6% of the general population, respectively); Michael Massoglia & Brianna Remster, *Linkages Between Incarceration and Health*, 134 PUB. HEALTH REPS. 8S, 9S–10S (2019); Christopher Wildeman & Emily A. Wang, *Mass Incarceration, Public Health, and Widening Inequality in the USA*, 389 LANCET 1464, 1467–68 (2017); Christopher Wildeman & Christopher Muller, *Mass Imprisonment and Inequality in Health and Family Life*, 8 ANN. REV. L. SOC. SCI. 11, 18 (2012).

of whom require comprehensive and urgent pregnancy care while incarcerated.[10] Finally, jails house an aging population, with an estimated 500,000 older adults passing through jails annually.[11]

All jails are required to provide healthcare to individuals in their custody, a right that has been affirmed by the Supreme Court.[12] However, *how* jails provide care—for example, the specific services provided, the types of healthcare providers employed or contracted with, and the amount of funding allocated for healthcare are typically determined by county officials and jail leadership.[13] Further, the standards for deciding whether to detain someone pretrial do not typically take account of health-related factors. The U.S. Supreme Court's ruling in *United States v. Salerno* held that pretrial detention was permissible under the federal Bail Reform Act of 1984, only where the government provided a robust, adversarial, on-the-record hearing and a judge made a finding by clear and convincing evidence that detention was necessary.[14] The relevant factors concerning flight and public safety approved under the Act at issue in *Salerno* take into account individual liberty interests balanced against government regulatory or crime-control interests,[15] but they do not consider health as part of the individual's liberty interest. As will be discussed below, Eighth Amendment standards regarding jail healthcare are similarly deferential, as was apparent when people challenged conditions during the COVID pandemic.[16]

This Article describes a qualitative inquiry into how jail officials respond to the health needs of individuals. Little is known about these practices and responses to health crises and medical needs. The Article uncovers, through interviews with jail staff in four states, and in facilities in jurisdictions of different sizes, that despite the absence of formal rules permitting judicial officers to consider health, informal means exist to secure the release of individuals whose health would be at risk given the available care in custody or whose health needs impose a financial burden on jails. One of the most commonly cited reasons for early release was pregnancy.[17]

---

[10] *See* Carolyn Sufrin et al., *Pregnancy Prevalence and Outcomes in U.S. Jails*, 135 OBSTETRICS & GYNECOLOGY 1177, 1182–83 (2020).

[11] *See* Meredith Greene et al., *Older Adults in Jail: High Rates and Early Onset of Geriatric Conditions*, 6 HEALTH & JUST. 1, 1 (2018); 2020 NRC REPORT, *supra* note 6, at 30–31.

[12] Individuals incarcerated in prisons also have a constitutional right to healthcare but have been regularly deprived of adequate care due to persistent regulatory failures across all three branches of government. *See* Sharon Dolovich, *The Failed Regulation and Oversight of American Prisons*, 5 Ann. Rev. Criminology 153, 164–65 (2022).

[13] *See* PEW CHARITABLE TRS., JAILS: INADVERTENT HEALTH CARE PROVIDERS 1, 7–9 (2018); Phil Schaenman et al., *Opportunities for Cost Savings in Corrections Without Sacrificing Service Quality: Inmate Health Care*, U.S. DEP'T OF JUST.: OFFICE OF JUST. PROGRAMS, 1, 3 (2013).

[14] 481 U.S. 739, 751–52 (1987).

[15] *See id.* at 750.

[16] *See infra* Section I.A.

[17] *See infra* Section II.B.1.

Other frequently cited reasons were significant injuries, serious illnesses requiring major medical attention (e.g., cancer) or expensive medication (e.g., HIV), physical disability necessitating special accommodations (e.g., paraplegia), and serious mental illness.[18] The data sheds light on the means by which health-related jail release occurs, what considerations jail officials take into account, and how they advocate with judicial officers and prosecutors. Nor are health-related jail releases always primarily occupied with the health and safety of persons in jail; they are also concerned with the cost of providing healthcare to at-risk individuals, liability considerations, and staffing. This Article asserts that most of the jails that reported early release for health-related reasons did so by making changes to the bond conditions.[19] Although laws in some states mention health as a possible consideration, none of the states in this study have clear legal procedures designed to actually take health into account when deciding what bond conditions or pretrial detention is appropriate.[20]

Today, pretrial policies and practices are once again in flux, with bipartisan calls for reform and growing media attention to the problem.[21] Those calls for bail reform, however, have not focused on the deep problem of jail health. Nor do existing constitutional and legal rules clearly address or safeguard jail health rights. Given how pervasive medical and behavioral health needs are in jail settings, this Article urges the development of standards that are keyed towards health-related concerns and that provide defined, rather than informal, health-related rights. The findings of the qualitative research described in this Article suggest why health-related considerations are important and a constant fixture in jail settings, and why rules actually designed to address health are needed.

I. THE PROBLEM OF JAIL HEALTH

With jail populations increasing over the past four decades, and with some constitutional regulation of the adequacy of healthcare, localities have increasingly partnered with outside providers to supply medical care in jail settings.[22] Many localities have outsourced healthcare in jails to private companies.[23] It is far less

---

[18] *See infra* Section II.B.1.

[19] *See infra* Section II.B.2.

[20] *See infra* Section I.B.

[21] *See, e.g.*, Kellen Funk, *The Present Crisis in American Bail*, 128 YALE L.J. F. 1098, 1113–14 (2019); Kamala D. Harris & Rand Paul, Opinion, *To Shrink Jails, Let's Reform Bail*, N.Y. TIMES (July 20, 2017), https://www.nytimes.com/2017/07/20/opinion/kamala-harris-and-rand-paul-lets-reform-bail.html [https://perma.cc/V29N-4NVV]; Margaret Talbot, *The Case Against Cash Bail*, THE NEW YORKER (Aug. 25, 2015), https://www.newyorker.com/news/news-desk/the-case-against-cash-bail [https://perma.cc/C5BM-FSY2].

[22] *See* PEW CHARITABLE TRS., *supra* note 13, at 9–10.

[23] *See* Rupert Neate, *Welcome to Jail Inc: How Private Companies Make Money off US Prisons*, GUARDIAN (June 16, 2016, 6:00 PM), https://www.theguardian.com/us-news/2016/jun/16/us-prisons-jail-private-healthcare-companies-profit [https://perma.cc/H9NT-43EB].

common, as compared with prisons, for localities to partner with public hospitals or universities.[24] States do have oversight bodies that can monitor contractor performance and adequacy of prison healthcare, but oversight over local jails has traditionally been extremely deferential.[25] Accrediting organizations, such as the American Jail Association and the National Commission on Correctional Health Care, for example, typically review only written policies, but not the actual quality of care provided or adherence to standards.[26] Later, this Article describes constitutional rules regarding medical care in jails, applicable pretrial rules, and what is known about the quality of care at jails.

A. Constitutional Regulation of Jail Health

Pretrial detention standards focus on the due process rights of arrestees, public safety and flight considerations of the government, and the liberty interests of the arrestee, but they do not clearly address health or public health concerns. Prior to the 1970s, there were simply no legal standards governing prison healthcare, and delivery of care was often left to unqualified or overwhelmed providers, leading to "inadequately available and frequently primitive" healthcare.[27] A series of lawsuits and federal court decisions culminated during the creation of a legal standard for healthcare under the Eighth Amendment. The landmark 1976 Supreme Court decision in *Estelle v. Gamble* requires that, under the Eighth Amendment, custodians ensure incarcerated individuals receive reasonably adequate healthcare.[28] The *Estelle* court defined "deliberate indifference to serious medical needs" of prisoners as the "unnecessary and wanton infliction of pain" proscribed by the Eighth Amendment.[29] Thus, a plaintiff challenging health conditions in a jail must show under that Eighth Amendment standard that, first, there was a sufficiently serious deprivation of medical care, and, second, that jail officials acted with a high level of intent, amounting to recklessness in depriving the individual of care, or deliberate indifference.[30]

For an overview, *see generally* Micaela Gelman, Note, *Mismanaged Care: Exploring the Costs and Benefits of Private vs. Public Healthcare in Correctional Facilities*, 95 N.Y.U. L. REV. 1386, 1389 (2020) ("The proliferation of private companies, despite major lawsuits and allegations of misconduct, continues because of failures in the correctional healthcare market. Specifically, the market lacks the factors necessary for successful privatization: choice, competition, and responsiveness to consumer preferences.").

[24] Gelman, *supra* note 23, at 1389.

[25] *Id.* at 1406–07.

[26] *Id.* at 1408. *But see* Nat'l Comm'n on Corr. Health Care, *Benefits of NCCHC Accreditation*, NCCHC, https://www.ncchc.org/accreditation/ [https://perma.cc/54SK-K9RS] (last visited Dec. 8, 2022).

[27] Douglas C. McDonald, *Medical Care in Prisons*, 26 CRIME & JUST. 427, 427 (1999).

[28] *See* 429 U.S. 97, 103 (1976).

[29] *Id.* at 104 (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

[30] *See id.* at 106; *see also* Wilson v. Seiter, 501 U.S. 294, 297, 303 (1991).

