

A TEXAS CIVIL RIGHTS PROJECT
HUMAN RIGHTS REPORT
2011

“A THIN LINE”
The Texas Prison Healthcare Crisis and
The Secret Death Penalty

“Right now the [health care] system is constitutional... but we’re on a thin line.”¹
– Dr. Ben Raimer, Former Chief Physician Executive for UTMB Correctional Managed
Care



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EXECUTIVE SUMMARY

Texas is well known for executing more prisoners than any other state. Executions are the public death penalty—they take place with transparency.

Texas, however, also practices a “secret” death penalty. Prisoners are killed and maimed in Texas by appalling medical care.

Texas incarcerates approximately 154,000 people in 112 Texas Department of Criminal Justice (TDCJ) prisons around the state. The Federal Constitution requires Texas to provide basic medical care for prisoners’ serious medical conditions. In the past, federal courts have had to monitor Texas prisons for grossly failing to meet this basic humane obligation.

Texas is now facing a return to the “bad old days” when the courts had to intervene in prison health care. Texas pays just \$9.88 per prisoner per day for health care, compared with \$28.55 per prisoner per day in California—which is already under judicial supervision and has been ordered to release over 40,000 prisoners so the remaining inmates can receive constitutional care.

In this legislative session, the Governor has asked all state agencies to make significant cuts to their budgets. Prison health care will be a tempting target—prisoners have no powerful lobby, and are an easy political punching bag. Indeed, legislators have proposed slashing the prison health care budget by almost 25 percent. Texas would pay \$6.00 a day, or less, per prisoner on health care.

This would be disastrous. Balancing budgets on prisoners’ backs now invites far more expensive federal intervention later. California has been required to pay billions of dollars to make its prison health care constitutionally adequate because of short-sighted planning.

To avoid federal court intervention and expensive upgrades later, there are very low-cost reforms Texas could enact now. A small number of elderly, extremely sick prisoners account for a very large percentage of the total health care costs. Paroling these low-risk prisoners so they can be cared for in the community, while still monitored by the state, would create substantial savings.

The majority of TDCJ prisoners are parole eligible and incarcerated for non-violent crimes. If Texas (and the Board of Pardons and Parole) thought more carefully about who it imprisons (and for how long), it could save substantial amounts of taxpayer dollars without compromising public safety.

This legislative session represents an opportunity for Texas. Our representatives can continue to follow expensive, failed “tough on crime” policies, or become “smart on crime,” incarcerating the most dangerous criminals while working to re-integrate non-violent offenders into society. The best way to solve the prison health care crisis, and to end the secret death penalty, is to stop relying on extended incarceration as our only crime-control policy.

METHODOLOGY

The Texas Civil Rights Project's Prisoners' Rights Program has reviewed thousands of complaints from inmates in Texas prisons and jails. We have tracked individual complaints electronically since 2009 with the Client Tracking System (CTS). CTS allows us to collect and record specific data on the types of complaints prisoners make, demographic and geographical data from each complaint, and anecdotal evidence of conditions in Texas prisons and jails.

TCRP's Prisoners' Rights Program has also conducted an exhaustive review of other available resources, including evaluations of prison operations conducted by the Texas Legislature's Sunset Advisory Commission, major newspapers, and criminal justice experts.

The goal of this report and its contributors is to provide information and make recommendations to improve the quality of healthcare provided to prisoners in Texas through cost-effective remedies.

INTRODUCTION

Medical horror story: David West

David West² died a horrific death at age 34 while serving a four-year sentence at the McConnell Unit in Beeville, Texas for larceny and assault convictions. At 8:40 a.m. on May 19, 2003, two correctional officers escorted Mr. West to the E-Pod showers. After his twenty-minute shower, the officers returned to re-shackle Mr. West's wrists to take him back to his cell several hundred yards away, but Mr. West allegedly refused. The officers removed the other inmates from the showers and continued on their rounds, forgetting Mr. West alone in a cloud of hot steam.

At 9:40 a.m., one of the guards on duty made a call, requesting a supervisor to check up on Mr. West. When the supervisor arrived, he glanced through the shower window and observed Mr. West slouching on the wet floor, his hands limp on his chest and a washcloth covering his face. According to the supervisor, Mr. West appeared to be breathing. Several officers, none of whom bothered to enter the shower to physically examine Mr. West, tried to rouse him by calling his name; but Mr. West did not stir.

The officers then called in the prison medical staff to evaluate the situation. A nurse arrived on the scene, but, like the officers, did not enter the shower. Instead, she decided to evaluate the situation through the tray slot on the shower door. Through the haze of steam, she declared that Mr. West was "faking" and that, "if he had fallen, he would not be in the position he was currently in." The prison staff left Mr. West unconscious in the shower with hot water streaming over his body and continued on their rounds.

At 10:35 a.m., the sergeant on duty instructed the prison staff to keep watch on Mr. West. The staff immediately reported back that Mr. West was not breathing. Almost two hours after Mr. West's shower began the sergeant was the first person to take the time to physically evaluate him. The sergeant went to the shower pod, opened the door, and discovered Mr. West, his body red and distressed, collapsed on the floor. He was not breathing. Attempts at resuscitation failed, and Mr. West was pronounced dead at 10:45 a.m.

An autopsy later revealed Mr. West had literally been cooked alive—the two-hour long exposure to water temperatures in excess of 150 degrees Fahrenheit had devastated his internal organs and caused heart failure. Mr. West's body temperature was at least 107.9 degrees – the thermometer could not read any higher.³

The terrible indifference that caused David West's death was not an isolated incident; rather, it is indicative of a systemic problem within the Texas Department of Criminal Justice regarding the medical care Texas provides to prisoners.

TDCJ PRISONER COMPLAINTS

TCRP divides prisoner complaints into the above categories.

“Conditions” complaints deal with general problems in the prisons, such as unsanitary food, insect infestations, mold infestations, etc.

“Criminal” complaints include any issues with the prisoner’s criminal trial (such as ineffective lawyers, prosecutorial and police misconduct, etc.), and include claims of actual innocence.

“Medical” complaints deal with medical care provided to the prisoner while in custody.

“Classification” complaints generally include issues with prisoners’ good-conduct time and custody status.

“Disability” complaints address problems with programs and services that prisoners with disabilities cannot access (such as failures to provide sign-language interpreters for the deaf, etc.).

“Excessive force” complaints involve prisoners’ claims they were unjustly injured by prison staff.

“General civil” issues are civil legal problems unrelated to the prisoner’s incarceration, such as divorce, child custody, inheritance, etc.

“Parole” issues include claims that a prisoner should have been released on parole.

“Religious liberty” complaints allege a prisoner is not being allowed to practice his or her religious beliefs.

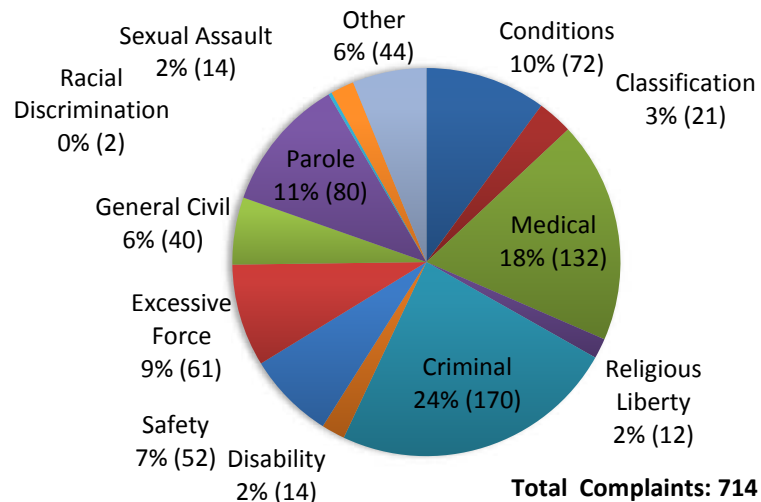
“Safety” complaints involve prisoners concerns that the prison environment is not safe for them, and include complaints they have been threatened by other prisoners or prison staff.

“Sexual assault” complains allege a prisoner has been sexually assaulted by prison staff or fellow prisoners.

“Other” includes complaints that do not fit within any other category.

The Texas Civil Rights Project, a statewide non-profit organization, receives hundreds of letters from individuals incarcerated in Texas prisons. About one fifth of these letters describe problems obtaining medical care and troubling medical practices. This percentage is almost equal that of complaints about criminal convictions, the issue that one would expect to be most prisoners’ primary concern.

Complaints of TDCJ Inmates (2009)



The letters come from many different parts of the TDCJ 112-unit system throughout Texas and provide a disturbing picture of medical care available throughout the state, from difficulty obtaining medication for serious conditions to the inattentiveness of medical personnel in response to emergency situations. When medical personnel responded to Mr. West’s situation, the nurse “diagnosed” him through the tray slot of a steamy shower. The correctional officers relied on the nurse’s medical expertise to make a decision on how to effectively manage the situation. This indifference ultimately cost David West his life and similar mistakes are costing the lives and health of many others in the Texas prison system.

Texas has created a “secret death penalty”: poor medical care can turn temporary imprisonment for relatively minor offenses into a death sentence.

LEGAL HISTORY OF PRISON HEALTHCARE IN TEXAS

Historical Overview of Medical Care in Texas Prisons

Since the ratification of the Bill of Rights, the United States Constitution has protected the rights of prisoners: the Eighth Amendment prohibits “cruel and unusual punishments.” Actually protecting those rights, however, is a fairly recent development.

In the “early years of the Republic,” American judges were aware of harsh prison conditions but did not view the Eighth Amendment as protecting prisoners from cruel treatment.⁵ During this time, lower courts usually dismissed prisoner complaints on the theory that courts had no business interfering with prison management.⁶ Further, prisoners were actually regarded by some courts as “slave[s] of the State.”⁷

This “hands off” approach continued until the late 1960s and early 1970s, when “judicial expansion of civil rights . . . enabled litigants to bring complaints against prisons and finally persuaded federal courts to intervene.”⁸ Prior to the mid-twentieth century, the federal constitution only protected citizens from the *federal* government because the Supreme Court had not “incorporated” the Bill of Rights to apply it to the states. In 1976, the Supreme Court applied the Eighth Amendment to a state prisoner’s grievance for the first time, holding that harsh conditions and lack of medical care constituted cruel and unusual punishment.⁹ This recognition that “prisoners were entitled to minimum constitutional standards during their confinement” spurred courts across the country to begin ordering prison reforms.¹⁰

Prisoners’ Right to Medical Care under the U.S. Constitution

The Supreme Court, in *Estelle v. Gamble*, established “the government’s obligation to provide medical care for those whom it is punishing by incarceration.”¹¹ In *Estelle*, an inmate of the Texas Department of Corrections (“TDC”)¹² sued the Director of the TDC, the warden of the prison, and the chief medical officer of the prison hospital. The inmate suffered an injury while on a prison work assignment and brought a lawsuit alleging that the subsequent medical treatment, or lack thereof, violated the Eighth Amendment of the U.S. Constitution by subjecting him to cruel and unusual punishment.¹³

The Supreme Court stated that even though “the primary concern of the drafters [of the Eighth Amendment] was to proscribe ‘tortur[ous]’ and other ‘barbar[ic]’ methods of punishment, . . . the Amendment proscribes more than physically barbarous punishments.”¹⁴ The Court held that certain penal measures violate the Eighth Amendment when they are contrary to “evolving standards of decency” or “involve the unnecessary and wanton infliction of pain.”¹⁵

Estelle prohibited the “unnecessary and wanton infliction of pain, proscribed by the Eighth Amendment.”¹⁶ A prisoner’s constitutional right is violated by prison doctors or prison guards who deny, delay, or interfere with medical treatment.

Judge Justice



Though he died in 2009, prisoners still write to TCRP hoping that Judge William Wayne Justice will be able to hear their case.

A native of Athens, Texas, Judge Justice was appointed to the federal bench by President Lyndon Baines Johnson in 1968.

In *Ruiz v. Estelle*, Judge Justice forever changed how TDCJ operates. Many of the changes his court ordered are still standard TDCJ procedure today. His rulings vastly improved the lives of Texas prisoners.

