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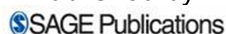

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The Evolving Standard of Decency: Postrelease Planning?

Jeff Mellow, PhD, and Robert Greifinger, MD

In the 30 years since the U.S. Supreme Court's decision in *Estelle v. Gamble* (1976), the evolving standard of decency on which the decision was based has been better articulated and defined by other courts, using *Estelle* as a basis. This article addresses the practical, ethical, and legal issues in understanding the recent emphasis on planning for an inmate's release back to the community. Specific court cases and laws are discussed to highlight which inmate health and behavioral needs presently require comprehensive discharge planning and what can be expected in the future.

Keywords: correctional health care; inmate health; discharge planning; reentry; *Estelle v. Gamble*

A wartime desertion case, more than half a century old, is the unlikely place to begin to understand the future of postrelease planning and transitional health care for inmates in America. In 1944, during World War II, Albert Trop, a U.S. Army private, escaped from a military stockade in Morocco; he was convicted of desertion and sentenced to 3 years hard labor. Trop did not realize, until he was denied a passport 8 years later, that by law his wartime desertion conviction made him stateless and no longer a citizen of the United States (*Trop v. Dulles*, 1958). Trop appealed his case to the Supreme Court, claiming that this collateral sanction of denationalization was a violation of his Eighth Amendment rights under the cruel and unusual punishment clause. The court agreed, and in one of the most well-remembered statements made by the court, Justice Warren said that the Eighth Amendment "must draw its meaning from the evolving standards of decency that mark the progress of a maturing society" (*Trop v. Dulles*, 1958, p. 22).

From that inception, the theme of the "evolving standard of decency" was instrumental in the court's decision in *Estelle v. Gamble* (1976), the first Supreme Court case dealing with correctional health care. To quote the court, "the infliction of such unnecessary suffering [failure to treat an inmate's serious medical needs] is inconsistent with contemporary standards of decency" (*Estelle v. Gamble*, 1976, p. 5). Although *Estelle* is remembered for the court's determination that deliberate indifference is the standard of review for constitutional violations concerning alleged correctional health care maltreatment, another legacy of *Trop*

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v. Dulles and, subsequently, *Estelle v. Gamble* is the recognition that society's changing legal and ethical interpretation of decency dramatically influences correctional agencies in their policies and practices when implementing postrelease planning and transitional health care.

There is increasing attention and an emerging consensus about matters of inmate reentry to the community (Council of State Governments, 2006). Nevertheless, public declarations do not translate into plans that are implemented. At the present time, only a small minority of state prisoners are engaged in a comprehensive and formalized prerelease program. In 1997, for example, only 10% of prisoners discharged received any prerelease planning (Angiello, 2005). The majority of the current discharge programs are voluntary and available primarily in minimum-security prisons (Austin, 2001). To our knowledge, there are no published data of current discharge planning from jails nationwide. In a study of continuity of care for mentally ill inmates in jails, 49% of the 379 inmates in the study, located in seven separate city and county facilities, received a discharge plan before release (Veysey, Steadman, Morrissey, & Johnsen, 1997). The study, however, did not assess the quality of the discharge plans. Thus, comprehensive postrelease planning and continuity of care is still in its infancy.

The questions this article will address are twofold. First, why has postrelease planning emerged as a task for correctional administrators? Second, what influence have the courts and legislatures had in mandating the way correctional institutions implement postrelease planning?

Emerging Consensus

The lexicon of the correctional field now includes postrelease planning, discharge planning, inmate reentry, continuity of care, community-oriented corrections health model, and transitional health care. This indicates how far the field has come from the get-tough-on-crime vocabulary of "lock 'em up and throw away the key" and "three strikes and you're out." One could argue that this philosophical change in corrections has little to do with moral issues of decency or social practicality. Rather, the new interest may be grounded in the budgetary realities that state and county governments no longer have the funds to build their way out of the increased rate of incarceration and increased length of stay during the past few decades. The idea, though perhaps not the implementation, is probably all three; correctional policies and procedures are fluid, depending not only on characteristics of the incarcerated population but also on the present societal norms, which trigger, among other things, the entry of the courts in issues related to discharge planning. Therefore, practical, ethical, and legal issues are each important to understand the recent emergence of interest in postrelease planning.