A separate due process claim is also available to individuals confined pretrial in jails. In *Bell v. Wolfish*, the Court reaffirmed that the government cannot subject people in jails, prior to adjudication of guilt, to conditions that amount to punishment, and the Court set forth a due process rule used to distinguish punishment conditions from those that have a reasonable relationship to legitimate, non-punishing detention objectives.[31] Every circuit except for one now use the reasonable-relationship standard to adjudicate the constitutionality of jail conditions under the Due Process Clause.[32] However, some courts have merged the *Bell* and *Gamble* analysis and, in doing so, require a deliberate indifference showing in the jail setting, conflating the two inquiries.[33] This case law helps to explain why during the COVID-19 pandemic, courts often did not conduct a reasonableness inquiry into the objective merits of jail responses to that public health emergency.[34]

In *Brown v. Plata*, the Supreme Court ordered California to reduce overcrowding in prisons under the Eighth Amendment, noting the associated failure to provide healthcare to all inmates.[35] In his majority opinion, Justice Kennedy referenced the lower court's reasoning that overcrowding could lead to an "unconscionable degree of suffering and death," and, along with Justices Ginsburg, Breyer, Sotomayor, and Kagan, ultimately affirmed the relief granted below.[36] This intervention is noteworthy because it is the only example of a large-scale release ordered under the Eighth Amendment following years of protracted litigation.

---

[31] *See* 441 U.S. 520, 535, 539 (1979); *see also* Block v. Rutherford, 468 U.S. 576, 584 (1984) (holding that the reasonable-relationship standard is "to be applied in evaluating the constitutionality of conditions of pretrial detention").

[32] *See, e.g.*, Almighty Supreme Born Allah v. Milling, 876 F.3d 48, 55 (2d Cir. 2017) (adopting standard); E. D. v. Sharkey, 928 F.3d 299, 307 (3d Cir. 2019) (same); Williamson v. Stirling, 912 F.3d 154, 182 (4th Cir. 2018) (same); Garza v. City of Donna, 922 F.3d 626, 632 (5th Cir. 2019) (same); Malone v. Colyer, 710 F.2d 258, 261–62 (6th Cir. 1983); Mulvania v. Sheriff of Rock Island Cnty., 850 F.3d 849, 856 (7th Cir. 2017) (same); Baribeau v. Minneapolis, 596 F.3d 465, 483 (8th Cir. 2010) (same); Shorter v. Baca, 895 F.3d 1176, 1184 (9th Cir. 2018) (same); Blackmon v. Sutton, 734 F.3d 1237, 1241 (10th Cir. 2013) (same); Jacoby v. Baldwin Cnty., 835 F.3d 1338, 1345 (11th Cir. 2016) (same); Jones v. Horne, 634 F.3d 588, 598 (D.C. Cir. 2011) (same).

[33] *See, e.g.*, Whitney v. St. Louis, 887 F.3d 857, 860 (8th Cir. 2018) (extending two-prong Eighth Amendment standard to pretrial detention context); Dang *ex rel* Dang v. Sheriff, 871 F.3d 1272, 1279 (11th Cir. 2017) (same); Alderson v. Concordia Par. Corr. Facility, 848 F.3d 415, 419–20 (5th Cir. 2017) (same).

[34] *See* Brandon L. Garrett & Lee Kovarsky, *Viral Injustice*, 110 CALIF. L. REV. 117, 163–64 (2022).

[35] *See* 563 U.S. 493, 545 (2011). Prior to this ruling, in 2010, the ABA Standards for Criminal Justice on the Treatment of Prisoners were approved as a "long overdue" revision of the 1981 Standards on the Legal Status of Prisoners, which had become "sadly outdated and incomplete." Margo Schlanger et al., *ABA Criminal Justice Standards on the Treatment of Prisoners*, 25 CRIM. JUST. 14, 15 (2010).

[36] *Brown*, 563 U.S. at 507, 545.

The federal Americans with Disabilities Act (ADA) also protects individuals with disabilities in public and private accommodations, including jails.[37] Inmates have attempted to challenge jail conditions under the ADA.[38] To successfully challenge jail practices under the ADA, a plaintiff must prove that they have a qualifying disability and that they were harmed by intentional discrimination, a disparate impact, or a failure to make a reasonable accommodation.[39] Given the intentional discrimination showing that must be made under the statute, the ADA has not often been successfully used to challenge jail practices.[40]

A pressing recent example of these constitutional rules in action during a public health crisis, was the response of courts to jail healthcare concerns during the COVID-19 pandemic, which powerfully affected jails and other carceral settings. On March 15th, eight days before the first Centers for Disease Control and Prevention (CDC) guidance on correctional settings, the World Health Organization (WHO) published its interim guidance regarding COVID-19 in prisons and other places of detention.[41] In May, WHO, along with the United Nations Office on Drugs and Crime (UNODC), the Joint United Nations Programme on HIV and AIDS (UNAIDS), and the Office of the United Nations High Commissioner for Human Rights (OHCHR), released another statement: recommending that states first and foremost reduce overcrowding in prisons and other closed settings, as overcrowding "constitutes an insurmountable obstacle for preventing, preparing for or responding to COVID-19."[42] On March 23, 2020, the CDC issued an "interim" guidance for all types of correctional and detention facilities, which was later updated, in several iterations.[43] The CDC noted the heightened danger in correctional settings.[44] In general, however, the CDC resources, produced by the nation's top public health officials, left decision-making to the discretion of local officials.

In response, during the COVID-19 pandemic, jails did take some actions to reduce their population, as did other actors. But, in general, they did little to prevent

---

[37] *See* 42 U.S.C. § 12101(a)(2)–(3).

[38] See *infra* Section II.C.1; *see generally* Prianka Nair, *The ADA Constrained: How Federal Courts Dilute the Reach of the ADA in Prison Cases*, 71 SYRACUSE L. REV. 791 (2021).

[39] *See* Nair, *supra* note 38, at 809–10.

[40] *See generally id.*

[41] *See generally* World Health Org., *Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention*, WHO (2020), https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y [https://perma.cc/MCV9-Y546].

[42] World Health Org., *UNODC, WHO, UNAIDS, and OHCHR Joint Statement on COVID-19 in Prisons and Other Closed Settings*, WHO (May 13, 2020), https://www.who.int/news/item/13-05-2020-unodc-who-unaids-and-ohchr-joint-statement-on-covid-19-in-prisons-and-other-closed-settings [https://perma.cc/U4AU-6DS9].

[43] CDC, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (Mar. 23, 2020).

[44] *See id.*

the rapid spread of COVID-19 to people in jail and the surrounding communities, and judges declined to intervene under the relevant Fifth, Eighth and Fourteenth Amendments constitutional standards.[45] In some cases, lower courts granted injunctions regarding constitutionally inadequate jail health protections.[46] However, on three occasions, the U.S. Supreme Court rejected lower courts' preliminary injunctions regarding jail conditions on its shadow docket, sending a strong message to lower courts that intervention was not warranted.[47]

The COVID-19 pandemic did result in a remarkable and sudden decline in jail populations; based on available information, between January and June of 2020, the average jail population fell by 20 percent.[48] Much of this trend, which began to reverse by 2021, was accounted for by reduced crime, reduced arrests and admissions to jail, and use of sentencing alternatives.[49] Thus, it was informal decarceration, and not health rights–based releases, that may have accounted for the decline in jail populations across the country during the pandemic. This makes sense given the highly deferential health-based constitutional rights described, as well as the lack of other legal rules concerning jail health, further explored in the next section.

B. State and Local Regulation of Jail Health

States typically provide little to no statutory oversight of jail healthcare provisions.[50] Of the four states in our study, Georgia has the most detailed, albeit still deferential, rules concerning jail healthcare: healthcare in Georgia jails and prisons is the responsibility of correctional authorities.[51] While incarcerated individuals

---

[45] *See supra* Section I.A.

[46] *See, e.g.*, Mays v. Dart, 456 F. Supp. 3d 966, 1017 (N.D. Ill. 2020), *aff'd in part, vacated in part, rev'd in part*, 974 F.3d 810, 824 (7th Cir. 2020) (granting preliminary injunction to improve conditions in Chicago's Cook County jail).

[47] *See, e.g.*, Ahlman v. Barnes, 445 F. Supp. 3d 671 (C.D. Cal.), *stay granted*, 140 S. Ct. 2620 (2020) (ending the preliminary injunction requiring Orange County Jail officials to implement heightened COVID-19 precautions); Valentine v. Collier, 455 F. Supp. 3d 308 (S.D. Tex.) (granting preliminary injunction), *stay granted*, 956 F.3d 797 (5th Cir.), *application denied*, 140 S. Ct. 1598 (2020) (denying application to vacate stay ordered by the Fifth Circuit); Valentine v. Collier, 141 S. Ct. 57 (2020) (denying another application to vacate stay ordered by the Fifth Circuit).

[48] *See* 2020 NRC REPORT, *supra* note 6, at 50.

[49] *See id.* at 52–54.

[50] Local governments are typically in charge of operating jails, including their healthcare. *See generally* Nat'l Ass'n of Counties, *County Jails at a Crossroads: An Examination of the Jail Population and Pretrial Release*, 2 NACO WHY COUNTIES MATTER PAPER SERIES (2015). However, in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont, the state is responsible for both prisons and jails. E. Ann Carson, *Prisoners in 2020—Statistical Tables*, 4 (2021), https://bjs.ojp.gov/content/pub/pdf/p20st.pdf [https://perma.cc/BU52-9866].

[51] *See* GA. COMP. R. & REGS. 125-4-4-.01 (2009).

cannot be required to pay for any medical or dental treatment they receive, "a reasonable deduction" from their money accounts may be used to "defray the costs paid by the Department or its contractor,"[52] if the request for treatment is initiated by the prisoner, for conditions unrelated to pregnancy or chronic illness,[53] or for "injuries inflicted by the prisoner upon himself or herself or others unless the inmate has a severe mental health designation."[54] Emergency medical or hospital care that costs over $1,000.00 for individuals in county jails must be covered by the Department of Corrections or its contractors.[55] Each correctional institution must provide part- or full-time access to a licensed physician,[56] and maintain "adequate space, equipment and medical supplies for physical evaluations, administering first aid, and for the examination of inmates."[57] Health services must be able to address "illnesses, injuries, immunizations and vaccinations, and psychiatric and psychological studies and/or treatment as recommended by the institutional physician" and individuals with a "remediable physical or mental condition" must be offered suitable treatment.[58] Incarcerated individuals also "shall receive dental and optical treatment," the cost of which is borne by the county jail.[59] Individuals assigned to a state prison from a jail must receive a physical examination.[60] Finally, individuals under administrative segregation or disciplinary isolation must be reviewed by the jail physician prior to and during their isolation as to whether they can "tolerate the physical and mental stress" of solitary confinement.[61]

The remaining three states provide even more limited statutory oversight over jail healthcare. In North Carolina, local governments must establish a jail medical plan that describes the jail's policies and procedures on health screening, routine medical care, management of chronic and communicable conditions, administration

---

[52] *Id.* 125-4-4-.01(b).