In addition to his work in *Ruiz*, Judge Justice also presided over many other important civil rights cases. He ordered the desegregation of Texas public schools and public housing, and required undocumented immigrant children be provided a public education. He also protected the rights of juvenile prisoners incarcerated in the Texas Youth Commission in *Morales v. Turman*.

Judge Justice's work on behalf of the downtrodden did not make him popular in East Texas. Repairmen refused to work at his house. His family received death threats.

Despite it all, Judge Justice saw his duty to protect people's civil rights. "I was never underprivileged, but I have human feelings. If you see someone in distress, well, you want to help them if you can."

Since *Estelle*, however, courts have consistently made it very difficult for a prisoner to win a suit alleging deficient medical care. *Farmer v. Brennan*, decided eighteen years after *Estelle*, held that "a prison official cannot be found liable under the Eighth Amendment . . . unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."¹⁷ The Court explained that "act[ing] with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk,"¹⁸ and furthermore, that "a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious."¹⁹

*Ruiz v. Estelle*²⁰ is the seminal U.S. Fifth Circuit case dealing with prison conditions in Texas, decided after *Estelle v. Gamble*, but before *Farmer v. Brennan*. In a speech at Stanford University, William Wayne Justice, the judge who presided over the district court proceedings in *Ruiz*, provided insight into the background of the case.²¹ After Judge Justice made some minor attempts to balance the inequity in prisoners' proceedings against the TDC by cross-examining TDC witnesses himself, he began receiving a very large number of letters from prisoners describing their complaints. Subsequently, he was invited to speak at a SMU seminar on prisons and prison reform, which spurred his desire "to see at least one case where the plaintiffs were adequately represented."²²

Based on the advice of a fellow judge, Judge Justice decided to involve the United States by ordering the Department of Justice to appear as amicus curiae in order to give the inmates better access to resources that would otherwise not have been available.²³ The Department lawyers were so appalled by what they found in their investigation of Texas prisons that "the United States filed a motion to intervene as a party plaintiff."²⁴

After 159 days of trial, the district court issued a 118-page memorandum opinion, setting forth the relief it proposed to grant. Judge Justice required TDC to "prepare and file with the [c]ourt a plan which will assure that prisoners receive necessary medical, dental, and psychiatric care from the moment of their arrival in TDC."²⁵ The plan must include provision for:

1. Prompt identification of immediate needs for medical, dental, and psychiatric care;
2. Compliance with American Medical Association (AMA) Standards for Health Services in Prison, including a plan for implementation;
3. Development of standards for architectural, engineering, or equipment needs of prison health care facilities to the extent they are not addressed by the AMA standards;
4. Accreditation by the Joint Commission on Accreditation of Hospitals (JCAH) of the TDC-UTMB Hospital;
5. Adequate inpatient and outpatient psychiatric and other psychological care, including the provision of appropriate facilities for that purpose;
6. A system to assure that no prisoner is assigned to do work that is contraindicated for his medical condition; and
7. Full access to health care for all prisoners, regardless of segregation status.²⁶

Judge Justice also required TDC to assure that nonmedical staff did not countermand any medical order regarding a prisoner's treatment, work, or other related circumstances, and that prisoners are not denied access to work, recreation, education, or other programs or opportunities because of health status unless required for medical reasons as determined by a licensed physician.²⁷ Prisoners who arrive with medication and a prescription for that medication will not be deprived of that medication until a licensed physician has examined them and made a medical determination regarding the continuation of that medication.²⁸ Finally, Judge Justice specifically required TDC to initiate a program of accreditation by the AMA.²⁹

The U.S. Fifth Circuit Court of Appeals reviewed Judge Justice's order on appeal, comparing the order to the standards set forth by the U.S. Supreme Court. The Court concluded "[t]he state has an obligation to provide medical care for those whom it is punishing by incarceration."³⁰ In addition, the Court decided "acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs of inmates constitute cruel and unusual punishment."

A fairly recent Fifth Circuit case provides a useful application of the Supreme Court's holdings in *Estelle v. Gamble* and *Farmer v. Brennan*. In *Easter v. Powell*, a prison inmate brought a claim against a prison nurse alleging she violated the Eighth Amendment when she refused to treat his chest pains.³¹ In this case, the Fifth Circuit first stated that the Supreme Court has interpreted the Eighth Amendment "as imposing a duty on prison officials to 'ensure that inmates receive adequate ... medical care.'" The court explained that "the 'deliberate indifference standard' requires 'a showing that the official was subjectively aware of the risk [of serious harm to the inmate].'"³² The court found, based on the inmate's allegations, the nurse was aware of a substantial risk of harm to the inmate's health based on circumstantial evidence.³³ The circumstantial evidence included the inmate's history of heart disease on his medical chart and testimony that the nurse had been exposed to that chart.³⁴ Further, after finding the nurse was

aware of a substantial risk, the court found she exhibited deliberate indifference by sending the inmate back to his cell without providing any treatment for his severe chest pain.³⁵

Managed Health Care in Prisons and Potential Violations of the U.S. Constitution

The Texas prison system has adopted a managed health care plan. Details on that plan and the contractual obligations of each side are included in the “Contractual Problems” section of this report, pages 16-18. Generally, “[t]he goal of managed health care is to have a health care system that operates more cost-effectively than the traditional fee-for-service system.”³⁶ To achieve this goal of cost-effectiveness, the focus is usually on the financial bottom line and cutting costs.³⁷

When the focus shifts too heavily to the financial aspects of the health care, at the expense of the medical needs of prisoners, there is the potential for widespread constitutional violations.³⁸ “[P]rison health care providers may not place financial considerations ahead of the medical needs of prisoners” and “[c]ourts have firmly established that a lack of funds does not justify constitutionally inadequate treatment of inmates, particularly in the case of medical care.”³⁹ The Second and Eleventh Circuits have held that “a treatment decision based on non-medical considerations constitutes deliberate indifference.”⁴⁰ In the Eleventh Circuit case, the court held that the inmate’s allegations that the officials put the financial interests of the prison system ahead of her medical needs were sufficient to state a constitutional violation.⁴¹

The use of managed care in the correctional setting creates a risk that medical decisions will be based on fiscal, rather than medical, considerations.⁴² Based on these holdings, a prisoner could likely make out a valid constitutional claim if there was evidence that TDCJ was cutting costs through the managed health care plan at the expense of the medical needs of prisoners.

Conclusion

All prisoners have the right to at least some medical care under the Eighth Amendment to the U.S. Constitution. However, in order for there to be a violation of the Eighth Amendment for which relief can be granted, the inmate must prove that the person administering medical care or another prison official was deliberately indifferent to the inmate’s serious medical needs. Deliberate indifference is a subjective standard, but is more than inadvertence or mere negligence.

Texas law also provides some guidance as to what medical care prisoners are entitled. These statutory provisions lay the foundation for the relationship between TDCJ, the University of Texas Medical Branch at Galveston (UTMB) and the Texas Tech University Health Science Center (“Tech”), which provide the health care services for Texas prisons. The Agreement between the CMHCC and TDCJ, based on Chapter 501 of the Texas Government Code, provides specifics on the medical care that is guaranteed to state prisoners. Texas has adopted a managed health care plan, which can potentially violate the Eighth Amendment if financial considerations are placed above the medical needs of the prisoner. In 2011, as legislators prepare to balance the

state budget, they have proposed cutting funds for prison health care—the precise action that could create constitutional problems.

While the recognition and enforcement of a prisoner’s right to medical care has come a long way since the 1960s, with the increasing prison population in Texas and the limitations on an inmate’s ability to seek relief, more reform is surely needed. If nothing else, Texas must work to prevent from sliding backward to the “bad old days.”

CURRENT MEDICAL CARE IN TEXAS PRISONS

Current Texas guidelines divide prison healthcare into two categories: access to care and quality of care. Several bodies have different roles within this system:

The **Texas Department of Criminal Justice (TDCJ)** is responsible for access to care, defined as “timely access to health care provider evaluation and health care provider prescribed treatment.”

The **University of Texas Medical Branch (UTMB)** and **Texas Tech University Health Sciences Center (Tech)** are responsible for providing “proper, adequate, and effective” quality care, both at their hospitals and at prisons, in which the medical personnel are UTMB or Tech employees. UTMB provides care for about 80% of Texas inmates in the eastern and central part of the state, while Tech is responsible for the care of the other 20%, mostly in West Texas.

The **Correctional Managed Health Care Committee (CMHCC)** is a TDCJ body that oversees, coordinates, and contracts for the delivery of healthcare to inmates. It is contractually responsible for “developing, implementing, and monitoring the correctional managed health care services.”⁴³ It is composed of nine appointed members, five of whom must be physicians.

Prisoners’ Rights to Medical Care under Texas Government Code

Texas statutes also require prisoners be given medical care. Reacting to the *Ruiz* litigation, Texas codified some of the required reforms.

1. Texas Government Code § 501.051 Medical Facilities at University of Texas Medical Branch. This provision falls within the chapter on inmate welfare and the subchapter on general medical and mental health care provisions. The provision states that “[t]he facility shall provide the same level of care as is provided for patients in other facilities of The University of Texas Medical Branch at Galveston,” i.e. patients from the “free world.”⁴⁴ Additionally, it requires TDCJ and UTMB to adopt a memorandum of understanding establishing the responsibilities of each of these two entities.⁴⁵

2. § 501.063 Inmate Copayments for Certain Health Care Visits. If an inmate who is held in a facility operated by TDCJ initiates a visit to a health care provider, that inmate must make a \$3 copayment to TDCJ out of the inmate’s trust fund.⁴⁶ If the inmate’s individual trust fund is insufficient to cover the payment, then fifty percent of each deposit to the fund shall be applied toward the balance owed.⁴⁷ However, if the health care is provided in response to a life-threatening or emergency situation, is initiated by TDCJ, is initiated by the health care provider, or is provided under a separate contractual obligation, then TDCJ may not charge a copayment.⁴⁸ Prior to inmate-initiated visits, TDCJ must inform inmates that a \$3 copayment will be deducted from their trust fund, but may not deny an inmate access to health care as a result of the inmate’s failure or inability to make a copayment.⁴⁹ The funds collected as copayments may only be used to pay the cost of administering this section of the code.⁵⁰

3. § 501.064 Availability of Correctional Health Care Information to Inmates. TDCJ must make the following information available to “any inmate confined in a facility operated by” TDCJ: “(1) a description of the level, type, and variety of health care services available to inmates; (2) the formulary used by correctional health care personnel in prescribing medication to inmates; (3) correctional managed care policies and procedures; and (4) the process for the filing of inmate grievances concerning health care services provided to inmates.”⁵¹

4. § 501.146 Managed Health Care Plan. This provision falls within the chapter on inmate welfare and the subchapter on managed health care⁵² and requires CMHCC to develop a managed health care plan for persons confined by TDCJ.⁵³ This managed health care plan must include the establishment of a managed health care provider network of physicians and hospitals, cost containment studies, care case management and utilization management studies, and a provision requiring the managed health care plan to accept certification by the Medicare program as an alternative to accreditation by the Joint Commission on Accreditation of Healthcare Organizations.⁵⁴

5. § 501.149 Disease Management Services. “Disease management services” means services to assist an individual in managing a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS.⁵⁵ The provision requires the managed health care plan to provide disease management services, including (1) patient self-management education; (2) provider education; (3) evidence-based models and minimum standards of care; (4) standardized protocols and participation criteria; and (5) physician-directed or physician-supervised care.⁵⁶

6. § 501.150 Quality of Care Monitoring by the Department and Health Care Providers. The CMHCC is required to establish a procedure for monitoring the quality of care delivered by health care providers.⁵⁷ Additionally, TDCJ and the medical care providers are required to report the results of their monitoring activities to the CMHCC and to the Texas Board of Criminal Justice, which oversees TDCJ prisons.⁵⁸ This report includes a list of and the status of any corrective actions required of the health care providers.⁵⁹

7. § 501.151 Complaints. The CMHCC is required to maintain a file on each written complaint filed with it.⁶⁰ Further, the CMHCC must make information available describing its procedures for complaint investigation and resolution.⁶¹ The CMHCC also must notify the person filing the complaint and each person who is a subject of the complaint of the status of the investigation unless the notice would jeopardize an undercover investigation.⁶²

Contractual problems

The contracts CMHCC makes with TDCJ, UTMB, and Tech are all problematic in ways that could easily contribute to poor levels of healthcare. Low standards and weak oversight have been codified as part of the contracts for the 2010-2011 fiscal year.