Practical Issues

The recent emphasis on postrelease planning is based in the reality that the correctional system does not have a rehabilitative effect. The high rate of rearrest and reincarceration is a strong indicator that nearly half of the released inmates are not positively reintegrating into their home communities. On average, 62% of released state prisoners are rearrested within 3 years and 41% are reincarcerated (Beck, 2000). Large urban jails face even higher reincarceration rates. In New York City, for example, 40% of the 80,000 inmates discharged annually are readmitted within 12 months (New York City Department of Corrections [NYC DOC], 2005). In other words, if rearrest and reincarceration rates are the standard measure

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of success, then the current process is failing. A coordinated discharge planning process may help decrease the number of readmissions.

Prisoners have had an increased burden of illness over the last decades (National Academy of Public Administration, 2006). This raises the question as to whether the prisoners' morbidity is as much of a barrier for successful reintegration as the stigma of a felony record.

The medical ailment in *Estelle v. Gamble* (1976) was severe back pain from a job-related injury in prison. Though inmates still suffer physical injuries, a high proportion have a host of health, behavioral, and social problems that precede their incarceration. Eighty percent used drugs before their arrest, 13% have a mental health problem, 19% are illiterate and 40% functionally illiterate, 31% were unemployed before arrest, 2% to 3% have HIV/AIDS, and 18% are infected with hepatitis C (National Commission on Correctional Health Care [NCCHC], 2002; Petersilia, 2003). In New York City, 40% of the jail inmates require mental health services during their incarceration (with 29% diagnosed as seriously mentally ill), 30% report being homeless within 3 months before incarceration, 75% have a history of substance abuse, 20% require detoxification on admission, and 32% are functionally illiterate (City of New York, 2003; NYC DOC, 2005).

Correctional facilities have become the new asylums and addiction centers. As noted in a recent roundtable discussion of correctional health experts, "estimates of mental illness among the prison population range from 15% to 20%, largely due to transinstitutionalization—the movement of the mentally ill from publicly funded mental health hospitals to nursing homes and correctional institutions" (National Academy of Public Administration, 2006, p. 9). Likewise, mandatory drug sentencing laws adopted in the 1980s have filled the prisons and jails with individuals who need drug treatment, vocational training, education, and other services to prevent them from using and selling drugs and returning to prison. In 1980, 6% of state prisoners were incarcerated for a drug offense. By 2002, the percentage had risen to 22% (Bureau of Justice Statistics, 2006). In many jails, the percentage of those incarcerated for drug offenses is even higher, because jails house detainees and those convicted of misdemeanor offenses.

Another practical reason for developing discharge plans is the potential positive effect on the public health and safety of the community. Ninety-three percent of all inmates are eventually released from prison; some would argue that they return to their communities with more severe health problems than when they were incarcerated (Massoglia, 2006; Petersilia, 2005). Others disagree. What is known is that released inmates account for a large percentage of the population with health problems, communicable disease in particular. In the United States, released prisoners are estimated to account for 20.1% to 26.2% of people with HIV infection, 29.4% to 43.2% of those with hepatitis C, and 39.6% of those infected with tuberculosis (Hammett, Harmon, & Rhodes, 2002; NCCHC, 2002). In addition, discharged inmates with undiagnosed and/or untreated communicable diseases (e.g., tuberculosis, hepatitis B and C, sexually transmitted diseases, HIV/AIDS) who are not given the proper medication, education, and outreach will increase transmission rates of these conditions to the general population (New York City Commission on HIV/AIDS, 2005). The leading cause of death for African American females between the ages of 25 and 35 years is AIDS, with 78% contracting the disease from heterosexual activity (Centers for Disease Control and Prevention, 2006).

Finally, data exist that suggest that early intervention and provision of services that directly meet the needs of released inmates can be a method of proactive problem solving that attempts to deal with problems or issues before former inmates violate parole or are arrested for a new offense (Aos, Phipps, Barnoski, & Lieb, 2001). Ultimately, a successful discharge plan requires that an optimal level of services is available and coordinated to ensure a continuum of care and treatment during the reentry process (Queralt & Witte,

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1999). There are data that support the proposition that preparing inmates for return to their community and linking them to community services and supports benefits the health and safety of both the individual and the public (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005).

Several states with comprehensive prerelease programs have preliminary data that indicate reduced recidivism rates for those who complete a discharge program compared with those who elect to be released without any programming (Finn, 1998; Nelson & Trone, 2000). However, recidivism rates are not the sole litmus test for health and public safety. Success can be measured by the number of ex-inmates employed, enrolled in treatment, testing negative for drug use, adhering to their medication, and having stable housing. In New York State, court-ordered case management of individuals with mental illness and a history of hospitalizations and/or violence, known as AOT recipients, has been highly successful in reducing harmful behaviors such as incarceration, arrest, psychiatric hospitalization, and homelessness (New York State Office of Mental Health, 2005).