[53] *See id.* 125-4-4-.01(b)(2)(i)–(ii). Chronic illness is defined as "[a]n illness requiring care and treatment over an extended period of time." This "includes, but is not limited to, hypertension, diabetes, pulmonary illness, a seizure disorder, acquired immune deficiency syndrome, cancer, tuberculosis B, hepatitis C, rheumatoid arthritis, a autoimmune disorder, and renal disease." *Id.* 125-4-4-.01(a)(2).

[54] *Id.* 125-4-4-.01(b)(3). The size of the deduction is established by the Department of Corrections but cannot be imposed when individuals have less than ten dollars in their account. Money accounts become frozen until all medical charges are paid. *See id.* at 125-4-4-.01(b)(4).

[55] *See id.* 125-4-4-.01(c).

[56] *See id.* 125-4-4-.02.

[57] *Id.* 125-4-4-.03.

[58] *Id.* 125-4-4-.04.

[59] *Id.* 125-4-4-.07.

[60] *See id.* 125-4-4-.05(a). At minimum, the examination must include "recording of physical measurements, blood pressure, visual and hearing examinations, clinical evaluations, and laboratory examinations to include testing for *Human Immunodeficiency Virus (HIV)*, urinalysis, and serology." *Id.* 125-4-4-.05.

[61] *Id.* 125-4-4-.08.

of medications, and more.[62] The plans must be developed in consultation with and approved by local health authorities to ensure it is adequate to "protect the health and welfare of the prisoners."[63]

In South Carolina, counties are merely required to provide access to jail medical personnel "whenever necessary" and to "preserve the health" of individuals in jail, as well as cover healthcare expenses.[64]

In Alabama, jail officials must provide "necessary medicines and medical attention" to those who are sick or injured "when they are unable to provide them for themselves," at the expense of the county.[65] Decisions regarding whether to appoint a physician to provide healthcare in the jail and which services the physician will provide are left to the discretion of the county.[66] Ill health may justify temporary transfer from jail to a health facility: if a judge is made aware that an individual's health will be "seriously endangered" by their commitment in jail, the judge must order their release to the nearest possible hospital or other location where they can safely remain until their health is restored, at which point they will be recommitted to the jail.[67]

In the absence of meaningful statewide regulation, there is often considerable within-state variation in jail health funding, services, and providers.[68] Providing healthcare is typically a significant burden on jails and resources are limited.[69] Services can be lacking even for the health issues that are most common among incarcerated populations. On-site, full-time medical staff may not be available, particularly in jails with fewer resources and smaller daily populations.[70] Given the limited medical and staff resources inside jails, incarcerated individuals are typically transported to local hospitals for emergency and specialized treatment.[71]

---

[62] N.C. GEN. STAT. § 153A-225(a)(1)–(3) (1967); Jill Moore, *Public Health Behind Bars: Health Care for Jail Inmates*, 71 POPULAR GOV'T MAG., 16, 18 (2005), https://www.sog.unc.edu/sites/www.sog.unc.edu/files/articles/article2_19.pdf [https://perma.cc/5TAA-8NPT].

[63] N.C. GEN. STAT. § 153A-225(a) (2018).

[64] S.C. CODE ANN. § 24-7-110 (2010).

[65] ALA. CODE § 14-6-19(2) (2019).

[66] *Id.* § 14-6-20(a)–(b).

[67] *Id.* § 14-6-9. A separate provision addresses the removal of tuberculosis patients from jail to a tuberculosis hospital. *See id.* § 14-6-60 (repealed 2015).

[68] *See* PEW CHARITABLE TRS., *supra* note 13, at 1–2 (finding wide variation in the number of vendors used, health services offered, and funding allocated to healthcare across jails; for example, in Virginia, spending on healthcare ranges from 2.5 to 33 percent of the jail's total budget). *Cf.* Noga Shalev et al., *Characterizing Medical Providers for Jail Inmates in New York State*, 101 AM. J. PUB. HEALTH 693, 693 (2011) ("The delivery of health services within the correctional system ultimately depends on the availability of trained medical care providers.").

[69] *See* 2020 NRC REPORT, *supra* note 6, at 31; Nat'l Ass'n of Counties, *supra* note 50, at 8 (finding in a national survey that reducing the number of individuals with mental illness, coordinating mental health treatment, and using insurance to pay for healthcare are among the top five challenges of county jails, alongside reducing jail costs and reducing jail populations).

[70] *See* PEW CHARITABLE TRS., *supra* note 13, at 16–17.

[71] *See* 2020 NRC REPORT, *supra* note 6, at 31.

The quality and scope of care provided in jails is often difficult to assess. Jail contracts with healthcare providers often lack performance requirements or financial penalties and incentives for holding contractors accountable to the service requirements of national accrediting bodies like the National Commission on Correctional Health Care.[72] Moreover, few states require jails to collect and report health data in a timely and comprehensive manner. As a result, incarcerated individuals' unmet needs, necessary improvements to healthcare services, and jails' compliance with health standards tend to be poorly understood.[73] For instance, even though North Carolina requires counties to establish jail medical plans, local health departments provide minimal oversight of the plans, which, coupled with a lack of comprehensive jail health data, makes it difficult to assess whether jails are following the policies set out in their plans.[74] Finally, because jails are not a part of the public health infrastructure, they may not have access to the health records of individuals entering their custody and thus are unaware of severe and even life-threatening health needs.[75]

C. Pretrial Detention and Health

In general, states have rules regulating when and whether individuals can be detained pretrial. The U.S. Supreme Court's ruling in *United States v. Salerno* held that pretrial detention was constitutional under the federal Bail Reform Act of 1984, where the government provided an adversarial, on-the-record hearing and a judge made a finding by clear and convincing evidence that detention was necessary.[76] There is a wide range in how states approach bail hearings, and a range of procedures adopted during them, including whether defense counsel is made available and whether a similar due process standard of proof is afforded.

In general, states offer several different pretrial release and detention options. The standard cash bail model permits a judicial officer to impose secured bonds, meaning a person must pay an amount up front in order to avoid jail detention.[77] That fee can be paid in cash, or through a loan (with a nonrefundable fee paid to a bail bonds company).[78] The judicial officer typically sets the bond amount by

---

[72] *See* PEW CHARITABLE TRS., *supra* note 13, at 1, 20.

[73] *See generally* BRANDON GARRETT ET AL., REPORT ON THE UTILITY OF A NORTH CAROLINA JAIL DATABASE (2021) (finding that reporting daily population counts and demographic and health variables can help improve care, particularly for the most common health issues, and manage public health crises in jails; states with standardized jail data collection efforts include Colorado, California, and Texas).

[74] *See* N.C. GEN. STAT. § 153A-225(a) (2018); GARRETT ET AL., *supra* note 73, at 6.

[75] GARRETT ET AL., *supra* note 73, at 17.

[76] 481 U.S. 739, 751–52 (1987).

[77] *Moving Beyond Money: A Primer on Bail Reform*, HARV. L. SCH. 6 (2016), https://www.prisonpolicy.org/scans/cjpp/FINAL-Primer-on-Bail-Reform.pdf [https://perma.cc/C8RS-PXSY].

[78] *See id.*

following a calculus based on: (1) the risk of non-appearance in court; and (2) the public safety risk that the arrestee poses.[79] Alternatively, a judicial officer can offer an unsecured bond, which does not have to be backed by any money or other collateral—although it does trigger, in theory, a financial consequence if the defendant does not appear.[80]

The pretrial statutes in each of the four states in which we collected data suggest that pretrial decision-making is typically focused on public safety and risk of flight, balanced against liberty interests, but with some room for consideration of health-related factors. Several of these states do note mental health and substance abuse as relevant considerations, but often without clear weight to be given to health-related factors, and some situations in which intoxication or other health crises are reasons to continue to maintain custody of a person to assure that they do not pose a danger to themselves or others.[81]

1. North Carolina

In North Carolina, the pretrial rules only briefly mention health-related considerations during the pretrial decision-making process. A person charged with a non-capital criminal offense usually has a right to pretrial release upon reasonable conditions, apart from cases involving capital murder charges and certain other offenses and classes of defendants.[82] If a secured bond or house arrest is ordered, the judicial official must determine that alternative conditions of pretrial release "will not reasonably assure the appearance of defendant as required; will pose a danger of injury to any person; or is likely to result in destruction of evidence, subornation of perjury or intimidation of potential witnesses."[83]

In general, when deciding what conditions of pretrial release to impose, a judicial officer is to consider a set of the factors listed in a statute: the nature and circumstances of the offense, weight of state's evidence, family ties, employment, resources, character, mental condition, intoxication, criminal history, and history of failure to appear.[84] Of those, "mental condition" and "intoxication" relate to a defendant's health, and

---

[79] *Id.*; *see generally* The Pretrial Just. Inst., *Scan of Pretrial Practices*, 20 (2019) (finding in survey sixty-four percent of counties used bail schedules). The American Bar Association has strongly opposed the use of such schedules: "[This Standard] flatly rejects the practice of setting bail amounts according to a fixed schedule based on charge." AM. BAR ASS'N, ABA STANDARDS FOR CRIMINAL JUSTICE: PRETRIAL RELEASE 113 (3d ed. 2007).