Grievances in TDCJ

TDCJ has a formal grievance system to resolve prisoners' complaints. Since the passage of the Prison Litigation Reform Act (PLRA) in 1996, inmates are required to go through the grievance process before they can file a lawsuit.

TDCJ has a "two step" grievance process. A Step One grievance makes the initial complaint, and is reviewed by staff at the prison. If the prisoner is not satisfied with the response to a Step One grievance, he or she can file a Step Two grievance which is reviewed by TDCJ staff off the unit. Grievances related to medical care are reviewed by medical staff at both levels.

Though the PLRA was intended to prevent prisoners from filing frivolous federal lawsuits, it also ultimately bars meritorious complaints when prisoners fail to comply with procedural requirements. Many prisoners are uneducated or illiterate, and do not understand how to use the grievance process. The TDCJ grievance process also includes many unforgiving deadlines, such as requiring prisoners to make their initial complaint within 15 days of the problem first arising.

Texas has a statute similar to the PLRA, at Chapter 14 of the Texas Civil Practice and Remedies Code.

Lack of accountability is one of the biggest problems in these contracts. UTMB and Tech are contractually rewarded for removing one of the most important sources of health care oversight and accountability: grievances filed by the inmates themselves. One performance measure included in these most recent contracts with UTMB and TTUHSC is the percentage of unsustained grievances: that is, grievances that are resolved against the inmate. The two providers are *contractually obligated* to sustain 10% or less of Step One medical grievances and 6% or less of Step Two medical grievances. This encourages providers to resolve even the most valid and pressing inmate grievances in favor of TDCJ rather than in favor of the inmate. If TDCJ employees feel they will be penalized for resolving valid grievances in favor of the inmate, then they will be encouraged to discard valid complaints, crippling the grievance system. The positive intent of this clause – to increase the quality of medical services so that fewer complaints are lodged – could be much more effectively reached by measuring the providers' reactions to and improvements following valid inmate grievances, which would reward improvement rather than unaccountability.

The contract also allows a relatively high percentage of vacancies in medical provider positions. The 2010-2011 fiscal year contracts permit up to a 12% vacancy rate for unit-level provider positions: that is, physicians, nurses, and other allied medical health providers who work in the prison units. A 12% vacancy rate is not success; it should be considered unacceptable. More healthcare providers in prisons means fewer necessary high-cost hospital and specialist visits, and thus fewer transportation costs. It also means faster healthcare, better healthcare, and fewer expensive complications from simple, easily-treatable ailments. TDCJ should prioritize recruitment rather than accept by contract an insufficient number of providers.

Finally, the contract gives performance measures for what constitutes adequate and timely access to care that are ultimately too weak to improve the system. Prisoners who submit sick call requests must be "physically triaged," or examined to evaluate the urgency of their complaints, within 48 hours (72 hours on weekends), and, if referred to a physician or other medical professional, must be seen by that professional within seven days of triage.⁶³ Though these standards seem

acceptable, the mandatory compliance rate is low enough to make these standards less meaningful: UTMB and Tech must comply with these standards only 80% of the time without penalty or additional monitoring. This means that for every five prisoners who submit sick call requests, one prisoner can go *entirely* without investigation of his or her complaint with no penalty to the medical providers. Since inmate self-monitoring is the primary TDCJ mechanism for identifying prisoner health problems, it is crucial that complaints are taken more seriously than this.

In addition, there are no standards for prompt *treatment*, only prompt *evaluation* of whether treatment is necessary. Even when a serious health complaint is observed, treatment of that complaint could be delayed indefinitely without the medical providers violating their contractual obligations. Monitoring of performance outcomes is a necessary addition to the contract and the only way to identify and address problems of the most important part of medical care: the success of medical treatment. Moreover, the contract specifies *no* performance measures for access to care in emergency treatment for prisoners, only for cases in which a sick call request is submitted. A prisoner like David West, who collapses in the shower, obviously cannot submit a sick call request, but under current guidelines nobody is strictly accountable for failing to treat him.

Major changes to these sections of the contracts are necessary to create a higher standard of accountability, to bring prison health care in line with general community standards, and ensure a higher level of both quality of care and access to care.

QUALITY OF CARE

Medical horror story: Larry Louis Cox

Larry Louis Cox was incarcerated at a Huntsville prison unit. On January 23, 2007, two guards, who were clearing his cell block for fumigations, approached Mr. Cox's cell to evacuate him from the building. Mr. Cox refused to leave. He allegedly kicked one of the guards, prompting the other guard and a sergeant to restrain him by forcing him to the floor. As Mr. Cox was taken down, he hit his head on his metal bunk and locker and began bleeding profusely.

Guards took Mr. Cox to the prison infirmary where he complained of neck pain and was transferred to Huntsville Memorial Hospital. There he underwent a CT scan which doctors reported was "unremarkable with no sign of fracture." Mr. Cox was taken back to the prison.

Six hours later, Mr. Cox "told (a guard) he hurt too bad to get up or move," according to reports. He claimed he was paralyzed. A guard offered him Tylenol, but Mr. Cox could not even move from the floor to his cell bars to take it. A nurse told the guard that Mr. Cox "would have to get up and accept the medication if he wanted it." As he could not stand to cross the cell, Mr. Cox did not even receive Tylenol while lying paralyzed on the floor.

This interaction was repeated at least three times over the next couple of days, as Mr. Cox lay in his own blood and waste on the floor of his cell, continuing to complain of pain and beg for help. One guard, worried Mr. Cox would die if he did not receive medical attention, contacted a supervisor. Twelve hours later, Mr. Cox was taken to UTMB's John Sealy Hospital in Galveston where doctors discovered his spinal fractures. For the next eleven days, Mr. Cox remained at John Sealy Hospital, where his health deteriorated steadily until his death.

The Galveston County medical examiner ruled his death a homicide as a result of blunt force trauma and medical negligence – a homicide in which no one was held responsible. The real killer: the appallingly low quality of medical care provided in TDCJ.

Accountability

One reason inmates like Mr. Cox continue to die preventable deaths in Texas prisons is the lack of accountability for such deaths and for quality of care in general. Limited contractual accountability obligations are one source of this problem. In fact, the lack of accountability caused Dallas County to drop UTMB as its jail healthcare provider.⁶⁴ Jefferson County also chose a different company, saying that UTMB wants "to make mistakes and have the contracting county eat the resulting lawsuits."⁶⁵ TDCJ should take note of these lost contracts and rethink how UTMB's performance is measured and whether this performance is at an acceptable level.

Another problem is the thick veil of secrecy kept over inmate deaths, denying public oversight, and increasing medical negligence. According to state law, nearly every report or inspection that could tell legislators or the public the truth about the state of prison healthcare is

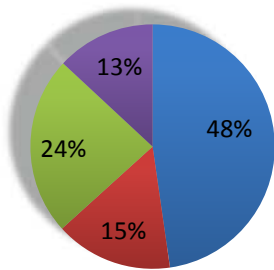
Who is in TDCJ?

UTMB’s prison medical director fears every prisoner wants to “slit [his] throat and kill [him].” But the majority of TDCJ inmates, 52%, are not incarcerated for violent crimes.

Offense Types	
Violent	78,783
Property	25,694
Drug	29,016
Other	21,583
Total	155,076

**Offense Type
(2009)**

■ Violent ■ Property
■ Drug ■ Other



kept secret – including everything from inmate grievances “to publicly-funded medical experiments to state inspections of blood-splattered kidney dialysis offices.”⁶⁶ It is impossible, for instance, for a patient to find out whether the dialysis machine he uses regularly is cleaned of biohazardous materials, like blood, whether he is in prison or in the free world – even though the state obtains that information for itself.⁶⁷

Moreover, the Texas Public Information Act, the primary way for citizens to obtain information on places like prison, does not extend to documents “about” a TDCJ inmate.⁶⁸ Even a prisoner’s family cannot get all the documents about why and how their loved-one died in TDCJ custody. Prison health providers cannot be held publicly or legislatively accountable even for preventable inmate deaths, which they may have helped to cause, and most certainly not for unsafe conditions that lead to the spread of disease.

It is imperative to increase transparency and accountability in the prison health care system. There is no legitimate state interest in hiding the horrors of prison healthcare. Maintaining secrecy only deprives the public and the legislature of their right to demand change.

Florida's prison health accountability system is a good model for reform. The Correctional Medical Authority (CMA) was created there for the sole purpose of monitoring the quality of state healthcare, including correctional healthcare. It works independently of state healthcare providers and contractors to remain completely unbiased. The CMA publishes all of its findings so that the public and legislature have easy access to information about the system. Consequently, failures can be more easily identified and corrected. The CMA can also issue citations, which often quickly solve the cited problem because of the exposure to public scrutiny.⁶⁹ Texas' prison healthcare needs such an independent auditor; it would undoubtedly improve quickly under such scrutiny.

Provider attitudes

Poor-quality medical care is often caused in part by provider and public attitudes that prisoners do not deserve proper medical care. This attitude affects the treatment administered by doctors as well as the funding appropriated by the legislature for medical care in prison.

The fear of inmate violence affects the attitude of some medical staff, although no UTMB personnel have ever been seriously hurt by an inmate, according to UTMB's own reports.⁷⁰ Despite this, Troy Sybert, UTMB's medical director at the prison branch of the hospital, admits, "Whenever I'm dealing with a patient, I imagine that he would slit my throat and kill me if he could."⁷¹

This mentality is indicative of the pervading view of all inmates as dangerous, lifelong degenerates not worthy of healthcare, as though the denial of basic human rights is just part of the standard punishment. But the truth is that the vast majority of inmates will return to live as citizens in the free world, where dehumanizing attitudes they experience in prison can lead to a poor readjustment to free life and can have a negative impact on the community because most sick state prisoners are eventually released to the free world, bringing their festering diseases with them.

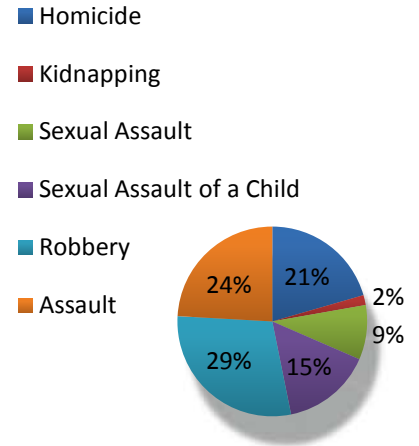
Providers need to remember that prisoners are their patients and human beings, and should have the same care as a free-world patient. Personnel training should encourage humane attitudes toward prisoners so that cold indifference on the part of personnel does not lead to more tragic deaths like that of Larry Louis Cox.

Infrastructure

Quality of care is adversely affected by the literally crumbling infrastructure of the health care system, particularly at the UTMB-Galveston hospital that serves Texas prisoners. As of 2006, before Hurricane Ike literally devastated the hospital, "bricks falling off the eight-story hospital's crumbling façade have forced officials to fence it off, to keep passers-by out of harm's way."⁷² In addition, the medical equipment shows the strain of underfunding:

Who is in TDCJ? (cont.)

Violent Offenses



Violent Offenses

Homicide	16,178
Kidnapping	1,329
Sexual Assault	7,324
Sexual Assault of a Child	12,057
Robbery	22,900
Assault	18,995

Dr. Sybert may be interested to learn that a TDCJ prisoner is almost twice as likely to be incarcerated for a drug offense as a murder.

Moreover, according to the Legislative Budget Board, less than a quarter of people convicted of a violent offense recidivate.

Legislative Budget Board, "Statewide Criminal Justice Recidivism and Revocation Rates," (January 2005) http://www.lbb.state.tx.us/PubSafety_CriminalJustice/3_Reports/Recidivism_Report_2005.pdf.

equipment that “no private doctor would touch” remains in use, and “derelict [x-ray] machines must be continually cannibalized to keep others in service.”⁷³

Directing additional funding to basic medical needs could go a long way towards improving the constitutionally-mandated quality of care the state of Texas provides to prisoners, as well as toward recruiting more and better medical personnel to the system.

The Texas Youth Commission, the juvenile prison system where UTMB is also responsible for healthcare, has reported difficulty in hiring medical staff due to deteriorating safety conditions,⁷⁴ a problem TDCJ will face in the future if it does not improve its infrastructure. Investing in the correctional health care infrastructure will improve greatly the level of care available.