Ethical Issues

Legal, public health, and practical issues aside, the responsibility for health care practitioners to work on postrelease planning is a moral responsibility (King, 2005). Under the code of ethics of the American Medical Association (AMA; 2004), physicians have a moral obligation to provide continuity of care for their patients.

The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care (AMA, 2004).

There is no reason to accept that physicians who practice behind bars should be exempt from this provision of the AMA code of ethics. Physicians who practice in prisons and jails have fundamental responsibilities to the physician–patient relationship. Among other things, according to the code of ethics, physicians have a moral duty to attempt to provide continuity and coordination of care for their patients when their care is being transferred to others. A release from a prison or jail is, in effect, a transfer of a medical home from the institution to the community. Therefore, the physician has a duty to help the patient with continuity of care on discharge. This duty includes, at a minimum, a needs assessment, a summary of essential medical information (with diagnoses, treatments, medications, and pending follow-up), an appointment for follow-up care in the community or a referral to a community resource, and a prescription and/or bridge supply of medication for the period between release and the next appointment in the community.

For New York City, the courts have affirmed this responsibility in the case of *Brad H. et al. v. The City of New York et al.* (1999, 2000, 2004). In this case, the parties agreed that discharge planning is an essential component of mental health care rendered in accordance with widely accepted standards of psychiatric practice (*Brad H.*, 2003). The court ordered the defendants to comply with that agreement. *Brad H.* is an inmate who was diagnosed with chronic paranoid schizophrenia and alcohol dependence. He had been admitted to the NYC DOC 26 times. He received treatment for his mental illness, but had never been provided discharge planning before release. He did not receive medication, public health benefits, or housing.

Some jurisdictions have implemented a continuum of care for inmates without the nudge of litigation. One model program is the Hampden County Correctional Center in Ludlow, Massachusetts. This facility has understood the public health dimension of releasing inmates with health and behavioral needs back into the community. In conjunction with the public health department, regional medical centers, and community health centers, the

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inmates are part of a seamless health care delivery system, wherein the community health centers provide the inmates with health services inside the facility, develop individualized discharge plans before release, and then continue providing for their health care needs in the community after release.

Legal Issues

Though model programs, such as Hampden County, have been implemented on a limited basis throughout the country, some people argue that litigation or the potential for litigation is the driving force for the implementation of discharge planning and continuity of care. This group argues that practical and ethical issues alone will not be enough incentive for correctional agencies to increase discharge planning. *Estelle v. Gamble* (1976) codified American society's evolving view of decency. Discharge planning and transitional health care is part of that evolving view of decency. Because implementation has been slow, correctional health care litigation has expanded to include not just the most immediate evidence of harm but also issues that have a longer incubation period, such as discharge planning. *Estelle* established the basis for courts to recognize this standard of decency.

Since *Estelle*, the courts have ruled that it is cruel and unusual punishment and, therefore, unconstitutional for inmates to unnecessarily suffer from serious medical needs if it "causes pain, discomfort, or threat to good health" (*Dean v. Coughlin*, 1985, p. 15). In *Lugo v. Senkowski* (2000), the plaintiff filed a 1983 claim alleging violations of his Eighth Amendment rights because he was released from prison shortly after a metal stent was inserted in him during kidney stone surgery. He was discharged with no information on when and where to have the stent removed. The U.S. District Court for the Northern District of New York agreed that the severe pain Lugo experienced because he did not know how to get his stent removed was a violation of his Eighth Amendment rights because he was released before completion of his surgical procedure: "The state had a duty to provide medical services for an outgoing prisoner who is receiving continuing treatment at the time of his release for the period of time reasonably necessary for him to obtain treatment 'on his own behalf'" (p. 4).

Court decisions such as *Lugo* are evidence of the evolving standard of decency established by *Estelle*. As a result of *Lugo*, correctional facilities must attend to completing treatments begun behind bars. Now, correctional facilities must not only provide medical attention inside of prison but also provide for completion of the procedures for a serious medical need. In essence, the standard of care regarding discharge planning more clearly articulates the *Estelle* decision.

Based on the evolving social standards of decency established by *Estelle*, the courts are now involved in the standards for postrelease planning. The needs of inmates with serious mental illness can be more elusive than physical needs. Recent litigation has focused on postrelease planning needs of the mentally ill, more so than other disability groups, although claims are being made under the Americans with Disability Act for reasonable accommodation for both physical disabilities and serious mental illness. Nevertheless, the standards of decency for the seriously mentally ill is also evolving, beginning with court orders to provide continuation of psychotropic medicine after release.