[80] ABA STANDARDS FOR CRIMINAL JUSTICE, *supra* note 79.

[81] *See infra* Sections I.C.1–3.

[82] *See* N.C. GEN. STAT. § 15A-533 (2017) (right to pretrial release in capital and non-capital cases); *id.* § 15A-534 (procedure for determining release conditions).

[83] N.C. GEN. STAT. § 15A-534(b) (2021).

[84] *Id.* §§ 15A-534(c), (g).

specific provisions relate to release of intoxicated defendants (including assuring that they have sobered or that another assumes responsibility for the person).[85]

For public health reasons, a person can also be detained based on exposure and risk of transmission of a communicable disease or for other public health reasons.[86] Individuals under an involuntary commitment order have no right to pretrial release and must be returned to the mental health facility that was previously executing their involuntary commitment in lieu of release.[87] For defendants arrested in manufacture of methamphetamine cases, evidence indicating the individual's dependency upon or regular illegal use of methamphetamine creates a presumption of detention.[88]

2. Georgia

In Georgia, all misdemeanor offenses and some felonies are bailable by a court of inquiry.[89] For persons charged with misdemeanors, courts cannot refuse bail or impose excessive bail, and must only impose conditions that are "reasonably necessary to ensure such person attends court appearances and to protect the safety of any person or the public."[90] Courts are authorized to release on bail any person who is found to pose no significant flight or public safety risk.[91] When setting bail, courts must consider the defendant's financial circumstances.[92]

A defendant's health is a consideration in pretrial release in certain circumstances, for example, intoxicated individuals whose blood alcohol level is above the legal limit may be detained up to six hours after booking.[93] Additionally, individuals charged with an act of family violence will have to meet specific conditions, which may include enrolling in substance abuse therapy or other therapeutic requirements in order to be eligible for pretrial release.[94] In addition to posting bail, defendants may be released under the condition that they comply with an electronic pretrial release and monitoring program and pay associated fees.[95] If a defendant is indigent or has an "extraordinary medical condition requiring ongoing medical treatment," they may be exempt from paying the fees associated with electronic release and monitoring.[96]

---

[85] *See, e.g.*, *id.* § 15A-534.6.
[86] *Id.* § 15A-534.3.
[87] *Id.* § 15A-533(a).
[88] *Id.* § 15A-534.6.
[89] *See* GA. CODE ANN. § 17-6-1(a) (2022) (felony offenses that are bailable exclusively before a superior court judge).
[90] *Id.* § 17-6-1(b)(1).
[91] *Id.* § 17-6-1(e)(1).
[92] *Id.* §§ 17-6-1(e)(2)(A)–(C).
[93] *Id.* § 17-6-1(b)(2)(A).
[94] *Id.* § 17-6-1(f)(2).
[95] *Id.* § 17-6-1.1(a) (2015).
[96] *Id.* § 17-6-1.1(h)(3).

3. South Carolina

In South Carolina, the right to bail is guaranteed for all offenses that are not punishable by capital punishment or life imprisonment, and excessive bail cannot be charged.[97] However, magistrates may deny bail for violent offenses due to the evidence and "the nature and circumstances of the event."[98] Courts may require a bond, place the person in the custody of a person or organization, place restrictions on movement, or impose any other conditions that are "reasonably necessary to assure appearance as required" as a condition of release.[99] When determining conditions of release, courts must consider all available evidence on the defendant's criminal record, pending charges, lawful presence in the United States, and gang affiliation.[100]

Pretrial release rules briefly refer to the mental health of the defendant. When determining release conditions, the magistrate or municipal judge may consider, in addition to the nature of the offense, the defendant's family ties, employment, financial resources, character, mental condition, length of residence in the community, conviction record, and flight record.[101] When considering release on bond in domestic violence cases, the court may consider the defendant's mental health in addition to their criminal history and dangerousness. When considering release on bond charged in harassment or stalking cases, the judicial official may order a mental health evaluation to determine whether to order mental health treatment or counseling as a condition of bond.

4. Alabama

In Alabama, individuals charged with bailable offenses may be released on their own recognizance or on bond, unless the court determines that this will not assure the defendant's appearance in court or pose a "real and present" danger to public safety.[102] The defendant's "reputation, character, and health" are among the factors to be considered when making that determination.[103] The judicial official shall consider: the nature and circumstances of the offense; the evidence against the defendant; characteristics of the defendant including their family ties, financial resources, character and mental condition, past conduct, length of residence in the community, conviction record, and flight record; and any input of the district attorney or prosecutor.[104]

---

[97] S.C. CONST. art. I, § 15.
[98] *Id.*
[99] S.C. CODE ANN. § 17-15-10(A) (2015).
[100] *Id.* § 17-15-30(B).
[101] *Id.* § 17-15-30(A).
[102] ALA. R. CRIM. PROC. 7.2(a).
[103] *Id.*
[104] ALA. CODE § 15-13-147 (1993).

Across all four states in this study, pretrial release criteria make minimal reference to health, as is typically the case in correctional systems around the country.[105] Health is only included as an optional, rather than mandatory, factor to be considered during pretrial release decisions.[106] Defendants' mental health or "condition" is mentioned more often than physical health, without elaboration on which aspects of mental health are to be considered, or how to consider them.[107] The potential uses of health information included in the pretrial criteria either justify extended detention, due to instances of intoxication or public health risks, or additional bail conditions, such as completion of a treatment program, rather than expedite release.[108]

D. Evidence Concerning Jail Healthcare

Researchers have collected data regarding healthcare in prisons in national studies by the National Center for Health Statistics (NCHS) partnering with the Bureau of Justice Statistics (BJS) to develop and conduct the National Survey of Prison Health Care (NSPHC).[109] In contrast, very little work has been done to survey the provision of medical care in local jail facilities,[110] but there are some prominent examples. One prior survey examined perspectives of local correctional staff with regard to persons with mental illness in local jails.[111] Another prior survey examined jail mental health screening, evaluation, and suicide prevention.[112] A Federal Bureau of Justice Statistics report described "Medical Problems of State and Federal Prisoners and Jail Inmates," based on survey data collected in 2011 and 2012.[113]

---

[105] 2020 NRC REPORT, *supra* note 6, at 61 ("[D]espite the feasibility of decarceration from the viewpoint of public safety and its desirability from the perspective of public health, there is too little scope in current law for accelerating releases for public health reasons. Indeed, medical or health criteria for release, even in pandemic emergencies, are largely nonexistent at the state level and highly circumscribed in the federal system."); Nat'l Ass'n of Counties, *supra* note 50, at 12 ("[R]esponding county jails reported state statute(s) as the source of pretrial release authority for only 36 percent of the physical health care treatment programs supervising pretrial detainees . . . .").

[106] *See supra* Sections I.B–C (discussing statutes on pretrial release from four states in the study).

[107] *See supra* Sections I.B–C.

[108] *See supra* Sections I.B–C.

[109] *National Survey of Prison Healthcare*, CDC, https://www.cdc.gov/nchs/dhcs/nsphc.htm [https://perma.cc/53AH-82NB] (last visited Dec. 8, 2022).

[110] There have been surveys of local jail inmates, that ask about those person's healthcare needs. Bureau of Just. Stat., *Survey of Local Jail Inmates* (May 26, 2009), https://bjs.ojp.gov/data-collection/survey-inmates-local-jails-silj [https://perma.cc/8YED-HY7S].

[111] AZZA ABUDAGGA ET AL., INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES IN COUNTY JAILS: A SURVEY OF JAIL STAFF'S PERSPECTIVES i (2016), https://www.treatmentadvocacycenter.org/storage/documents/jail-survey-report-2016.pdf [https://perma.cc/GN55-QNQP].

[112] Suzanne Morris et al., *Mental Health Services in United States Jails: A Survey of Innovative Practices*, 24 CRIM. JUST. & BEHAV. 3, 3 (1997).

[113] Maruschak & Berzofsky, *supra* note 9 ("This report uses data from the 2011–12

Finally, a survey of county jails and state prison facilities in Washington, Oregon, and Idaho assessed what healthcare services were available.[114]

Two of the authors of this Article have interviewed jails in four states—Alabama, Georgia, North Carolina, and South Carolina—in order to assess the medical care provided. Among the thirty-two jails, more than 91 percent (n=29) contracted with nine distinct private companies to provide primary healthcare services.[115] Staffing for healthcare varies widely and is generally aligned with jail size. Larger jails (capacity equal or greater to 250) typically had medical providers (physicians and advanced practice providers such as nurse practitioners and physician assistants) on-site three to seven days per week and around-the-clock nursing presence. In contrast, in smaller jails, medical providers were typically on-site once a week or less, and nurses were only on-site weekdays.

Regardless of jail size and healthcare staffing availability, detention officers played a critical role in the provision of healthcare. It was common for detention officers to transport and accompany individuals to healthcare appointments (on- and off-site); accompany nurses during "pill pass" (i.e., medication administration); conduct suicide watch; and serve as the "eyes and ears" in the housing units to identify and respond to medical emergencies, including contacting the healthcare team and providing basic care and first aid.

Upon entry into the jail, nurses or detention officers decided whether the arrested individual had any medical needs (typically immediate, severe needs such as major wounds or risk of overdose due to severe intoxication) that would prevent their safe housing in the jail. If such conditions were identified, the arresting officer was required to take the individual to the emergency department to obtain care and "medical clearance" (i.e., a statement from a healthcare provider that a person's health status does not preclude incarceration) prior to returning the arrested person to the jail.