Telemedicine: a partial solution

Telemedicine is a system in which doctors examine patients through videoconferencing rather than in person. It is an increasingly well-regarded substitute for a direct visit with a doctor, and has obvious benefits in the realm of prisons: it allows for faster treatment, controls costs, and removes the burden and potential danger of transporting inmates to a medical facility that is usually hours away.

Moreover, studies show patients are equally satisfied with teleconferenced “doctor’s visits” as they are with face-to-face consultation, even among prisoners.⁷⁵ In a study conducted in the early days of telemedicine, 91% of prisoners surveyed were satisfied with the care they received via telemedicine.⁷⁶

In 2007, UTMB conducted approximately 70,000 patient visits using telemedicine.⁷⁷ Electronic stethoscopes and other instruments replace the hands-on examination typical of a doctor’s visit and a medical staff member at the unit, like a nurse practitioner, helps resolve any confusion on the doctor’s part. Many of these “doctor’s visits” simply consist of a specialist examining a patient’s tests to provide a diagnoses, a task that lends itself well to telemedicine’s format. Some are as in-depth as extensive psychiatric evaluation and prescription of sensitive medications. Organizations from UTMB itself to the AMA to the American Psychiatric Association agree that telemedicine is a viable alternative to standard doctor’s visits, especially in a sensitive arena like prisons.⁷⁸

Telemedicine is not flawless, however. One of its risks, as used by UTMB, is the extremely short time period a teleconferencing doctor spends with each patient. In a recent hearing, witnesses testified that prison doctors see about 60 patients via teleconference in an eight-hour workday – only *eight* minutes spent with each patient.⁷⁹ This is unacceptable and the consequences of such a short appointment time can be dire.

An inmate at the Polunsky Unit, who corresponded with TCRP, injured his left eye and was examined by a doctor via videoconference for less than three minutes. The doctor concluded

the inmate needed psychotropic drugs rather than treatment for his eye. This was a complete misdiagnosis, which left the inmate completely blind in one eye. The failure of telemedicine wasn't entirely responsible for his injury, however. The inmate complained about going blind for nearly a month before he was seen by any medical professional (even through telemedicine), filing formal requests for care on ten separate occasions before the telemedicine appointment.

Telemedicine, supplemented by efficient and effective health care procedures at other points, could work well in a prison setting. Still, this case highlights the room for mistakes in telemedicine practice. Though TCRP recommends the expansion of telemedicine as a way to save costs and transportation time, as well as provide quality care, this recommendation is absolutely contingent on a substantial increase in time spent per patient. In addition, a nurse or physician's assistant should always be present with the inmate in person to assist the teleconferencing doctor and avoid costly and dangerous mistakes.

Recommendations:

It is imperative that TDCJ, policymakers, and other stakeholders make a commitment to raise the level of medical care within Texas facilities to acceptable contemporary standards. Meeting these standards will improve accountability, increase transparency, and improve agency efficiency which will lead to cost savings for the state. Texas should consider acting on the following recommendations:

- Increase accountability and transparency of high-risk practices including preventable inmate deaths - which may end in costly lawsuits - by revising current medical contracts, and making amendments to the Public Information Act to make information about prison conditions public.
- Encourage the use of “best practices” in personnel trainings that foster a more humane attitude toward prisoners.
- Divert additional resources toward improving the infrastructure of TDCJ, including buildings and medical equipment, particularly at UTMB-Galveston in light of the devastation of the hospital by Hurricane Ike.
- Expand the telemedicine system as a cost-efficient way to extend healthcare to more inmates.
- In addition to the expanded use of the Telemedicine, ensure doctors spend sufficient time with each patient and that a unit-level provider is present to avoid mistakes.

ACCESS TO CARE

Medical horror story: Adam Whitford⁸⁰

Not everyone who is a victim of TDCJ's medical neglect dies; some are only disabled for life. Adam Whitford injured his ankle in 2004, before he was incarcerated. But the limited care he received in prison and the unsanitary conditions he lived in caused him to develop a severe staph infection, which became an oozing wound on his foot. He was prescribed antibiotics for the infection to be taken every 6 hours: at 4 a.m., 10 a.m., 4 p.m., and 10 p.m. But the prison pill window system of distributing medication meant he often had to wait up to two hours for his medication from the time he was supposed to take it. If not taken at proper intervals, antibiotics allow the bacteria they are supposed to fight to develop immunities and grow stronger.

This is exactly what happened to the staph infection in Adam Whitford's body. His doctors at UTMB-Galveston ordered that the wound be cleaned twice daily. But, back in TDCJ custody, it was cleaned only twice *weekly*. Unit medical staff even refused to provide Mr. Whitford medical supplies to clean it more often himself. The infection worsened. Due to the simple administrative problems of ineffective medicine distribution and insufficient medical supplies, Mr. Whitford's foot was amputated above the ankle. If he's lucky, he will get to keep his leg.

Distribution of medication

Adam Whitford's story illustrates several serious problems in TDCJ's medical care, including the poor distribution of medication. Prescriptions are usually distributed through "pill windows," which are open only at limited times. This creates two challenges: first, some medications, like anti-HIV drugs and antibiotics, are most effective when taken at specific times. When the pill windows are not open at the time prisoners need their medicine, the prisoners can't take their drugs on the prescribed schedule and the pills are less likely to work. Second, the lines are so long that the windows sometimes close before all the inmates are served, so many are turned away with no medication at all.⁸¹ TCRP has received a number of letters from physically disabled prisoners forced to stand while they wait for medication at the pill window, causing extreme pain and exacerbating the medical problems their medications are meant to improve.

Few inmates are fortunate enough to be allowed KOP, or "keep on person," medications, and even with permission these medications are sometimes confiscated during searches for genuine contraband.

In addition, mix-ups of medications are not unheard of. TCRP has received complaints from inmates who were given the wrong medications entirely, with disastrous side effects.

“Work Restrictions”

Texas prisoners typically must work at a job to help in the upkeep of the prisons. They are not paid for this labor, and can be disciplined for failing to work. Prisoners can lose their “good conduct” time (delaying possible parole) and other privileges for not working.

One of the prison medical providers’ important responsibilities is to determine if a prisoner is unable to work (or unable to work certain jobs). The provider fills out an “HSM-18” form which notes what activities the prisoner cannot do (like lift over a certain weight, or be exposed to heat, chemicals, etc.).

TCRP receives many letters each year from prisoners complaining that their medical restrictions were changed incorrectly or are simply being ignored by TDCJ.

Recently, a TCRP client had his work restrictions removed. Although he is sixty-years old and suffers from congestive heart failure and had work restrictions in place since 2002, a clerical error removed the restrictions. He lost good time credit and privileges and was placed in solitary confinement until the issue was resolved.

A dramatic example of the effects of improper medication distribution on a large scale is seen in a groundbreaking study by Dr. William A. O’Brien, a UTMB doctor, showing that Texas prisoners frequently have a drug-resistant form of HIV,⁸² one that was most likely caused by the inconsistency in proper medication and the lack of routine physician care. If anti-HIV drugs are taken irregularly, the small amounts of medication received cause the virus to mutate and become stronger. Not only does this increase HIV’s prevalence and deadliness in prisons – it creates a grave public health risk when these prisoners are eventually released from custody and they bring the drug-resistant HIV into the community.

Communication breakdown

One of the most common complaints TCRP receives is that physicians’ recommendations of care, specific diagnoses, and prescriptions, are all ignored when the prisoner leaves the hospital and returns to their unit. This problem can be so bad that some prisoners claim the only way to be assured access to care is to enroll in a provider-sponsored experimental medical study.⁸³ Common examples of how prescribed medical care is ignored at the unit level include withheld medication, missed medical appointments, and disregarded work and cell restrictions. A TCRP client recently missed her scheduled surgery, and was forced to wait weeks for attention to her painful medical problem, simply because guards failed to show up to transport her to UTMB’s hospital in Galveston.

Treatment delays

Delays in treatment caused by the poor communication between unit-level and hospital-level providers are far too common in prison health care and often exacerbate both injury and ultimately cost of treatment. In one example, an inmate who corresponded with TCRP spent over six months without a hip joint after his hip replacement was removed due to a staph infection because his medical appointments were continually cancelled or pushed back by unit staff. According to letters received by TCRP, this is far from an uncommon problem in Texas prisons. Medical appointments are often pushed back indefinitely if, for example, transportation from the unit to a hospital is not available on the day of the appointment.

Moreover, because prison clinics are designed to work like emergency rooms and handle acute problems, inmates with chronic conditions requiring check-ups are not prioritized, despite the fact that their conditions can easily worsen and become needlessly expensive to taxpayers without regular care. Automatic, electronic scheduling of regular checkups for inmates with chronic conditions would help alleviate these problems.

In addition, inmate self-reporting of medical problems should be taken seriously, since this is the primary mechanism for the early recognition of potentially serious problems like the ones discussed above.

Recommendations:

Texas should take the following steps to ensure that doctor-ordered care is implemented at the unit level:

- Reform the medication distribution system, by allowing more keep-on-person medication, particularly for drugs like anti-HIV medications, insulin, and antibiotics that must be taken regularly to avoid complications, drug resistance, or potential public health dangers.
- Improve unit provider compliance with medical cell- and work-restrictions by requiring unit officials to implement medically-recommended cell- and work-restrictions of prisoners.
- Improve communications between hospital providers, unit-level providers, and non-medical personnel through a universally available records system.
- Create an automatic “check-up” system for inmates with chronic conditions requiring regular care. This would diminish the wait period for individuals who require chronic medical care and is especially important to alleviate the worsening of their medical condition.
- Ensure adequate and prompt responses to all medical complaints. Medical complaints – especially for prisoners with an established medical history – must be taken seriously and be addressed promptly. Adequate and prompt care is essential to increasing efficiency and reducing long-term costs.

PROBLEM AREAS

OVERCROWDING IN TEXAS PRISONS

Overview

A major contributing factor to the poor quality health care in Texas prisons is overcrowding. Texas ranks fourth in the nation for the percentage of its population in the criminal justice system: *one in every twenty Texans* is either in prison or on probation or parole.⁸⁴ Texas does not have the facilities or the budget to house and constitutionally care for its growing and aging population of inmates. In its quest to incarcerate more people than its prisons can hold, Texas has sacrificed both the level of prison healthcare and the money of taxpayers.

Texas prisons recently faced both an overcrowding and understaffing crisis. In 2005, the *Houston Chronicle* published a report predicting that prisons would be full by March of the same year.⁸⁵ As late as 2009, some prisons were woefully understaffed, with Dalhart and Fort Stockton Units facing a 20% guard shortage.⁸⁶ Both of these areas have improved in the short term: probation reform helped divert some people away from prison, while the economic crisis has increased the demand for jobs, filling more of the vacant positions.

Looming budget cuts, however, threaten to reverse this progress. TDCJ has proposed a layoff of 3,052 employees, including 2,037 security staff.⁸⁷ These cuts, along with an aging and increasingly expensive prison population, threaten to aggravate the existing problems of the Texas prison healthcare system.

The Texas Legislature's traditional solution to the problem of overcrowding is to add more beds, but the economic crisis has ruled out building new prisons as a possible solution. Building more prisons is exorbitantly expensive; new facilities cost as much as \$400 million for construction alone,⁸⁸ not including the annual cost of upkeep.

Building new prisons would also be an ineffective measure because, as the budget cuts show, there is no money to staff new prisons.

Moreover, the employees who staff existing prisons are often not qualified for the job. State Senator John Whitmire, chair of the Texas Senate Criminal Justice Committee, acknowledged that Texas is hiring “18-year-olds just a few months out of high school [as well as] 70-plus-year-old guards and others who are physically not able to protect themselves or others.”⁸⁹ This understaffing problem leads to both security and medical risks: a lower guard-to-inmate ratio means inmates are more susceptible to assault or fights with other inmates, which can lead to injury. Further, inmates in understaffed prisons cannot access sick call procedures as easily, and an inmate with an urgent medical problem or a worsening condition is more likely to go unnoticed.