In *Wakefield v. Thompson* (1999), a correctional officer refused to give Wakefield a 2-week prescription of a psychotropic medication on his release from prison, even though it was ordered by the medical staff to continue treatment to control his delusions. Without medication, 11 days after his release he had an episode of violence as a result of his illness. He was rearrested. The court determined that Wakefield's constitutional rights were violated

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because "a prisoner's ability to secure medication on 'his own behalf' is not necessarily restored the instant he walks through the prison gates and into the civilian world" (p. 5). The state has a duty to provide a parolee with medication for his immediate postrelease period.

A new question is whether society's standard of decency requires correctional facilities to help find a doctor, make an appointment, complete the appointment, get a prescription, get it filled, find housing, and secure a job for all inmates with acute or chronic illnesses who return home. Even if these broad responsibilities cannot be supported under *Estelle v. Gamble*, is there other legislative action that could mandate this comprehensive planning for inmates on release?

In 2003, New York City settled a class action lawsuit about the appropriate steps for discharging mentally ill inmates from NYC DOC, the second largest jail system in the country. The class action complaint, *Brad H. et al. v. The City of New York et al.,* was filed in 1999 and claimed that the city neglected to provide comprehensive discharge planning and transitional health care for mentally ill inmates. It cited the normal procedure where inmates, regardless of their behavioral or health needs, were discharged between 2 a.m. and 6 a.m., transported to a subway station, given $1.50 in cash, and two fares for a roundtrip ride on the subway (*Brad H.*, 2000, p. 18). According to the lawsuit, inmates did not receive any written discharge plans, medications, prescriptions for medication, or referrals or linkages to mental health services or housing (*Brad H.*, 2000, p. 19).

Though the *Brad H.* lawsuit did not reference *Estelle v. Gamble*, it did argue that New York City was in violation of several laws: the New York State Mental Hygiene Law 29.15 that mandates

> Providers of inpatient health services to provide discharge planning . . . , a New York State regulation that requires providers of outpatient mental health services to provide discharge planning, . . . and a provision of the New York State Constitution prohibiting cruel and unusual punishment (Barr, 2003, p. 101).

The Mental Hygiene Law 29.15 specifically states the legal requirement for discharge planning, including a written service plan prepared by staff familiar with the person's case history. At a minimum, the discharge plan must include the following:

1. A statement of the patient's need, if any, for supervision, medication, aftercare services, and assistance in finding employment following discharge or conditional release
2. A specific recommendation of the type of residence in which the patient is to live and a listing of the services available to the patient in such residence
3. A listing of organizations; facilities, including those of the department; and individuals who are available to provide services in accordance with the identified needs of the patient
4. The notification of the appropriate school district and the committee on special education regarding the proposed discharge or release of a patient under 21 years of age, consistent with all applicable federal and state laws relating to confidentiality of such information
5. An evaluation of the patient's need and potential eligibility for public benefits following discharge or conditional release, including public assistance, Medicaid, and supplemental security income.
   (New York State Consolidated Laws: Mental Hygiene)

According to Barr (2003), the *Brad H.* case is unique not because it mandates discharge planning for the incarcerated mentally ill but because inmates are "entitled to discharge planning because they are the patients of a mental treatment provider [the New York State

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Office of Mental Health under NYC DOC], and patients have a right to discharge planning" (p. 118). At least 11 states "require discharge planning in mental health treatment settings," so litigation in other parts of the nation is expected to follow (Barr, 2003, p. 118).

New York City settled the case in lieu of continuing the litigation. Under the settlement, the city agreed to provide comprehensive discharge planning support and access to treatment for the incarcerated seriously mentally ill, including the following:

1. Releasing inmates during the day, when service agencies are open
2. Making medication and transportation to community residences or shelters available on discharge
3. Helping eligible inmates to obtain Medicaid, Social Security, disability, and public assistance benefits before release
4. Enabling family and community members with clinical information about an inmate to relay such information to discharge planning or jail mental health staff
5. Establishing a monitoring system overseen by the court that will set performance goals for city agencies and assess their compliance for at least 5 years.
   (Council of the City of New York, 2003, p. 8)

HIV/AIDS is another disability that the courts have considered in cases concerning the adequacy of discharge planning. In *Foster et al. v. Fulton County, Georgia, et al.* (1999), the county settled a case in lieu of continuing litigation. The court-ordered settlement requires the sheriff to provide discharge planning for each HIV-infected patient incarcerated at the jail. The agreement states the following:

> Prior to discharge from the Jail to the community, all HIV-positive inmates shall have an appropriate discharge plan. A post-discharge appointment with an appropriate HIV medical care provider in the community shall be scheduled for every HIV-positive inmate, and each inmate shall be informed upon discharge of the date, time, and location of that appointment. If the inmate is on any prescribed medications, defendants shall provide sufficient medications to prevent gaps in the availability of those medications. (*Foster v. Fulton County*, 1999, p. 9)

The consent decree requires a 4- to 7-day supply of medication and a medical summary on transfer. It further requires that community-based HIV service organizations be allowed to work with and educate HIV-infected patients during their stay behind bars.