Shortly after being booked into the jail—and sometimes during the booking process—individuals were screened by a nurse or detention officer about their health and medical history via a questionnaire and an observation. The information collected during the intake screening process served several functions, typically guiding decisions about housing, diet, determining whether additional testing was needed,

---

National Inmate Survey (NIS-3) to describe the health status and the health services and treatment received by state and federal prisoners and local jail inmates.").

[114] Hannah Neill-Gubitz et al., *Availability of Health Care Services and Medications for Opioid Use Disorder in Carceral Facilities in Washington, Oregon, and Idaho*, 33 J. HEALTH CARE POOR & UNDERSERVED 407, 407 (2022).

[115] Interview data were collected as part of the research study described in this Article. To encourage candor, interviews were conducted under the condition that participants' identifying information remain confidential. Copies of interview transcripts created from audio recordings are maintained by two authors. Transcripts redacted for identifying information were shared with the journal editors as part of their process to validate the accuracy of quotations used in the Article.

how soon the individual needed to be seen by a nurse or medical provider, and if and when medications were initiated. Jails commonly also conducted a routine physical examination on every individual within the first month of incarceration, and had a process for individuals to request nonurgent healthcare.

II. INTERVIEWING JAILS REGARDING HEALTH AND RELEASE DECISIONS

To develop a comprehensive understanding of healthcare in local jails, we conducted in-depth interviews with jail personnel in four southeastern states—Alabama (AL), Georgia (GA), North Carolina (NC), and South Carolina (SC)—all of which have county-operated jails. Sampling, interview guide development, data collection, and analysis are briefly described below. A more complete description of the methods and an analysis that focuses on the structure and resources of jail healthcare can be found in a separate publication.[116] The institutional review board at the University of North Carolina at Chapel Hill (UNC-CH) approved this study.

A. Interview Methods

We identified the universe of jails based on those documented in the 2006 and 2013 Bureau of Justice Statistics Census of Jails, and we added and subtracted from this list based on internet searches for jail closings and openings. We categorized jails by size and classified jails' rurality based on the county where they were located. We purposefully targeted recruitment of personnel at jails that reflected a diversity of jail sizes, rurality, and geographic locations within our study states. We called top jail administrators and healthcare staff at targeted jails to identify potential respondents, seeking the person recognized by jail personnel to be most knowledgeable about healthcare delivery within that facility.

We conducted interviews with participants in thirty-two jails from August 2018 to February 2019. The sample included 11 percent (n=7) of county jails in AL, 6 percent (n=9) in GA, 13 percent (n=12) in NC, and 9 percent (n=4) in SC. The majority of interviews were conducted in person and 19 percent were conducted by phone. Interviews were typically completed in one to two hours. The interviewers had experience conducting qualitative interviews with healthcare providers and in carceral settings.

1. Interview Guide Development

We developed the interview guide by conducting a detailed review of the scientific literature, including previous jail-based surveys, and eliciting input from an expert team of seven people with more than seventy-five years combined carceral

---

[116] *See generally* Jessica Carda-Auten et al., *Jail Health Care in the Southeastern United States from Entry to Release*, 100 THE MILBANK Q. 1, 1–5 (2022).

health services research experience. Prior to initiating the interviews, we piloted a draft of the guide to two jails and made revisions based on their feedback. During the study, we iteratively modified the guide to be responsive to emerging themes. The final version of the interview guide includes questions on jail staffing; health screening and testing; healthcare and treatment; jails' use of community healthcare resources, safety net enrollment; release; and budget, billing, and administration. The section on release includes questions on the jail's typical release process, including for individuals taking medication; processes for enrolling people in benefits prior to release; and communication with and linkage to community healthcare providers.

2. Data Analysis

We audio recorded interviews and had them professionally transcribed; personal identifiers were removed. We used a coding-based thematic analysis approach and the Framework Method to identify themes within and across the in-depth interviews.[117] To begin, members of the analytic team independently read the transcripts and produced summaries of each interview, using a template to organize main themes of interest. The team then developed a codebook, with coding categories derived *a priori* from the study aims and from themes that emerged during transcript review. We piloted the codebook with a subset of initial interviews, iteratively editing the codebook to refine codes and code definitions to facilitate their consistent application. Using Dedoose, two analytic team members independently read and deductively coded each transcript. The team then met to reconcile any discrepancies by consensus. Once coding was complete, we created detailed matrices for relevant codes and summarized content relevant to each code by and across participants.

B. Understanding Health-Based Early Release

1. Common Reasons for Early Release

Although the interview guide did not contain questions on health-based early release, interview subjects at the majority of jails described that incarcerated individuals were sometimes considered for early release from a jail due to their medical needs. One of the most commonly cited reasons for this was pregnancy (mentioned by twelve jails), in particular if there were potential complications, including miscarriage symptoms or recent opiate use, or if the individual was nearing delivery. Other

[117] The Framework Method is a form of qualitative content analysis whereby date is organized in a matrix, with one case per row, one code (conceptual label) per column, and cells with summarized data. This structure allows the research team to compare data across cases and within individual cases. Nicola K. Gale, Gemma Heath, Elaine Cameron, Sabina Rashid & Sabi Redwood, *Using the Framework Method for the Analysis of Qualitative Data in Multi-Disciplinary Health Research*, 13 MC MED. RES. METHODOL. 117 (2013).

common reasons included significant injuries or serious illnesses requiring major medical attention (e.g., cancer) or expensive medication (e.g., HIV) (mentioned by fourteen jails),[118] serious mental illness (mentioned by five jails), and physical disability necessitating special accommodations (e.g., paraplegia) (mentioned by two jails).

2. Early Release Mechanisms

Jails reported that they expedited the release of individuals with medical conditions in a number of different ways. The mechanism used and timing of release generally depended on an individual's charges or perceived threat to public safety, the type of medical care needed, and when the medical condition was identified. Once an individual has been booked into the jail, the primary mechanism used to expedite the release of those with medical conditions is changing the terms of the bond. Most commonly, jails work with the district attorney and judge to modify the bond by "unsecuring" it, but other procedures exist, including releasing a person on their own recognizance.

As the following participant described, the judicial officer may also reduce the amount of the bond to make it more likely that the individual could be released: "Sometimes they let 'em sign their own bond. Sometimes they relay to the judge what's goin' on with them. They might reduce it, or they can pay or make some kind of arrangement or whatever."[119] Making changes to the bond was typically only an option when the individual's charges were minor and their release presented no more than a minimal risk to the community.

As noted, when jails release an individual by unsecuring their bond, it is done on the condition that they will appear in court when required. Jails or judges may impose additional conditions upon those that are released early, including the requirement that they receive the recommended medical care within a specific time frame. One participant, who provided the example of an individual that needed surgery, described this in the following way:

> I had a female that was booked in. She had a vascular hernia. That's something that can rupture at any time. You can bleed out. You'd be dead in second . . . . She got released pending that she went to a surgeon to have the procedure done. They follow up on that too . . . . If you haven't done what you're supposed to in the allotted time, then they're gonna pick you back up.[120]

---

[118] This category was mentioned most often likely in part due to its broadness; it includes mentions of HIV, Hepatitis C, dialysis, serious cardiac problems, diabetes with complications, bleeding disorders, cancer, cirrhosis, brain bleed, "major illness," major surgery, severe respiratory problems, palliative care, and long-term hospital stay for unspecified reasons.

[119] Transcript from Jail 28 [Small] at 15 (2022).

[120] *Id.*

Another jail described a situation in which the judge requested the name of a pregnant individual's doctor and an assurance from her family that the baby would receive care before he allowed her to be released to deliver her baby. And, in this case, she was also required to return for a court date following the birth.

> Usually, the court can work something out where they can say, "Okay, we're gonna let you go, but you better be here on this date." Have gone as far as, a judge last year wanted the name of the girl's doctor and wanted to talk to the family that was gonna take care of the baby while she was incarcerated to make sure the baby was gonna be safe before he even agreed to let her out to go have the baby cuz they wanna protect the baby first . . . . [she was released] [o]n her recognizance, so she could go out and have the baby. Her family took her to her doctor. She had the baby, and I think they made it so her court date would be like three months after she gave birth . . . . Yeah, and she may have to go to prison, but they at least delayed everything so that she could at least have her baby in peace and have a few months, and that's assuming that they didn't do something horrible.[121]

The interview subjects described how they explained health-related concerns to judicial officers at bail hearings. For example, one described:

> One of the things we do is—I get a list every day of the people who are in the hospital. I look at what's wrong, and if it looks like it's gonna be somethin' that's gonna be a long, drawn-out thing—we have a sergeant here. She and I go to court. I go to court a lot because the judges don't understand medical, and they need to understand before they say no. I will call her and say, "Look. Joe Smith's in the hospital. He's got cardiac disease. He's not doing well. We need to do somethin'." She will call the judge, and the judge will say, "I need to know more about it." Then I'll go down and talk to the judge. Depending on what the charges are, they'll sometimes release 'em . . . . Let 'em go. . . . Sometimes they won't, depending on the charges . . . . It's gonna be end-of-life . . . . Because it's—we just had a young man die a few months ago, and we were all so close to him because he was in the clinic. I had had him sign the Do Not Resuscitate. We had talked to him. We didn't have hospice come in because we

[121] Transcript of Jail 30 [Medium] at 39–40 (2022).