TDCJ's medical contractors face an even more severe staffing shortage, caused by poor incentives for recruitment and worsened by Hurricane Ike. The storm devastated the coastal

Community Based Drug and Alcohol Treatment

Texas incarcerates 29,016 people for drug offenses, and an additional 6,233 people for DWI. (Another 2,020 people are in TDCJ for “public order” offenses, many of which probably involve alcohol abuse.) In total, almost a quarter of TDCJ prisoners are incarcerated for drug or alcohol-related offenses.

If just a portion of these men and women were sent to mandatory community-based drug treatment programs, the State could save substantial money and allow prison resources to be reserved for the most dangerous criminals.

hospital of UTMB-Galveston, resulting in destroyed infrastructure and huge cutbacks. Nearly half of the hospital's staff was laid off in 2008.⁹⁰ Similarly, UTMB plans to cut more than ten percent of its staff providing medical care to prisoners in the coming year.⁹¹

These cuts, however, only add to the understaffing problem. Because of the state’s low salary rates, it is doubtful that many young medical school graduates would choose to work in a prison clinic or at UTMB for a pittance rather than in private practice. For medical staff in particular, salaries and benefits must improve if Texas hopes to make up its current personnel shortages. As it stands, the staff shortages lead to a constitutionally unacceptable level of care, and increasing prison populations will only worsen this problem.

To see the potential consequences of failing to control the prison population, Texas need only look to California. There, the state is discovering the consequences of “three strikes and you’re out” sentencing—prisoners are serving life sentences for relatively minor offenses. Because of the capacity problems “three strikes” created, federal courts have now placed the prison system under supervision. Complying with the federal court’s orders could cost as much as \$8 billion, and require releasing 40,000 prisoners.⁹²

Contrary to popular belief, overcrowding is not a result of high crime rates. In fact, crime rates per capita in Texas have been decreasing steadily, dropping 9% from 1998 to 2007.⁹³ Incarceration rates, however, have dramatically increased. From 1978 to 2004, Texas’ state population increased by 67%, but Texas’ prison population increased by 573%.⁹⁴ In actuality, prison overcrowding is caused by a number of factors, independent of crime rates:

1. Overly harsh sentencing laws;
2. Dishonest fiscal notes on legislation to increase sentences;
3. Chronic failure of the Board of Pardons and Paroles to meet its own standards for releasing low-risk prisoners; and,
4. An aging prison population.

Overly harsh sentencing laws

Texas' overly harsh sentencing laws are one problem that contributes heavily to overcrowding and the subsequent strain on healthcare. Juries often give the maximum sentence with the idea that the offender will serve only half that sentence before being released to parole, but the broken parole system inhibits this approach, as discussed below.

One example of absurd sentencing is the 35-year prison sentence which a man in Tyler received for the possession of just over four ounces of marijuana. He got off easy – the prosecutor asked for a 99-year sentence.⁹⁵ In another case, a Matagorda County jury recently sentenced a man to 60 years in prison for possession of 1.3 grams of crack cocaine, about half the weight of a U.S. dime. There was no evidence of intent to distribute.⁹⁶ A court in Williamson County recently sentenced a DWI-offender to life in prison,⁹⁷ and a jury in Anderson County sentenced a man to 99 years in prison for theft.⁹⁸

Ultimately, the Texas legislature is responsible for giving juries these outrageous options, overselling their impact on crime. Lengthy sentences for non-violent offenders will cost millions in room, board, and healthcare as they spend many years, or even the rest of their lives, in prison at taxpayer expense.

In order to control the prison population, Texas should revise current sentencing laws by creating a Sentencing Review Commission, charged with the task of creating new sentencing laws more consistent with those nationwide. Especially for non-violent drug crimes, probation and parole are good alternatives to incarceration. Substance abuse treatment can be made a condition of probation or parole to address the offenders' problems, rather than just incarcerating them (where they may, or may not, get the treatment they will need when they are eventually released). Texas should reduce enhancements and change minor felonies to Class A misdemeanors to divert more low-level inmates to county jails and probation, where the crowding crisis is less severe. Releasing all prisoners on parole when they have served 90% of their sentence would both create savings from early release and ensure some state-supervision of newly freed prisoners who have spent decades in prison.

Dishonest fiscal notes

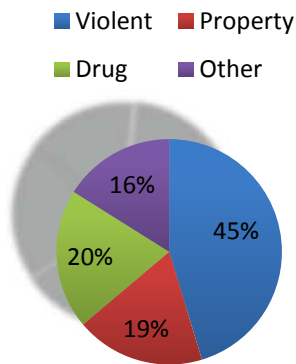
A second problem is fiscal notes, estimates of the expected cost or revenue of new laws that must be attached to every new bill in the Legislature. Fiscal notes for enhancements of criminal penalties almost always underestimate the high cost of incarceration as a solution to social problems.

Prisoners Eligible for Parole

Texas releases prisoners before they complete their sentence on either parole or discretionary mandatory supervision (DMS). Both parole and DMS allow a prisoner to complete their sentence while living in the community under the supervision of TDCJ's Parole Division.

Sixty-five percent of TDCJ prisoners are currently eligible for release on parole or mandatory supervision.

Prisoners Eligible for Parole by Offense Type



A recent bill proposing to increase the penalty for vehicle burglary from a misdemeanor to a felony had a fiscal note estimating a cost of about \$9 million annually for housing an additional 500 prison inmates. The note entirely ignored that, at the time the bill was under consideration, the prison system was entirely full. Just 500 more inmates would require building an entirely new facility, actually costing the state up to \$300 million.⁹⁹

Not only does this lack of accurate fiscal estimates reduce the perceived cost of overly harsh sentencing laws, but it also causes even bigger holes in the budget when a “\$9 million” law costs taxpayers over 30 times more than anticipated. In addition, it allows legislators to pass expensive but politically popular sentence enhancements – and falsely claim that they will be of little or no cost to the state.

Chronic failure of the Board of Pardons and Paroles

The Board of Pardons and Paroles' failure to administer parole according to its reasonable official guidelines is another source of overcrowding. In fiscal year 2008, there were 139,134 inmates in TDCJ custody; of those, 90,880, or 65%, were eligible for parole.¹⁰⁰ However, only 32,548, or 36% of these eligible inmates were actually released to parole.¹⁰¹

At first, one might think this is because the other 60,000 inmates were dangerous criminals with violent histories who would be unwelcome in our communities, but this is not always the case. In fact, only 45% of the prisoners eligible for parole and still in custody were convicted of violent offenses.

Rather, the problem is the way the Parole Board makes decisions. Consider the way the parole system is set up. The parole system assigns each parole-eligible inmate to a level from 1 to 7 denoting his or her likelihood of successfully completing parole and reintegrating with the community. Level 1 is the lowest chance and Level 7 is the highest. This level assignment is based on both the severity of the original offense and personal factors about the inmate, such as age, prison gang status, and employment history. For example, an inmate convicted of capital murder can never receive a level

higher than 3, while an inmate convicted of forgery who has good prison conduct, is not in a gang, and has no violent history may be assigned to level 7.

According to the Board's own guidelines, Level 7 inmates should be released anywhere from 76% to 100% of the time.¹⁰² Yet in 2006, the Texas Sunset Commission discovered Level 7 inmates were released on parole only 38% to 58% of the time, depending on the region, leaving thousands of nonviolent, low-risk inmates crowding our prisons and wasting our tax dollars.¹⁰³ There is no requirement the Parole Board follow its own guidelines, and no existing mechanism to force the Board to comply.

Why this discrepancy? One possible answer is the unbalanced makeup of the Board of Pardons and Parole itself. As of 2007, 17 of the 19 voting members of the board had professional backgrounds in law enforcement or criminal justice,¹⁰⁴ with no defense-side or social work backgrounds to provide another view. This does not at all reflect the makeup of the Texas juries which set sentences expecting that the maximum time will not be served. Considering that each parole decision is based on the votes of only three members, a more balanced board is necessary for administering fair decisions. When making appointments, the governor should consider the consequences of appointments likely to keep prisons overcrowded.

The Board also has little accountability for its decisions. Parole decisions are made in secret, and inmates are given little information about why their parole was denied, preventing them from working toward obtaining parole at their next hearing. Texas law doesn't require the Board to meet with inmates for their parole hearings, or even to discuss their decision as a group. Parole "hearings" essentially amount to individual Board members reviewing an inmate's file and making snap decisions on whether or not to grant parole.

Moreover, inmate parole files can contain gross errors – in one case, an inmate was denied parole because his modest arrest record was accidentally replaced with the long and violent criminal record of another inmate with the same name.¹⁰⁵ The prisoner has no access to the documents the Board reviews, making it impossible for errors to be corrected, or even know the mistake was happening.¹⁰⁶ A system that denies inmates a chance to clarify potential errors of this magnitude is a broken system.

When combined with the issue of medical care, the cost of the failing parole system becomes apparent. A bill from the 80th Legislative Session, HB429, required TDCJ to investigate the cost-savings of releasing to parole inmates over age 55 who are receiving medical care and have not committed a "3G" offense.¹⁰⁷ The study found that this release, which would affect only 5,000 inmates, would save \$20.2 million in medical costs annually, \$29 million in reduced contract beds, and cost only \$6.4 million in increased parole supervision costs.¹⁰⁸ That's a net savings of \$42.8 million – money that could be reallocated to the sundry medical reforms TDCJ healthcare really needs instead of being used to cover the exorbitant medical costs of a small group of low-risk prisoners.

An aging prison population

Medically Recommended Intensive Supervision Failures

Below is a small sample of elderly prisoners eligible for MRIS who remain incarcerated. Their names have been changed to protect their privacy.

- Martin Jimenez: age 69, parole eligible since 1997 – Mr. Jimenez is legally blind with one amputated leg, and his kidneys are failing. Every two days, he needs a four-hour dialysis treatment.
 - Donald Gomez: age 87, parole eligible since 2006 – Mr. Gomez uses a walker. At age 87, he was given a four year “set off” by the Board preventing him from being considered for release until age 90. He recently died in custody.
 - Jack Carter: age 68 – Mr. Carter is blind and suffers from brain damage caused by a gunshot to the head. He is partially paralyzed on his left side (due to a stroke), and suffers from Hepatitis C, high blood pressure, and high cholesterol. He’s served over 33 years in prison.
-

HB429 brings to light a fourth problem: the aging population of Texas prisons, a side effect of excessively long sentencing and failure to release eligible parole candidates. The number of prisoners aged 55 and over is increasing at a rate of 10% each year. These prisoners are more likely to have chronic and expensive health conditions: Though they made up only 5.4% of the prison population in 2005, they accounted for 25% of hospitalization costs.¹⁰⁹

Another way to decrease the costs of geriatric prisoners is medically recommended intensive supervision, or MRIS. MRIS is a recommendation from UTMB or Texas Tech that a prisoner be released early due to medical problems that make him or her no longer a threat to society. Increasing MRIS recommendations and approval would relieve taxpayer burden without increasing any criminal threats.

However, the Parole Board frequently denies MRIS to qualified applicants. In fact, of the 70 or so inmates recommended for MRIS each month, the Board only approves an average of seven,¹¹⁰ another indicator of its poor performance in terms of following appropriate release guidelines.

Among the eligible applicants for MRIS is Carlos Chavez. Mr. Chavez’s cancer was in its terminal stage, giving him 60 to 90 days to live.¹¹¹ He was denied MRIS because the Board thought he was a “threat to society,” despite being literally unable to get out of bed. Instead of spending his last few weeks with his family, he spent that time in TDCJ’s medical and fiscal care.

These are only a few examples of the many geriatric inmates with extensive and expensive medical problems. Their release to MRIS could save the state millions of dollars, which could be reallocated to address urgent and underfunded health care problems.

Recommendations

- Provide incentives for potential employees to help TDCJ hire and retain qualified security and medical staff. Incentives could include competitive salaries, loan-forgiveness program, or a positive and supportive work environment that encourages job longevity.
- Create a statewide Sentencing Review Commission charged with the task of creating new sentencing laws that are consistent with nationwide standards, reducing the reliance on excessively long sentences, and examining the fiscal and human costs of sentencing in Texas.
- Demand accurate fiscal notes on all legislation that increase sentence length through enhancing punishment or the creation of a new offense, and look at the cost of adding prison beds and units.
- Hold the Board of Pardons and Paroles accountable for its parole decisions, and demand that it follow its own release guidelines. Because the Board of Pardons and Paroles has complete discretion in determining who will be released to parole, it is essential that they follow their own guidelines so that they are releasing low-risk individuals more often than high-risk individuals.
- End the secrecy and mitigate costly errors during the parole process by allowing prisoners access to their own file and the information that is being considered by the Parole Board. These parole files often contain grave errors including incorrect information related to the individual's criminal history which can delay their parole release. Allowing access to view what the Board is considering – save any sensitive information related to victims – can ensure that the information inside the file is correct, accurate, and relevant to the individual being considered for parole.
- Increase MRIS approval rates to a reasonable level as established by a Sentencing Review Commission. This can be done by implementing the findings of the study passed by HB429 for the release of prisoners over 55 years of age with a non-3G offense who are receiving medical care. This would allow them to be supervised in the community where they are eligible to receive Social Security and/or Medicare benefits to pay for their care.