The standards of decency continue to evolve and be defined by statute. In 2005, the City of New York enacted a comprehensive discharge planning law (New York City Administrative Code, 2004, pp. 1, 2). The uniqueness of this law is that it transcends the idea that only special needs inmates should have the legal right to discharge planning. Rather, NYC DOC inmates who serve a sentence of 30 days or more are entitled to heightened level of postrelease services, regardless of their health and behavioral needs. Under this law, the NYC DOC is mandated to do the following:

1. Develop a process to identify individuals who repeatedly are admitted to city correctional institutions and who, in addition, either immediately before admission or after release, are housed in shelter provided by the department of homeless services.
2. Collect, from any sentenced inmate who will serve, after sentencing, 10 days or more in any city correctional institution, information relating to the inmate's housing, employment, and sobriety needs. With the inmate's consent, the DOC will give information to any social service organization that is providing discharge planning services to the inmate under contract with the DOC.

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3. The DOC will make applications for government benefits available in areas accessible to inmates in city correctional institutions.
4. The DOC will provide assistance with the preparation of applications for government benefits and identification to sentenced inmates who will serve, after sentencing, 30 days or more in any city correctional institution and who receive discharge planning services from the DOC or any social services organization under contract with the DOC and, in its discretion, to any other inmate who may benefit from such assistance.
5. The commissioner of correction will submit an annual report to the mayor and the council regarding implementation of its discharge planning efforts and, beginning in 2008, regarding recidivism among inmates receiving discharge planning services from the DOC or its contracted social service agencies.

Conclusion

Clairvoyance aside, predicting that postrelease planning and transitional health care will change as much, if not more, in the next 30 years as it has since *Estelle v. Gamble* is not difficult if one projects forward from recent changes in the environment. The correctional environment has changed during these three decades. There are more mentally ill people behind bars as a consequence of transinstitutionalization. There is vastly more communicable disease, notably HIV, which was unknown in 1976, and viral hepatitis C, which was unrecognized at that time. There is also the realization that the health status of inmates has an effect on the public health. Finally, there is increasing acknowledgment of physicians' moral responsibility to provide continuity of care for their sickest patients.

We expect that the public will be more vocal in demanding that public health and safety be paramount when releasing inmates. Medical professionals are required in several states to submit identifying information to the local health department of all patients who test positive for HIV/AIDS. In New York, for example, the state has the right to notify the patient's partners of his or her HIV/AIDS status. Browne-Marshall (2005) argues that these laws should also apply to correctional health professionals. She advocates for mandatory HIV/AIDS testing of prisoners at intake and discharge, and mandatory reporting of test results to their sexual partners to help stem the transmission of infectious diseases like HIV/AIDS (p. 57). Although mandatory testing remains highly controversial, routine (but not mandatory) testing is increasingly recommended for personal health and public health benefits.

Finally, in addition to the courts, the government, from the federal to the local level, will take a more assertive approach in determining the standards for discharge planning and transitional health care. Recent settlement agreements with the U.S. Department of Justice have specific requirements for medication on discharge. For example, a 7-day supply of medication on discharge is required in Santa Fe County, New Mexico (2004). In Nassau County, New York (2004), the agreement requires a 7-day supply for patients on medication for HIV and a 5-day supply for patients on psychotropic medication.

The two largest barriers for correctional agencies are the development of financial resources and the ability to adopt technology to assist in providing a continuum of health care for inmates regardless of which agency (e.g., department of corrections, homeless services, department of health, community health care provider) is caring for their needs. At the very least, more correctional facilities will share a common electronic database platform with health and human service agencies in the community of return. For example, federally funded community health centers and others will have real-time data of the medical tests and procedures their client received while incarcerated. One could also imagine that the inmates will be provided with a health "smart card" so that they are empowered with their

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own medical information. Information on the card could include insurance information, medical contact information, diagnoses, medications prescribed, and planned appointments.

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