> were doin' hospice. We had all the medications he needed, and we took care of him. He was supposed to go off to prison, but he was too sick to make the ride, so we had to keep him here . . . . We begged the judge to let him go home, and he wouldn't do it. A couple of days before he died, he was hurting so bad we just couldn't control the pain anymore. He asked to go the hospital, and we sent him. He died there at the hospital, but he died without his family being there with him, and that bothers me and everything . . . . I said that was just cruel. You could've let that family see him . . . . Well, yeah [that decision was related to his charges], but—it was manufacturing drugs. So what? We got people here that do a whole lot worse than that . . . . But he just had a vendetta out for this guy. He wouldn't let him go home, so the family missed that last day with him . . . . We just felt like we had to make the judges aware that they can't just make the decision based on what they think is wrong with a patient. They need to know the whole story, so I will make a copy of the chart, a copy of the x-rays. I will go down and talk to him, show him what the doctor said, and—think about it. Some people, they'll actually do it, but this guy he wouldn't do.[122]

Other, less commonly mentioned early release mechanisms included allowing for extra phone time to help the individual find somebody to pay bail, expediting the "parole pick-up process," expediting sentencing, expediting transfer to prison if the individual was already sentenced, expediting the court date, "working closely with Colonel,"[123] went "to the jail admin,"[124] and "giv[ing] them another court date."[125]

C. Factors Motivating Health-Based Early Release

The early release of individuals from jails most commonly occurred when there was a convergence of specific medical issues and underlying structural factors. We identified five structural factors that motivated the early release of those with medical conditions: an inability to provide healthcare, the belief that it would be overly burdensome to provide healthcare, liability concerns, workforce burdens, and concerns that care would be a financial drain on the jail. Each participant that described early release of individuals with medical issues either explicitly or implicitly stated that one or more of these factors motivated the release.

---

[122] Transcript of Jail 22 [Large] at 60–62 (2022).
[123] Transcript of Jail 31 at 36 (2022).
[124] Transcript of Jail 22 at 24 (2022).
[125] Transcript of Jail 16 at 33 (2022).

1. Inability to Provide Healthcare

Some jails reported that they released individuals when they were unable to provide the level of healthcare needed or when they believed that the individual needed to receive care elsewhere. These were cited as the motivating factor in cases involving serious mental illness, individuals recovering from major surgery, and, as described by the following participant, for disabilities requiring significant accommodations like paraplegia:

> We had a paraplegic come on a murder charge . . . . There was no way that he could just let him go, but he knew that we could not provide the care for him here either, so he got with the judge, and it was special stipulations on the bond, and he was able to leave and be at home. Of course, I know he wasn't gonna be able to run anywhere, so they just let him go . . . . That's when you work together, and the judge gets involved and the security.[126]

Jails typically had the ability to house individuals with serious mental illness and had ways to prevent them from hurting themselves or others. However, some jails also recognized that they were not able to provide adequate healthcare and found ways to have the individuals released in order to access better care. In the following example, after an individual attempted suicide, it was determined that he would be best served by inpatient psychiatric care. If he remained in the jail, he would be placed on a months-long waitlist for a psychiatric hospital, whereas if the jail released him and had him involuntarily committed, he could receive care immediately. The interview subjects described how they explained health-related concerns to judicial officers at bail hearings. In one example, the participant described the frustration of being unable to convince a judge to facilitate a health-based release. The participant said:

> I could just tell—he was starin' off—somethin' wasn't quite right. I talked to [psychiatrist]. She did the little—we made an appointment for her to do the little telehealth thing . . . . His mom come up here . . . . She came up here and she was like, "I want you to tell me what I need to do," cuz she was gonna bond him out. I told her—I said, "Honestly, I can't tell you what to do with your child and if you should or shouldn't bond him out, but I can give you my opinion of if it was my child, I would make sure that if I was bondin' him out that he was gonna be somewhere to get mental health ASAP—like, not go home and hang out for a little

[126] Transcript of Jail 31 at 37 (2022).

> while—because he attempted suicide in here, and he was for real." . . . . I told his mom my recommendations and [psychiatrist's] recommendations, which was for him to get involuntarily committed, and if she wanted to bond him out that we would give him a courtesy ride straight to the ER as long as she had the papers stamped and sealed from the judge, because if she wanted to bond him out, we weren't gonna let him go on the street. If she had those papers stamped and sealed, the hospital has no choice but to find him a bed at a mental health facility whenever they release him . . . . That actually ended up workin' a lot better because in situations like that at the jail, the downfall there is he would've sat here and waited months for a bed . . . . Cuz they'd have been like, "Well, y'all can watch him." This isn't somewhere for somebody to get psychiatric help. This is a jail. Yeah, they can talk to her through there, and we can give them medicine, but it's not the same. It's not the help that he needed. She did do that, and, hopefully, he is getting the help he needs now.[127]

Jails also reported releasing individuals early when the individual needed surgery that would entail an intensive recovery period, as described by the following participant.

> That does happen on occasion. We've had one that I can think of. He had a very large hernia and was gonna have to have hernia surgery . . . . Then the recovery for that is gonna be not—it's gonna be a lot easier at home versus recovering from something like that inside the jail here, so they let him go ahead and bond out to be able to have that.[128]

In the same way that a jail might be able to keep an individual with serious mental illness from harming themselves, if no other options were available, a jail might be able to provide care for someone recovering from major surgery. However, when making a decision about whether to provide this care, jails typically weighed their ability to provide the care needed against their options for getting the individual out of the jail.

2. Overly Burdensome to Provide Healthcare

Some jails described releasing individuals when the care needed would be overly burdensome to provide. This was reported in cases where individuals needed

---

[127] Transcript of Jail 21 at 25–27 (2022).
[128] Transcript of Jail 33 at 35 (2022).

a high level of care or special accommodations, including those with a pregnancy nearing delivery, individuals that were very sick, and those with a physical disability. As described by the following participant, when incarcerated persons' morbidity was viewed by participants as overly burdensome to address in jail, participants were eager to utilize options for early release when court officers were amenable:

> I go to the jail admin and try and get them out of custody . . . . If they got cancer . . . . Those are the only people that I've had that come in on those high dose of morphine, so yeah . . . . Well, and too, they're usually sick people too. Yeah, if they're on that kinda medication and they're on hospice care, then they're sicker than we wanna deal with.[129]

When describing the release of individuals whose care would be overly burdensome, as described in the following example, jails often referenced the need to weigh the difficulty of providing care against the difficulty of securing an early release.

> Sometimes we might have a female come in here pregnant and she has a very complicated pregnancy and high risk, and she might be close to due date. Then she's gonna bond court that next morning so we'll tell the officers this is her situation so let's see if we can get her out of here, so we do that and they work with us. They'll take it up to jail administration and let them know what's goin' on and they'll try and get the person out if they see it's gonna be more for us to handle than it is worth the charge in the first place.[130]

3. Liability Concerns

Some jails described liability concerns as the motivating force behind early release. Once an individual has been booked into the jail, a medical issue like a high-risk pregnancy (e.g., an individual on opiates or experiencing symptoms of miscarriage), pregnancy nearing delivery, or an illness that requires complex management could prompt concerns about liability for the jail, which could lead the jail to release the individual early. If no other options were available, healthcare staff in a jail might be able to deliver a baby or manage a pregnant individual withdrawing from opiates. However, some jails recognized that it was risky to deliver a baby outside of a healthcare setting and that allowing a pregnant person to withdraw from opiates without medications for Opioid Use Disorder (OUD) had the potential to

---

[129] Transcript of Jail 29 at 41 (2022).

[130] Transcript of Jail 12 at 32–33 (2022).

harm the fetus, which in turn presented a liability for the jails. Thus, as described by the following participant, jails frequently found ways to release individuals with high-risk pregnancies or those approaching delivery.

> Initially, she had no complaints because I think she thought she was gonna bond out . . . . I had went home, and the nurse called me and said that, "That pregnant female back there is now complaining of abdominal pain, and she hadn't eaten since 11:00, and she's vomiting, and she's due for her C-section on this date . . . ." I said, "Well, she has to go on out." . . . She was still in booking . . . . I said, "Well, let me call Colonel [name of colonel] first to see if he will just let her go because she's just here on a truancy charge, if he'll release her to go." They spoke with him, and he said that the mom was on the way to bond her out . . . . Now whether or not she actually had all that going on, it didn't matter. It was a liability . . . . I told the nurse to stop that screening process. She had to go out. Either they were gonna let her go, or they were gonna send her to the ER, and they were gonna document to cover us.[131]

Sometimes multiple factors—liability concerns and the determination that care would be too burdensome to provide—motivated jails to release individuals early. An example of this was serious medical conditions that required consistent management. As described in the following participant, an individual with a bleeding disorder presents both a condition that is difficult to manage in the jail setting and one that is "high-risk" for the jail to manage:

> It does occasionally [happen that inmates have cancer or some sort of major illness]. Those are the people that we're gonna try and get out . . . . We have had some people that have had bleeding disorders. They're on Coumadin. You have to have weekly blood drawn for Coumadin because it's a blood thinner . . . . It's not impossible, but it does complicate things, so we really try very hard to get them out . . . . You know, they're from [name of state] and they've got family in [name of state]. I will ask the booking sergeant, "Let them make as many phone calls as they have to make to get somebody to bond them out and get them out of here." "We don't need this in the jail." . . . . It's not that we *can't* manage it, it just makes it more difficult . . . . They would be very high-risk.[132]

---

[131] Transcript of Jail 31 at 26–27 (2022).

[132] Transcript of Jail 15 [Small] at 45–46 (2022).

In this example, as with those above, the jail raised particular concerns for high-risk patients and described aggressive efforts to locate options for care outside the jail.

4. Workforce Burdens

When incarcerated individuals were sick or injured and needed nonemergency transportation to an off-site medical facility, detention officers and sheriff's deputies were typically tasked with transporting these individuals. Some larger jails had "transport teams" dedicated to this, while smaller jails pulled officers and deputies from other duties to transport individuals. While the individual was receiving care, the officer or deputy (potentially multiple, depending on the security risk of the individual) was required to remain at the medical facility for the duration of the medical visit.