MENTAL HEALTH

Medical horror story: Josh Dillard

Josh Dillard had a long, well-documented history of mental illness.¹¹² Before entering TDCJ, Mr. Dillard suffered from Attention Deficit/Hyperactivity Disorder (ADHD) and had numerous bouts of depression. Since childhood, he had been admitted to multiple psychiatric facilities, including Austin's Shoal Creek residential psychiatric hospital.

His mental state worsened after he entered TDCJ. By 2002, he had attempted suicide four times. Mr. Dillard was transferred to a psychiatric facility, where UTMB determined he was at heightened long-term risk for suicide, especially during times of increased depression. By 2003, Mr. Dillard had been diagnosed in TDCJ with a major depressive disorder, a psychotic disorder, polysubstance abuse, antisocial personality disorder, and schizoaffective disorder.

Even one of these diagnoses should have been enough to ensure close supervision and mental health care for Mr. Dillard. Yet, in 2004, UTMB failed to update Mr. Dillard's electronic mental health records with his recent suicidal behaviors when he was transferred between prisons. Consequently, a unit psychiatrist, without even evaluating Mr. Dillard personally, changed his mental health diagnosis to "no diagnosis," removing Mr. Dillard's designation as an inmate with current psychiatric illness.

Two years later, in February 2006, a unit psychotherapist finally saw Mr. Dillard. However, the psychotherapist disregarded Mr. Dillard's extensive history of mental instability and suicide attempts, and instead determined he was at low risk for suicide and did not need any mental health follow-up care. This was Mr. Dillard's last visit with anyone in TDCJ's Mental Health department.

Had Mr. Dillard been accurately diagnosed, perhaps TDCJ would not have cleared him on December 27, 2006 for placement in administrative segregation, otherwise known as solitary confinement, as a punishment for a violation of prison rules. The UTMB system did not make the screening nurse aware of Mr. Dillard's past psychiatric history, nor did it require her to ask him about his history of suicide attempts, although TDCJ policies strictly prohibits housing suicidal or mentally ill inmates in segregation. He was easily cleared for solitary confinement, according to documents and testimony from litigation.

The next day, December 28, the inmates housed across the hall from Mr. Dillard discovered that he was no longer responding when they yelled for him. The inmates then yelled for a guard to check his cell. At 7:40 p.m., guards discovered Mr. Dillard hanging from a sheet tied to the lamp fixture in the cell. He was also bleeding profusely from a deep wound in his left arm which he had made with a razor blade found in his cell. Mr. Dillard was taken to a local hospital and pronounced dead an hour later.

***The Other Victims –
Prisoners’ Families***



*Jane Campos and her son,
Joshua Dillard, as a child*

When he was very young, Josh Dillard was adopted by Jane Campos. Mr. Dillard’s biological mother used drugs and alcohol during her pregnancy, and abandoned him as a small child. Ms. Campos raised him as if he was her own son, despite his life-long serious mental illness.

Ms. Campos learned her son died when she got a call late at night on her cell phone. She was returning home from her job as a sergeant at the Bastrop County Jail. The prison chaplain callously told Ms. Campos her son was dead, and hung up.

Ms. Campos’ son died just a few days after she had visited him on Christmas Eve.

“My son was not a throw away,” said Ms. Campos. “I want my son’s story to be known. People forget the people in prison are human beings with families that love them. My son was loved by me. He may not have been loved by anyone else in this world, but every person in the prison system is loved by somebody.”

TDCJ and UTMB’s callous disregard for Mr. Dillard’s mental health history caused his death. UTMB did not keep Mr. Dillard’s mental health records up-to-date, which caused his current mental illness to go unnoticed. Mr. Dillard should never have been in solitary confinement, an utterly unsuitable environment for a mentally ill, suicidal person. In addition, a number of mental health employees violated TDCJ and UTMB policies and procedures by failing to adequately evaluate Mr. Dillard’s mental health and his risk of attempting suicide. TDCJ and UTMB have policies that should prevent people like Mr. Dillard from being placed in un-safe solitary confinement. These life-saving measures, however, are often ignored.

TDCJ and UTMB staff must follow established policies in order to improve its medical practices for inmates with mental illness in order to avoid deaths in custody – including avoidable suicides.

Overview of mentally ill prisoners

Mentally ill persons are a group often ignored in Texas prisons, perhaps because it doesn’t make much sense for them to be imprisoned in the first place. Incarcerating mentally ill people does not serve the goals of rehabilitation or punishment. The standard prison setting lacks the resources and professionals necessary for effective mental health treatment and does not provide a safe environment for mentally ill individuals or those around them. Moreover, a prisoner with a severe mental illness is unlikely to understand he is being punished thus making his incarceration senseless and wasteful.

Mental illness in prison is regrettably common. In fact, 27.25% of Texas prisoners, or 42,556 people, are identified as mentally ill or mentally retarded.¹¹³ Sources suggest this number may be far higher.¹¹⁴ In contrast, for every eight mentally ill people who enter jail or prison in Texas, only one enters a mental hospital.¹¹⁵

The complications of imprisoning the mentally ill, rather than effectively treating them, are dangerous and costly to society. Mentally ill people are substantially more likely to recidivate after their release than other prisoners, about 12% more likely for first-time reoffenders. Mentally ill repeat offenders cost the state \$682 million each year in prison beds

and treatment. On the other hand, treatment in a community mental health center for the same number of individuals for one year would cost only \$92 million.¹¹⁶

The Texas Civil Rights Project receives many letters from obviously mentally ill prisoners. Notable examples include the prisoner who sent copies of “peace declarations” between himself and the United States for the Civil War, World War II, and Vietnam, the prisoner who threatened to sue the Project through the Intergalactic Space Court, and the prisoner who asked us to bring FBI Agents Mulder and Scully, the characters of the TV show *The X-Files*, to investigate the way the government was programming his brain to make him commit crimes. These are not prisoners in mental health treatment facilities. These are prisoners in top-security TDCJ units, receiving bare-minimum mental health care that contributes little toward their rehabilitation.

It is understandable that some mentally ill offenders will go to prison rather than be diverted into effective community programs. Yet prisons are still required by law to provide them with a constitutional level of care, and accommodations for their mental illnesses under the Americans with Disabilities Act. Of the 42,556 mentally ill inmates in TDCJ custody, 11,388 have been diagnosed with schizophrenia, bipolar disorder, or major depression: the three mental illnesses considered the most serious by the Texas legislature and the only illnesses with funding set aside for their treatment.¹¹⁷

About 20,000 inmates have mental health problems so severe they must take medication to treat them.¹¹⁸ Yet TDCJ contracts with only 432 psychiatric employees, total; about one psychiatric employee for every 50 prisoners on medication. Even this isn’t evenly distributed, though. Thirty-seven out of the 112 TDCJ units do not have a *single* mental health professional on staff, including *four out of the five* Substance Abuse Felony Punishment (SAFP) units, special units for individuals with substance abuse issues.¹¹⁹

Not only does this extreme staff shortage adversely affect the 27.25% of inmates with a diagnosed mental illness, but it also affects the thousands of other inmates who live with these mentally ill persons in an environment that fosters anxiety, stress, and physical altercations.

Furthermore, some prisoners who are not diagnosed as mentally ill, such as sex offenders, violent offenders, or prisoners with drug problems, could likely benefit from psychiatric help if such help were available to them. This benefit would extend to the public, who would have fewer mentally unstable ex-prisoners returning to their communities on release.

Available mental healthcare

The psychiatric treatment currently available in prisons is wholly insufficient. The contract between TDCJ and CMHCC specifies certain access-to-care measures particular to mentally ill prisoners.¹²⁰ Mental health outpatients who submit sick call requests must be seen within 48 hours (72 hours on weekends), and must be seen by a qualified mental health professional within 14 days of triage. These low response standards, the same ones used for

Mental Illness in Solitary Confinement

Human Rights Watch observes “Some inmates with no prior history of mental illness develop clinical symptoms of psychosis or severe affective disorders [in administrative segregation]. For prisoners with a history of mental illness, the isolation, lack of social interaction and lack of structured activities can aggravate their symptoms. Even worse, mental health service for prisoners in segregation is usually far worse than for the general population. The result is mental agony, sometimes to the point of suicide.”

In 2009, TDCJ housed 8,639 prisoners in administrative segregation—TDCJ’s form of solitary confinement.

Prisoners in “ad seg” are kept in a cell that is barely large enough for a bunk and a toilet. They have just one hour of indoor recreation each day. Their only human contact is with the guards who feed them and take them out for exercise.

Prisoners write to TCRP complaining they have spent years in ad seg, and have no opportunity for release to the general prison population. The Fifth Circuit Court of Appeals found similar conditions in Mississippi unconstitutional in *Gates v. Cook*.

dental care in TDCJ, are unwise for a type of health problem that can quickly degrade into self-destruction, violence against others, or even suicide, especially since this section extends to outpatients with histories of mental health problems who should be closely monitored. TDCJ must improve this response time to prevent severe mental health consequences.

Negative effects of prison

Prison is a damaging and expensive place for people with mental illnesses. Guards are untrained in mental health procedures and available therapies in prison are extremely limited. There is almost no follow-up after the prescription of sensitive medications. Solitary confinement, known in TDCJ as administrative segregation or “ad seg,” is commonly used to house mentally ill prisoners. It is a punishment that not only aggravates existing psychopathic conditions but can cause new ones in otherwise healthy inmates.¹²¹ According to expert testimony from a board-certified psychiatrist, who has spent over 20 years on the faculty of Harvard Medical School, solitary confinement can cause “severe psychiatric harm” and induce panic attacks, hallucinations, paranoia, and self-destructive behavior.¹²² These and other negative effects mean continuing to warehouse mentally ill individuals in prisons is not an acceptable option.

Additionally, as TDCJ populations increase toward the units' maximum capacity, special psychiatric housing fills up quickly, leaving many mentally ill inmates housed within the general population. This can be damaging to both groups. One inmate wrote the Texas Civil Rights Project after being attacked by the schizophrenic prisoner with whom he had to share a cell. In addition, mentally ill or mentally retarded inmates (also known as MHMR inmates) are much more likely to be victims of assault, sexual assault, or exploitation, and are especially vulnerable when housed in understaffed units with regular inmates. MHMR inmates, by nature of their disabilities, also have a more difficult time making prison employees aware of their health problems and are less likely to be believed when they ask for help.

The most effective and humane way to improve mental health care in prisons is to divert mentally ill individuals away from prison conditions that may only exacerbate their

problems, and instead relocate them to treatment facilities or community supervision where they can access helpful programs.

Recommendations

- Develop and expand a state-wide prison diversion program for mentally ill persons, including prevention, diversion, and discharge elements to redirect mentally ill persons to healthier and less expensive options like state hospitals and community mental health care centers.
- Greatly expand the use of Telepsychiatry use in TDCJ prisons to better serve the needs of those who are mentally ill and who must necessarily remain in prison.
- Follow established policies and eliminate the use of solitary confinement for mentally ill inmates and institute proper screening for mental illness before placement in solitary confinement. Instead, rely on less destructive punishments, such as taking away privileges. If solitary housing is absolutely necessary to protect the individual, staff, or other prisoners, move the inmates to a single cell within the general population and require frequent staff observation and evaluations.
- Substantially increase mental health staff in prison units.
- Regularly screen the prisoner population to identify inmates with a history of mental illness and ensure proper treatment is provided. This can be done by reducing the response time by one-half to inmate mental health complaints, especially complaints from inmates who have an established history of mental illness.