As such, individuals with medical conditions requiring regular appointments or lengthy hospital stays often became candidates for early release due to the workforce burden that they presented. This was particularly common for individuals that needed dialysis, as it was extremely rare for jails to provide dialysis on-site and treatment is typically needed three times per week and takes five hours to complete. The following participant described the workforce burdens associated with having dialysis patients and how quickly the jail works to release these individuals:

> We have [had people on dialysis], but they don't stay. [Laughter] . . . . I'm gonna get with the colonel, and they're gonna get out of here . . . . Now, we have had them where they may have stayed like two days, and they did have to make it to their dialysis appointment, but it no longer is. They're not staying, no, cuz the deputy has to transport them, and the deputy's gonna have to sit there for hours, and he's gonna get with colonel that's over the roll patrol. He's gonna be like, "Colonel, you've just gotta get him out of here." . . . . It ties up his officers, his deputies, also.[133]

Another participant described the same sense of urgency and workforce burdens, but also referenced the individual's charges, illustrating the way that jails weigh the motivating factor (in this case the workforce burden) against the ease with which they are able to release the individual, which is directly related to their charges (in this case, failure to appear in court).

> We try and get rid of dialysis patients as quickly as we can too, because they don't wanna have to transport them three days a

[133] Transcript of Jail 31 [Medium] at 64 (2022).

> week to dialysis . . . . Yeah, it's a lot of man hours used up . . . . Usually it's somethin' stupid, like they didn't show up to court.[134]

As noted above and described by the following participant, jails also released individuals early because of the workforce burden presented by lengthy hospitalizations.

> That's the reason that they'll release 'em sometimes. If somebody's in the hospital long term, they'll give the DA and [un]secure their bond or something so that they don't have that manpower out there at the hospital. Two officers, a lot of the times, just out there sitting in the hospital, and so they'll release 'em. Medically, we're still responsible for the bill if we initiated that hospital stay.[135]

In this example, the jail described releasing hospitalized individuals early to avoid the need for multiple officers to remain there to accompany them, even if they would still end up paying the full hospital bill for that person.

5. Financial Drain on the Jail

Jails also commonly cited financial drain as one of the factors motivating the early release of individuals with medical conditions, and this was most frequently described in cases where the individual needed expensive medications or a lengthy hospitalization. Some, like the following participant, referred generally to "high-dollar inmates" and noted that these individuals must also be "low risk," or someone incarcerated for a less serious crime.

> We have to notify them, "We got this patient that has a lot of medical issues. Is there anything that we can do for relief"—any relief? That's one question [Laughter] that I ask them. Is there any relief that we can have? [Laughter] . . . . Somebody who's really sick that we already anticipate that it's gonna be, what I call, a high-dollar inmate . . . . It has to be a low-risk inmate. If it's somebody who's a high-risk inmate who was here for a serious crime, then you just have to eat that. [Laughter] . . . . Yeah. If it's something minor or some child support. We pay child support. We could've paid the child support bill.[136]

---

[134] Transcript of Jail 29 [Medium] at 41–42 (2022).
[135] Transcript of Jail 11 [Medium] at 56 (2022).
[136] Transcript of Jail 11 [Medium] at 56–57 (2022).

Jails commonly described situations in which they released early those individuals with medical conditions that necessitated expensive medications, like Hepatitis C or HIV. The following participant noted that having a single individual with HIV could cost the jail $1,000.00 a week and describes a couple of ways that the jail might release someone with this type of condition, including giving them another court date or releasing them under supervision with a leg monitor.

> To be 100 percent honest, I mean, sometimes the major of the jail and the court will—you've got somebody here who didn't show up for court, so they got them arrest for failure to appear. Okay. Well, then give them another court date and give them another chance. Send them home . . . . Yeah. I mean, it's $1,000.00 a week to keep them here [if they have HIV and need medications]. No, let them go home and come back to court . . . . There are times that people get sent home strictly because of the medications or treatments that are needed. It doesn't happen a whole lot, but there are circumstances where it's just not—it's not financially smart to keep that person here in jail when you can put a leg monitor on them and send them home. I mean, I think they should do that more than what they do. I bet they could save tons of money by putting ankle monitors on some of these people and sending them home . . . . I mean, there's some you can't do that with, but some of them you can that are not—like you say—not really a risk to anybody in society. They're just making some stupid decisions or something . . . . I think that would be an option that definitely gets used, just not enough.[137]

When individuals needed lengthy hospitalizations, jails often reported releasing them early due to financial concerns. A couple of jails, including the following example, even described unsecuring the individual's bond on the way to the hospital to release someone who might end up costing the jail a lot of money.

> They'll unsecure the bond on the way to the hospital, so they don't have to pay for it. [Laughter] . . . . If you get somebody that they're bringing them in, and they're having a heart attack, if you don't unsecure the bond, then that's on us . . . . They'll unsecure the bond when they're coming to the hospital, yeah . . . . Usually, the major [makes that decision]. They talk up there, and I don't even know. I guess they go to the magistrate, and the magistrate will unsecure it.[138]

---

[137] Transcript of Jail 16 [Medium] at 33–34 (2022).

[138] Transcript of Jail 20 [Medium] at 21 (2022).

Another way officers will handle this situation is by corresponding with the judge. For instance, one participant described the exchange like this:

> Maybe we'll try to talk to the judge and say, "Hey, can we do this?" or whatever. He's really gonna be—we'd like to do this and this and this, but a lot of times, no, not with the judges we have. We have one right now with a colostomy bag. I would love for him to go home, but he's here. He's been here for weeks so it's not [background noise 00:34:40]. We're having to pay for those. [Healthcare company] or whoever is having to pay for it, the county or whoever is having to pay for those. They're not cheap. What do you do? He has to have it, and like I say, he's not going home no time soon. He's here.[139]

6. Strategic Use of Early Release

There was some indication that incarcerated individuals were aware of the fact that a medical condition could result in their early release from jail. In some cases, individuals seemed to use this awareness to receive care that the jail might not provide otherwise. In the following example, an individual who was newly diagnosed with HIV was aware of the fact that the jail was required to provide him with medical care and used this knowledge to advocate for medication, presenting jail staff with the option to either provide him with this medication or release him.

> If they were to request, and they said that they—like we did have a guy that requested for an HIV test. He said that he had been using drugs, and he had been with multiple partners, and he had this weird rash on his feet that he was developing. Doc saw him, and we tested him, and he was positive . . . . He wanted medicine, of course. Yeah, he was one of those ones saying, "Y'all gonna take care of me, or y'all gonna get me out of jail."[140]

Some participants described scenarios in which they perceived incarcerated individuals using their awareness to take advantage of the system and get out of jail early. In some cases, like that described by the following participant, individuals with an expensive medical condition like HIV, armed with the knowledge that the jail does not want to keep them incarcerated if it means they will have to pay for their medication, have gone directly to the judge to argue that they should be released early.

---

[139] Transcript of Jail 20 [Medium] at 21 (2022).
[140] Transcript of Jail 31 [Medium] at 66 (2022).

> When they're here for short times, usually, I've only had to order a month's supply. That's the least you can order of HIV meds. You can't say, "I've got this guy for seven days. Can I have seven pills?" No, you have to order a 30-day supply . . . . I think that these people cuz we have a few recurring that keep coming back, HIV, and I think they know that the jail doesn't wanna pay for their meds. I think they kind of use that against us sometimes to get out . . . . Just not bonding out at all, knowing that we're not—if they can bond out, and it's a big amount, they know they're not gonna keep them too long if they've been in the system . . . . Yes, it's your medical secret, but some of these people don't make it secret. They'll walk right into court in front of the judge, or in their 72-hour hearing, and, "I'm HIV positive. I've gotta get out. My medicines, I've gotta go get 'em." We don't tell. The nursing staff doesn't tell the court, but sometimes the court tells me.[141]

In other cases, like that described in the following passage, participants were concerned that jailed persons were fabricating symptoms that they thought could result in their release.

> [T]hey'll say, "Such-and-such is havin' difficulty breathing. EMS is on the way." Then EMS will say, "Yeah, he needs to go." We go by their vitals. If they've got good vitals and they're sittin' there goin' [sound of heavy breathing], we can see through it. They think that we'll get their bond unsecured for 'em . . . . It's a little bit of trickery sometimes.[142]

III. JAIL HEALTH RIGHTS

This Article has so far described the circumstances, motivations, and mechanisms for health-related release in jails. This Part explores what possibilities there are for making these mechanisms formal, and not purely informal. Of course, these mechanisms hinge not just on procedure, but also on the availability of care in jail settings, as well as the underlying approaches towards pretrial detention and sentencing. Early release might not be needed if persons with health risks were diverted before booking, or conversely, release to outside healthcare providers might not be needed if better crisis care could be provided in the jails. This Article suggests that those alternatives can be combined: early diversion to high-quality healthcare,

---

[141] Transcript of Jail 30 at 31–32 (2022).

[142] Transcript of Jail 9 [Medium] at 62 (2022).

outside of jail, can help avoid the need to make difficult healthcare decisions in the context of a jail.

In the past decade and a half, there has been a dramatic increase in state-level legislative activity concerning pretrial policies regarding detention in jails, with 500 enactments just from 2012 to 2017.[143] While bail reform efforts have emphasized more rigorous bail hearings, use of risk assessment, careful consideration of pretrial release options, and reconsideration of the role of cash or secured bond—very little of this legislative activity focuses on jail health, much less rights and procedures regarding consideration of health in pretrial decision-making.

To be sure, as these interviews found, a range of informal means do exist to consider health when making pretrial detention decisions. These types of informal rules became prominent when a number of states used non-constitutional regulations and informal practices to increase jail discharges during the COVID-19 pandemic. Indeed, the state courts that did afford relief to people held in detention, tended to do so under state law,[144] or other supervisory authority regarding pretrial detention rules.[145] The Hawaii Supreme Court used its supervisory authority to order release of individuals held pretrial during the pandemic; however, many other state courts refused to do so.[146] These rulings suggest avenues exist to supervise jail admission and take health concerns into account.

---

[143] Amber Widgery, *Trends in Pretrial Release: State Legislation*, NAT'L CONF. OF STATE LEGISLATURES 1, 3 (2015), https://www.ncsl.org/Portals/1/Documents/cj/pretrialTrends_v05.pdf [https://perma.cc/P4BP-H8KT]; Nat'l Conf. of State Legislatures, *Trends in Pretrial Release: State legislation Update*, NAT'L CONF. OF STATE LEGISLATURES (2017) [https://perma.cc/TD3W-EZBE].

[144] *See, e.g.*, Karr v. State, 459 P.3d 1183, 1186 (Alaska Ct. App. 2020) (interpreting bail statute and concluding COVID constituted "new information" supporting revisiting pretrial conditions).

[145] *See, e.g.*, Comm. for Pub. Couns. Servs. v. Chief Just. of Trial Ct., 142 N.E.3d 525, 533–34, 542–43 (Mass. 2020) (setting out presumptions and categories of people in pretrial custody eligible for release, and describing similar orders by Michigan, New Jersey, and South Carolina supreme courts); Foster v. Comm'r of Corr., 146 N.E.3d 372, 400 (Mass. 2020) (granting relief regarding drug-treatment-related civil commitments using supervisory authority); *In re* Request to Modify Prison Sentences, 231 A.3d 667, 673–74 (N.J. 2020) (adding due process protections to the Executive Order, including minors in custody of Juvenile Justice Commission). *But see In re* Pa. Prison Soc'y, 228 A.3d 885, 887 (Pa. 2020) (declining to use supervisory authority to order immediate releases, but rather directing lower-court judges to consider public health concerns and limit introduction of new people to facility).

[146] *See In re* Individuals in Custody of Hawai'i, No. SCPW-20-0000509, 2020 WL 4873285, at *1 (Haw. Aug. 17, 2020), *clarified on denial of reconsideration sub nom.*, Individuals in Custody of State, No. SCPW-20-0000509, 2020 WL 5036224 (Haw. Aug. 26, 2020). In contrast, several other state supreme and appellate courts refused to issue writs of mandamus to provide emergency relief in response to COVID-19 at correctional facilities. *See, e.g.*, Kerkorian v. Sisolak, 462 P.3d 256 (Nev. 2020) (denying mandamus petition and citing to similar rulings by the Kansas, Massachusetts, Montana, and Washington courts).

At the state level, there are models for better oversight of and more detailed regulations on jail healthcare. The rules in place in the four states we surveyed are limited and deferential to local authorities, which is typical of state rules around the country. However, more detailed jail healthcare rules do exist in other states. For example, New York details the procedures regarding the removal of individuals from jail due to health concerns,[147] and Massachusetts outlines extensive requirements for jails regarding medical treatment, screening, personnel, and more.[148] Such regulatory oversight, alongside consistent data collection and reporting requirements, could help address the large variation and gaps in healthcare services and release procedures across jails within a state.[149]

Few states have rules that create formal legal vehicles for non-admission or release from jails for health-related reasons. Arrest and charging diversion programs can direct people to treatment programs rather than detention at the point of arrest or charging. A prominent example is the "Miami Model," which uses pre- and post-booking diversion to divert individuals with Serious Mental Illness (SMI) and co-occurring substance use disorders away from jail, and into community-based treatment and support services.[150] The prebooking component consists of Crisis Intervention Team (CIT) training for law enforcement officers.[151] The post-booking component involves screening individuals booked into the Miami-Dade County jail and transferring those who are found to be in acute psychiatric distress to a crisis unit.[152] The program also provides discharge planning to participants returning to the community, including developing reentry plans, establishing linkages to community services, providing case manager monitoring, and assistance with enrollment in federal and state entitlement benefits.[153] Since the Miami Model's launch in 2000, Miami-Dade County has reduced the number of individuals with SMI in the county jail, recidivism, acute care costs, and chronic homelessness, as well as improvements in public health.[154]

---

[147] N.Y. CORRECT. LAW § 508 (Consol. 2021).

[148] *See* 103 MASS. CODE REGS. 932.00–932.19 (2009).

[149] *See* GARRETT ET AL., *supra* note 73, at 5 (recommending that if states do not have a policy requiring data reporting, jails should establish their own reporting procedures).

[150] Steve Leifman & Tim Coffey, *Jail Diversion: The Miami Model*, 25 CNS SPECTRUMS 659, 659–60 (2020); John K. Iglehart, *Decriminalizing Mental Illness—The Miami Model*, 374 NEW ENG. J. MED. 1701, 1701 (2016).

[151] Leifman & Coffey, *supra* note 150, at 660.

[152] *Id.* at 662.

[153] *Id.* at 665. Jail discharge planning has been shown to be effective in other jurisdictions and for populations with different health needs, as well. *See, e.g.*, Emily A. Wang et al., *Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail*, 98 AM. J. PUB. HEALTH 2182, 2183 (2008) (finding that individuals with HIV who receive discharge planning when leaving San Francisco County jail had improved healthcare access compared to individuals who did not receive the service).

[154] Leifman & Coffey, *supra* note 150, at 664.

Typically, such programs depend upon judicial, law enforcement, or prosecutorial discretion and support.[155] They are not enshrined in regulations or statutory standards regarding pretrial detention. One way that localities have made health-related pretrial work more formal is by creating pretrial services agencies, that can refer individuals to services and recommend community supervision and treatment. Particularly well known, as an early example of such an agency, is the Washington D.C. Pretrial Services Agency, which provides a range of treatment-related services and referrals.[156] However, prosecutors and judges are not required to refer any particular category of individuals for release or health treatment; such agencies may be influential, but their role is defined by the discretion of criminal legal actors.

We note that healthcare access remains challenging to provide due to other regulatory barriers triggered by an arrest and detention. At the federal level, policies impose a barrier to healthcare access both during and after incarceration. Health and legal experts and activists have long called for an end to the "inmate exception" of Medicare and Medicaid, which excludes incarcerated individuals, including those detained pretrial, from Medicaid and Medicare coverage.[157] This legislation has contributed to the exclusion of correctional healthcare from the funding, accreditation, and oversight mechanisms of the public health infrastructure. Repealing the inmate exception, particularly in the context of Medicaid expansion, could provide jails with resources to comply with Eighth Amendment standards, hold them to the same medical accreditation standards as healthcare providers in the community, bolster correctional and public health, and allow for significant cost savings.

---

[155] *See, e.g.*, LEAD National Support Bureau, *LEAD: Advancing Criminal Justice Reform In 2021*, https://www.leadbureau.org [https://perma.cc/69BC-5P75] (last visited Dec. 8, 2022) ("Law Enforcement Assisted Diversion (LEAD) is a community-based diversion approach with the goals of improving public safety and public order, and reducing unnecessary justice system involvement of people who participate in the program."); LEAD National Support Bureau, *How does LEAD work?*, https://www.leadbureau.org/about-lead [https://perma.cc/A6H2-WYWF] (last visited Dec. 8, 2022); IACP & UC Center for Police Research and Policy, *Assessing the Impact of Law Enforcement Assisted Diversion (LEAD): A Review of Research*, https://www.theiacp.org/sites/default/files/IDD/Review%20of%20LEAD%20Evaluations.pdf [https://perma.cc/4D3V-4SVT].

[156] Pretrial Services Agency for the District of Columbia, *Treatment and Related Services*, https://www.psa.gov/?q=programs/treatment_services [https://perma.cc/ENT3-WZ9D] (last visited Dec. 8, 2022) ("The Pretrial Services Agency for the District of Columbia (PSA) is committed to assessing accurately the extent of defendant drug involvement and providing or facilitating treatment as appropriate. Assuring that defendants appear for scheduled court hearings is central to PSA's mission. The connection between substance use disorders and crime has been well established. Success in reducing rearrest and failure to appear for court depends on two key factors—identifying and treating drug use and establishing swift and certain consequences for continued drug use.").

[157] *See* Kevin Fiscella et al., *The Inmate Exception and Reform of Correctional Health Care*, 107 AM. J. PUB. HEALTH 384–85 (2017); AM. BAR ASS'N, ABA STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS 281–83 (3d ed. 2011).

CONCLUSION

This Article has described novel data, based on qualitative interviews with jail medical staff in several states, exploring the circumstances and motivation for health-based needs releases from jail. It has uncovered widespread but informal and unwritten mechanisms for health-based release from jails. This data and these practices have implications for reforming the legal rules and the rights surrounding jail healthcare. Without clear rules, it is more challenging for defense counsel to advocate for clients or for jail staff to adequately address health needs. Instead, they have used informal means to raise issues before judges, who would then use secured bond rules to adjust conditions. Without clearly defined rights, persons facing pretrial detention lack clear recourse to safeguard their health.

The health-related jail releases that we learned of suggest the overuse of incarceration in jail settings. After all, if medically vulnerable people can be released, perhaps persons without medical vulnerability can just as readily be released. Some medically vulnerable persons might pose a reduced risk to public safety and flight, but it is telling that these were all individuals deemed detention-worthy, until their medical condition prompted reconsideration. Relatedly, the system does not often take a careful second look at detention decisions. The ad hoc, informal nature of these release mechanisms suggest unequal treatment within the legal system, where non-public considerations can alter outcomes for individuals. These health-related releases, while they may very much be just and warranted, provide just one example of the arbitrariness and the inequalities in how the jail system is implemented.

Consistent and formal rules that directly address health-related concerns with pretrial detention could not only better define access to care in jails, but limit admission of individuals with health needs in the first instance. Further, delivering healthcare in programs that provide alternatives to detention in jails can avoid the difficult challenges that we observed in studying how jail medical staff respond to health-based needs. Defined rights to jail health can protect individual rights, safeguard jail conditions, and improve community health.