INFECTIOUS DISEASE

Medical horror stories: H1N1 and norovirus

In 2009, a deadly new form of the flu took the nation and the world by storm. H1N1, or swine flu, caused widespread panic, killing 12,000 Americans and infecting 60 million more as of March 2010.¹²³

When a vaccine was found, approved, and delivered to Texas, it was first administered to high-risk groups in the public, according to Center for Disease Control (CDC) guidelines: pregnant women, juveniles, and those with medical conditions, like immune system disorders, that put them at higher risk for contracting the disease. After that, the state requested doses of the vaccine for 45,224 prison inmates who fit into the same high-risk groups,¹²⁴ a measure well in line with public health and constitutional objectives.

But many in the public were outraged – even though they were at much lower risk for contracting H1N1 than the inmates to be vaccinated, and even though the state is constitutionally obligated to provide adequate health care for prison inmates. Citizens complained of “preferential treatment” for prisoners, though the treatment would be equal, not superior, to that given the public. Some suggested that treating the prisoners would only be acceptable if they were used as “guinea pigs” for the vaccine,¹²⁵ showing the level of the public's misunderstanding about the state's responsibility for its prisoners.

After this outcry, and despite the huge stakes of a statewide prison system infected with swine flu, including a substantial risk to prison employees, the Texas Department of State Health Services suddenly became “unclear” about when it would fill the requests for the prison vaccines.

Fortunately, the impact of H1N1 in Texas prisons was limited. But a recent norovirus outbreak shows the potentially disastrous effect of infectious diseases in a prison environment. Over the course of a few weeks, an astonishing 1,600 inmates and employees in 26 different Texas prisons became infected with norovirus.¹²⁶ Sometimes called stomach flu, norovirus is a highly contagious disease that causes vomiting and diarrhea,¹²⁷ especially problematic symptoms in a small space with limited sanitation like a prison. Had the disease been anything more severe than norovirus, the chance of disastrous consequences for the inmates, the employees, and the public would be very high. Of course, if an H1N1 epidemic had taken hold, it would have cost the taxpayers far more to care for all the sick prisoners than to simply vaccinate them in the first place.

Centers for Disease Control and Prison Healthcare

The CDC provides specific guidelines for disease control in correctional facilities and is a good source of constitutional standards.

For example, for tuberculosis, the CDC recommends entry and periodic TB screening, treatment of both latent TB infection and TB disease, airborne precautions, and comprehensive discharge planning.

TCRP strongly recommends Texas adopt the CDC's standards for providing prison healthcare.



The reasons for prevention and prompt treatment of these kinds of infectious diseases are not limited to simply attaining constitutional care for inmates: public health and the state budget are also at high risk. Prisons are notorious breeding grounds for infectious disease. The close quarters, often poor sanitary conditions, and inconsistent identification and treatment of diseases in prison lead to a high rate of infection that is expensive for taxpayers and dangerous to public health. Moreover, prisoners often engage in high-risk behaviors that increase exposure to these diseases, such as tattooing, drug use, and risky sexual activity.

Prisons have become incubators of infections. Uneven treatment produces drug-resistant strains of diseases, which can be introduced to the public when prisoners are released. Hepatitis, tuberculosis, HIV/AIDS, and staph infections are among the most dangerous infectious diseases in prison. Each of these poses a serious risk to both prisoners and the public, and Texas prison health care must include proactive and preventative measures to prevent their spread.

Hepatitis

Hepatitis A, B, and C are three similar viruses that cause infectious liver disease, although the specific effects and mode of transmission differ. Hepatitis A has a relatively short duration and usually clears up on its own, but Hepatitis B and C can become chronic diseases requiring long-term treatment that places a large burden on the resources available for prison healthcare.¹²⁸ Hepatitis B is transmitted through bodily fluids such as blood or semen and can cause a chronic infection that sometimes leads to liver failure and death. The best course of care for Hepatitis B is prevention: an effective vaccine is available and should be offered to inmates upon entry. Infected inmates should be monitored regularly.¹²⁹

Hepatitis C, or HCV, has no vaccine, and is pervasive in the prison population. While only 1.8% of the general population is infected with HCV, it is estimated that nearly 40% of prisoners nationwide have the disease.¹³⁰ HCV is transmitted through blood, particularly through the use of non-sterile needles for drug injection and tattooing and, less frequently, through sexual contact. The complications can be serious, with 60-70% of those infected with Hepatitis C developing chronic liver disease and 1-5% dying from cirrhosis or liver cancer.¹³¹

Once HCV has progressed to a certain point, the only treatment option is a liver transplant, a \$400,000 procedure.¹³² The CDC recommends screening all inmates upon entry for HCV risk factors, and if those factors are present, testing inmates for the disease. This early identification of those infected will help save lives and money later on.

Tuberculosis

Tuberculosis is a bacterial disease that can lead to respiratory and other problems, including chest pains and coughing blood. It is spread through the air, and thus prison populations are especially vulnerable to it.¹³³ If not treated properly, TB can be fatal.

As of 2002, an incredible 20.4% of Texas prison inmates tested positive for tuberculosis, making it the most prevalent illness in the entire Texas prison system. All inmates are tested for TB at intake, making its identification relatively easy. Many inmates, however, don't finish the treatment they are prescribed, leaving lingering infections when they are released to the free world. It is important the prisons encourage inmates to finish their treatment courses and that prisons provide proper access to care to aid this treatment. Failure to do so harms not only the prisoners, but the communities they re-join upon release.

HIV/AIDS

HIV/AIDS is by far the most costly and dangerous disease in Texas prisons. Though only 1.7% of inmates are infected with HIV/AIDS, it is the number-one killer of Texas prisoners. Prisoners are infected with HIV at a rate five times higher than the general public.¹³⁴

Not only is HIV/AIDS deadly, it's expensive to treat. Over 40% of TDCJ's entire pharmaceutical budget goes towards HIV-related medications. Even one new case of HIV will cost over \$300,000 in treatment over the patient's lifetime. Preventative steps, like condom and clean needle distribution, should not only be encouraged, but mandated.¹³⁵

Texas prisons appear to do a decent job of making HIV testing available, offering it to all new inmates upon intake screening and mandating it upon release. Ten years ago, TCRP received many letters from prisoners complaining they were not receiving any HIV treatment at all—that flood has slowed to a trickle today. Most complaints TCRP receives about HIV treatment today relate to the schedules for administering HIV medications.

HIV is particularly sensitive to the uneven treatment that often occurs in prisons. The virus easily morphs into new, more drug-resistant strains when treatment is irregular. These drug-resistant strains of HIV are especially deadly, and can be brought into the “free world” when a prisoner is released. Prisons must take measures to ensure HIV-positive prisoners are provided the appropriate medications on the required schedules and checked on regularly.

Post-prison HIV care is one of the most important areas in which Texas must improve. HIV poses a significant public health risk due to the number of former inmates who do not

What Works: Florida's Staph Education Program

The Florida state prison system took the simple step of displaying large posters showing what staph infections look like and describing the symptoms, to great success in preventing staph complications. This system encouraged inmates to report possible staph infections, allowing for prompt screening and treatment.

TCRP frequently receives letters from prisoners complaining about large boils they believe are caused by “spider bites.” In fact, these boils are likely staph infections.

In some cases, the prisoner has seen medical personnel who misdiagnosed the “spider bite.” This anecdotal evidence suggests both prisoners and medical personnel could benefit from learning about how to recognize staph infections.

Staph is also easy to prevent with proper hygiene. Encouraging prisoners to wash their hands regularly, for example, and providing anti-bacterial hand soap could dramatically reduce the incidents of staph infections.

follow up on their antiretroviral therapy medication, or ART, after leaving prison. This creates drug-resistant HIV strains that could infect members of the general public due to continuing high-risk behavior.

A study led by a physician at UTMB-Galveston showed that only 5.4% of HIV-positive inmates filled their first 30-day ART prescription, which can be paid for by a government program if the inmate requests, within 10 days of release, or soon enough to avoid treatment interruption. An additional 47.7% filled their prescriptions within 60 days, but that was after an interval long enough to allow for mutation of the virus.¹³⁶ The study authors suggest this delay indicates released inmates face significant economic or administrative barriers to filling their prescriptions.

Prisons, parole authorities, healthcare facilities, and communities must work together to alleviate this problem and make access to essential medications easier, especially in communicating to inmates the availability of free ART treatment upon request. Without this coordination, the crisis of HIV/AIDS will only worsen as new strains and unchecked risky behaviors spread throughout the general public.

Staphylococcus

Staphylococcus bacteria, also known as “flesh-eating bacteria” or simply “staph”, can cause serious infections that sometimes lead to contagious open wounds, liver and kidney failure, sepsis, or even death. The bacteria are transmitted from skin-to-skin contact or through frequently-touched objects, such as doorknobs.

Staph is another example of a disease that has become drug-resistant over time,¹³⁷ making its prevention all the more imperative. In fact, prisons are the largest incubators of MRSA, the drug-resistant form of staph. Poor ventilation, overcrowding, and shared mattresses, toilets, and showers all contribute to staph thriving in prisons.¹³⁸

Prisoners with real staph infections are often told their infectious abscesses are only pimples or “spider bites”, and are not separated from the general population or from prison employees who are equally vulnerable to infection. This simple step of separation would greatly increase awareness of staph and reduce its devastating effect.

Inmate complaints of possible staph must be taken seriously. The \$28 it costs to test for a staph infection is a worthwhile price to pay for preventing a disease that costs taxpayers, on average, between \$20,000 and \$40,000 to cure.¹³⁹

Preventative methods

HIV/AIDS and Hepatitis B and C are transmitted largely through risky behaviors in prison, including sharing dirty needles for drug use or tattoos and engaging in unprotected sexual contact. A clear, cheap, and effective preventative method is to try to take the risk out of some of these behaviors.

Though programs like TDCJ's Wall Talk, a peer education program, do a good job of educating inmates about the risks of such behaviors, it cannot stop the behaviors from happening, nor can increased punishments or incentives. The distribution of condoms and clean needles is an important harm-reduction step. In the long run, this distribution has been proven to decrease rates of these infectious diseases and will save taxpayer money. The federal ban on prison needle exchanges was lifted in December 2009, opening up the way for expansion and innovation in those programs.¹⁴⁰ Though condom and needle distribution is sometimes seen as an encouragement of illegal behavior, when combined with education, it can go a long way toward moving prisoners to clean lifestyles, benefiting everyone when prisoners are released. Furthermore, programs in Canada, Europe, and parts of the U.S. have shown condom distribution to be an inexpensive and effective means of preventing expensive HIV and HCV infections in prison.¹⁴¹

Basic hygiene and sanitation can prevent infections like the norovirus and staph. TCRP receives a large volume of complaints about the sanitary conditions of TDCJ units, including reports of overflowing toilets and the denial of running water and soap, conditions which easily facilitate the spread of infectious disease. Prompt attention to maintenance problems could quickly resolve these disgusting conditions and cut off potential disease incubators.

As far as infectious diseases in prison, prevention really is the best medicine. Many of the most dangerous and expensive conditions in Texas prisons could be avoided if policymakers are willing to take the simple steps necessary to prevent them. Reducing the incidence of infectious disease in prison could also go a long way toward recruiting new prison employees and reducing TDCJ's revolving-door employment problem.

Recommendations:

- Improve sanitary conditions inside state prisons to prevent infectious disease outbreaks like H1N1 and norovirus. This is especially important in light of the fact that 95% of prisoners leave prison and return to Texas communities.

- Provide condoms and clean needles to inmates to stop the spread of costly and dangerous fluid-borne diseases like Hepatitis C and HIV/AIDS. Providing condoms does not condone sexual activity; instead, it provides an inexpensive solution to the spread of life-threatening diseases that ultimately costs the state millions in medical costs.
- Screen inmates for Hepatitis C upon entry, as CDC recommends, and begin early treatment, if necessary. Offer vaccinations for Hepatitis B which is the most effective way to prevent the disease.
- Ensure successful completion of tuberculosis treatments. Completing these treatments is essential to eliminating the threat of continual outbreaks.
- Increase education for both prisoners and staff members about staph infections and test all inmates who exhibit symptoms related to the infection. These measures will help avoid much higher costs down the road by providing prevention and intervention techniques.
- Develop new ways to ensure that prisoners continue their HIV/AIDS treatments post-release, including pre-release education on payment alternatives and the risks of uneven treatment, to prevent catastrophic public health consequences.

CONCLUSION

David West, Larry Louis Cox, Adam Whitford, and Josh Dillard represent only a few of the prisoners whose health and lives have been lost in the Texas prison health care system. There are hundreds more like them. The Texas Civil Rights Project hears from them and their grieving families daily. We dedicate this report to them.

This legislative session, our leaders will face tough decisions. In a time when cuts to education and health care programs are likely, it will be extremely difficult politically to resist slashing prison health care budgets. Fortunately, Texas can alleviate this serious problem by taking other, low cost, solutions. Parole non-violent offenders. Release the extremely ill on medically recommended intensive supervision. Closing a handful of prisons would both be politically easier than closing schools or hospitals, and help solve the prison health care crisis, without creating additional crime.

Times are tough now. But, if Texas is not careful, our prison system could end up in the same place as California's: paying additional billions of dollars, under federal supervision, and being forced to release tens of thousands of prisoners. It's time our legislators got "smart on crime," not just "tough on crime."

APPENDIX

Medical Horror Stories

Micah Burrell¹⁴²

Micah Burrell suffered from asthma since childhood. When he entered prison in 2001 on drug and property charges, he was diagnosed again at the unit's asthma clinic. He was prescribed an inhaler, and made regular visits to the asthma clinic to monitor his condition.

In 2004, Mr. Burrell was placed in administrative segregation—"solitary confinement." TDCJ and UTMB policy prohibits housing prisoners with certain medical conditions, including asthma, in "ad seg." A nurse screens prisoners for medical problems before they are segregated, but is not required to ask prisoners if they suffer from the identified conditions.

On August 1, 2004, around 1:00 p.m., other inmates noticed Mr. Burrell was having trouble breathing and called for the guards to come.

It wasn't until 1:15 p.m. that guards, performing a security check, noticed that Mr. Burrell was unresponsive. They could have called for medical help. Instead, they stood outside his cell calling in to him: "That doesn't look like an asthma attack!" "I can see your foot moving, you're faking!" "You should've pulled this on the next shift!" The guards laughed and pointed at Mr. Burrell instead of taking him to the infirmary as he gasped for breath.

Finally, at 1:32 p.m., when Mr. Burrell was convulsing on the floor and unable to breathe, a guard entered the cell and slapped Mr. Burrell's face to see if he would wake up. When the guards finally brought him out of the cell, a nurse treated Mr. Burrell, hearing only his death rattle. Mr. Burrell was rushed to the hospital, where he arrived at 2:20 p.m., but by then it was too late. Attempts at resuscitation failed and Burrell was pronounced dead at 2:35 p.m., at age 24, of an entirely preventable cause.

Donald Novel¹⁴³

Donald Novel entered TDCJ in December of 2005 on a drug charge. Mr. Novel lived his entire life with cystic fibrosis. CF causes lung problems, blocked sweat glands, and blockage of pancreatic enzymes so that the patient cannot digest food without help.

In the free world, Mr. Novel took Ultrase, an enzyme supplement, to control his condition. Ultrase gave him 100,000 units of lipase daily to help break down his food. Logically, an inmate with a chronic condition that is well-controlled in the free world should receive the same care once he is incarcerated. In fact, when Mr. Novel entered the Bastrop County Jail, his medications continued as prescribed. He was in excellent health, even gaining weight and doing well under Bastrop County's medical care.

When Mr. Novel transferred to TDCJ's Estelle Unit, however, things changed. Rather than following his "free world" doctor's orders, or continuing the very good care he was receiving in county jail, UTMB doctors decided to take their own approach to Mr. Novel's care. The unit doctor, obviously unfamiliar with CF, asked whether Mr. Novel's digestive problems were caused by excessive drinking, had him examine his own x-ray to see if it had worsened, and denied him liver function tests that are standard practice for CF patients.

Worse, Mr. Novel's medication was switched, against his "free world" doctor's recommendations, to a generic enzyme—a medication so ineffective that the Cystic Fibrosis Foundation has banned doctors from prescribing it. The generic provided only 24,000 units of lipase per day—less than a fourth of what Mr. Novel's deadly condition required. Suddenly, Mr. Novel's body could only process a quarter of the food it could before. He lost weight rapidly. Though he ate as much as any prisoner, his body, unable to take nutrients from his food, was essentially starving to death.

The medication switch was a costly mistake. Even so, Mr. Novel and his family took all the right official steps to correct it. His mother allowed the standard 45 business days to investigate a medical complaint, even as her son was rapidly losing weight. She called, e-mailed, and wrote to TDCJ and UTMB, and had her son's "free world" doctor, the director of the Austin Cystic Fibrosis Clinic, do the same. Then she waited, only to receive form letters in response. UTMB and TDCJ knew of Donald Novel's condition. They knew the medication wasn't working. They knew he was slowly starving. Yet they did nothing.

Finally, after Mr. Novel had lost 38 pounds and suffered from diarrhea for more than three months, the UTMB doctors finally decided that the generic medications were not working. Ultrase was ordered in April 2006. The diarrhea stopped two days later, and Mr. Novel began gaining back the weight he had lost.

But his problems were far from over. In June 2006, not long after the success of obtaining the correct digestive medications, Mr. Novel was taken off both Ultrase and one of his inhalant medications, essential for his CF-caused lung problems. He developed a cough and was prescribed a suppressant, causing mucus to sit in his lungs, the opposite of recommended care for CF. This exacerbated his breathing problems: his body was unable to get enough oxygen.

In December 2006, after months of weakening due to incorrect medications, Mr. Novel was hospitalized for low oxygen levels and severe breathing problems, an incident that was only the latest in a series of attacks. By April 2007, he was no longer able to eat solid foods and was oxygen-dependent. He could not breathe on his own for long enough to take a shower. Experimentation with cheap drugs and ineffective treatments weakened Mr. Novel to the point that he would never recover. He was transferred to a permanent medical facility to finish his sentence.

As a last resort, Mr. Novel applied for MRIS. He and his family hoped that, outside of prison, he could resume treatment with a CF specialist and receive the lung transplant he now

needed to live. His application was turned down, even though he had served almost his entire sentence. Mr. Novel waited to be released on his standard parole date in September 2007. He had lost 50 pounds after entering TDCJ care. He was unable to walk or breathe on his own.

Two days after his release, Donald Novel died in the hospital of a heart attack, caused by the lung condition that TDCJ had deemed not severe enough to warrant early release to a specialist's care.

Juan Palote¹⁴⁴

Juan Palote's death is perhaps the most horrific story of preventable death. It is particularly unconscionable that a crowd of TDCJ employees stood just outside his cell, easily able to help, and simply looked on as Mr. Palote committed suicide. On November 14, 2005 at approximately 8:45 a.m., a guard found Mr. Palote in his cell hanging from the ceiling by a bootlace tied around his neck. Mr. Palote was yelling, "Let me die!" in Spanish as he tried to hang himself – and that's what the TDCJ guards eventually let him do.

The guard ordered Mr. Palote to stop, and warned that chemical agents would be used if he did not obey. Mr. Palote did not stop and the guard sprayed with pepper spray, while he had a noose around his neck.

After being sprayed, Mr. Palote began beating his head against his cell repeatedly. The guard again ordered him to stop. Mr. Palote continued and was again sprayed. In the meantime, several more employees had arrived on the scene, including a physician's assistant, a lieutenant, and several other officers.

Once the lieutenant arrived on the scene, the guard suggested that they open the cell and go in to help, but the lieutenant instructed the staff to wait for the chemical agents to take effect. Mr. Palote continued to hang from the bootlace and bang his head against his cell. By the time the officers finally went into his cell, Mr. Palote was dead.

ABOUT THE TEXAS CIVIL RIGHTS PROJECT

The Texas Civil Rights Project (TCRP) promotes racial, social, and economic justice through education and litigation. TCRP strives to foster equality, secure justice, ensure diversity, and strengthen communities. Since its beginning, TCRP has achieved substantial system gains in ensuring justice for all Texans. TCRP uses education and litigation to make structural change in areas such as voting rights, police and border patrol misconduct, sex discrimination, employment bias, privacy, disability rights, grand jury discrimination, traditional civil liberties (i.e. free speech), and Title IX in secondary education.

TCRP was founded in 1990 as part of Oficina Legal del Pueblo Unido, a non-profit community-based foundation in South Texas. Oficina Legal del Pueblo Unido, Inc., started in 1978 as a community, grassroots foundation to provide legal assistance and education, without cost, to low-income people, particularly minority persons and individuals victimized by discrimination.

TCRP began with an unpaid staff of two in the Austin Peace Building—an attorney and an office manager. Within a few months, TCRP was able to hire an attorney for its South Texas office. TCRP now has offices in Austin, San Juan, Odessa, and El Paso, with a staff of more than 35 people.

For 20 years, the Texas Civil Rights Project has been a tireless advocate for racial, social and economic equality in Texas, through its education and litigation programs.

Our achievements include:

- * Handling more than 2000 cases;
- * Publishing eight Human Rights reports on issues such as hate crimes and the death penalty;
- * Compiling five “self-help” manuals;
- * Publishing 300 opinion editorials in Texas newspapers;
- * Giving 250 speeches and talks on civil rights; and,
- * Conducting community and lawyer trainings for more than 22,000 persons.

Our South Texas office has worked steadfastly to extend equal rights to farm laborers and colonia residents in the Rio Grande Valley, and improve their living and working conditions.

We have sued over every kind of misconduct in every part of Texas — city police, sheriff deputies, Department of Public Safety officers, and Border Patrol agents. Because of our work, jails in Hidalgo, El Paso, Henderson, Tom Green, Williamson, Travis, Bexar, Dallas, and Brown Counties do much more now in preventing inmate suicide, providing interpreters for deaf prisoners, protecting vulnerable inmates from sexual assault, administering HIV medications, and making them accessible for inmates with disabilities.

TCRP set the national model in ballot accessibility for blind voters, and has led more than two dozen regional compliance campaigns in Texas under the Americans with Disabilities Act (ADA). Thanks our efforts, churches and courthouses in Texas are much more accessible to people with disabilities – and government more accountable.

We pioneered a unique “circuit-rider” outreach program in rural West and South Texas serving abused and undocumented women and children under the Violence against Women Act (VAWA).

We have prodded the Texas Supreme Court to improve pro bono services for poor and low-income families in the state, 90% of whom have unmet legal needs each year.

Our Title IX educational and litigation programs on sexual harassment, bullying, and equal sports opportunities have helped make rural middle schools and high schools more hospitable for young women. Our work has also opened up the prospect of athletic scholarships to college for them.

Our “Equality under the Law” campaign addresses benign discrimination against African-Americans and Hispanic-Americans in banks, restaurants, motels, and other places of public accommodation.

Our efforts to help citizens, permanent residents, and students of South Asian and Arab descent, and of Muslim tradition, who fell victim to post-September 11 discrimination, include filing a suit against a major airline, and enlisting Texas attorneys on a pro bono basis to represent individuals who were questioned by the FBI.

We worked with the Mexican American Legal Defense and Education Fund (MALDEF) to help create single-member school board districts in Del Valle ISD, and assisted in redistricting the Texas Legislature and Texas Congressional districts so as to protect the voting and representational rights of minority citizens.

We assisted the NAACP in bringing the U.S. Department of Justice to review Austin Police Department policies and make changes to APD’s use of force practices in minority communities.

We joined with the American Jewish Congress in one of the first court cases in the country to challenge the constitutionality of government funding of a religiously orientated job-training program that used the Bible as a text and proselytized to its trainees.

We are a leading voice in raising questions about the fairness of Texas' death penalty scheme, and the possibilities of executing innocent people. So, too, are we an intrepid advocate of traditional civil liberties, such as free speech and assembly, due process, and equal protection under the United States and Texas Constitutions.

A history of Oficina Legal del Pueblo Unido, Inc. and The Texas Civil Rights Project is available at <http://www.texascivilrightsproject.org/about/history.htm>.

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Article XI, Section B

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Dallas County paid over \$2 million in judgments to prisoners and their families who suffered from poor health care while UTMB provided care at the jail. TCRP represented one family in *Sims v. Dallas County*, where a sixty-year-old grandmother with schizophrenia died when the jail failed to treat her pneumonia. During the litigation, TCRP learned only one nurse was on duty to care for over three thousand prisoners.

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