ALL HOPE IS NOT LOST: How the "Alabama-Utah Model" Can Revolutionize Prison Healthcare Service Provision

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Introduction

While imprisonment has been used to punish individuals found guilty of crimes in the United States since just before the American Revolution,[1] the last few decades have seen an unprecedented expansion of jails and prisons.[2] Today, there are over two million people incarcerated in prisons, jails, juvenile correctional facilities, and immigration detention facilities across the United States.[3] Despite housing all these individuals, these facilities are ill-prepared to deal with their inhabitants' general and mental healthcare needs; they miss many prisoners at intake and neglect to refer them for evaluation and treatment. Even those who are entered into the system often receive glaringly inadequate care.[4] In the worst cases, incarcerated individuals threatening self-harm are left to their own devices, resulting in the loss of human life. Policymakers are typically reticent to spend political and financial capital to improve prison conditions for the incarcerated—and this extends to providing quality healthcare.

With limited voice in the policymaking process and no support from elected officials, prisoners seeking recourse have limited remedies; the most common of these is to sue. Given how widespread poor provision of healthcare is, there is constant litigation across the country.[5] When judges conclude that prisoners' rights are being infringed, they tend to impose "command and control measures," such as strict rules and performance metrics, to turn the facilities around and get them to provide adequate healthcare. However, poor conditions like insufficient mental health counseling and placing mentally unstable individuals in solitary remain. Thus, even if litigants win their cases, they are often given little recourse by judges' impositions of strict deadlines and performance requirements; in such cases promises are often delayed if not outright illusory.[6]

This Article argues judicially-imposed rigid rules governing the conduct of those responsible for providing adequate healthcare to the incarcerated will not reform prison healthcare. This is largely because the "need to customize and adapt makes rules an ineffective means of controlling discretion."[7] Instead, judges and policymakers should supplant limited rules with principles of ongoing monitoring and correction of these facilities if they hope to improve these facilities' provision of

1. *See* Harry Elmer Barnes, *Historical Origin of the Prison System in America*, 12 J. of Crim. L. and Criminology 35, 36–40 (1921).
2. Kara Gotsch & Vinay Basti, *Capitalizing on Mass Incarceration: U.S. Growth in Private Prisons*, The Sentencing Project (Aug. 2, 2018), https://www.sentencingproject.org/publications/capitalizing-on-mass-incarceration-u-s-growth-in-private-prisons [https://perma.cc/7DQ8-HGF9].
3. *Growth in Mass Incarceration*, The Sentencing Project, https://www.sentencingproject.org/criminal-justice-facts [https://perma.cc/N4HT-4U8K].
4. *See infra* Parts II-III.
5. *See infra* notes 16–22 and accompanying text.
6. *See infra* Part III.
7. Kathleen G. Noonan, Charles F. Sabel, & William H. Simon, *Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform*, 34 L. & Soc. Inquiry 523, 524 (2009).

healthcare. Part I quickly describes the United States' criminal legal system and the dire conditions inside American prisons, jails, and detention centers. Part II surveys class-action litigation challenging inhumane healthcare provisions in four jurisdictions, each one using a different healthcare delivery model.[8] Part III examines how institutional systems and structures at these facilities may be improved by incorporating systems of ongoing monitoring and correction, in line with the principles used in the Alabama-Utah model of child welfare service provision. Finally, Part IV offers a brief conclusion and notes possible implications for correctional facilities across the country.

I. Overincarceration and Poor Conditions

The United States houses nearly 25 percent of the world's prisoners, despite comprising only about 4 percent of the world's population.[9] Despite taxpayers paying $260 billion every year to house millions of prisoners,[10] today there is general skepticism pertaining to the value of prisons as societal tools.[11] In fact, many studies suggest that there is overincarceration; in other words, while some cost is essential for public safety, a large portion is wasteful and leads to higher poverty and crime rates, as well as housing and health insecurity.[12]

8. Pew Charitable Trusts, *Jails: Inadvertent Healthcare Providers* (Jan. 24, 2018), https://www.pewtrusts.org/en/research-and-analysis/reports/2018/01/jails-inadvertent-health-care-providers [https://perma.cc/8UH6-TM2N] ("A survey of large jails, defined as those holding 1,000 or more people, found that 91 percent has been sued by an individual about medical care, and 14 percent had been the defendant in a class action lawsuit in the three years before the study.")
9. Michelle Ye Hee Lee, *Does the United States Really Have 5 Percent of the World's Population and One Quarter of its Prisoners?*, Wash. Post (Apr. 30, 2015), https://www.washingtonpost.com/news/fact-checker/wp/2015/04/30/does-the-united-states-really-have-five-percent-of-worlds-population-and-one-quarter-of-the-worlds-prisoners/ [https://perma.cc/J99Z-HS4H]. Worse yet, our prison population rate—664 incarcerated people per 100,000—is the highest in the world. Emily Widra & Tiana Herring, *States of Incarceration: The Global Context 2021*, Prison Pol'y Initiative (Sept. 2021), https://www.prisonpolicy.org/global/2021.html [https://perma.cc/J64L-MQUR].
10. Ronnie K. Stephens, *Annual Prison Costs A Huge Part of State and Federal Budgets*, Interrogating Just. (Feb. 16, 2021), https://interrogatingjustice.org/prisons/annual-prison-costs-budgets [https://perma.cc/8G2Q-KY6B]; Press Release, Communities United for Police Reform, The Path Forward: How to Defund the NYPD by at Least $1 Billion, Invest in Communities & Make NYC Safer (June 16, 2020), www.changethenypd.org/releases/path-forward-how-defund-nypd-least-1-billion-invest-communities-make-nyc-safer [https://perma.cc/P7HA-RVMN] (arguing the American criminal penal system fails to redress the societal harms it aims to address).
11. *See* Nat'l Rsch. Council, The Growth of Incarceration in the United States: Exploring Causes and Consequences, ch. 1 (Nat'l Academies Press 2014).
12. Alana Semuels, *What Incarceration Costs American Families*, The Atlantic (Sept. 15, 2015), www.theatlantic.com/business/archive/2015/09/the-true-costs-of-mass-incarceration/405412 [https://perma.cc/2BYN-GB7U]. *See also* Nat'l Rsch. Council, *supra* note 11, at 9 ("[T]hese high rates of incarceration themselves

A quick look into American correctional facilities explains this phenomenon. These facilities are overcrowded, unsafe, and plagued with recurring reports of violence, including sexual assault, between prisoners.[13] Beyond prisoner interactions, guards play a large role in the poor conditions.[14] In many facilities, there is rampant corruption, usually in the form of bribes or sexual favors in exchange for weapons, drugs, or cell phones. Such phenomena fuel the violence and despair that plagues these facilities.[15]

Taken together, the violence prisoners are exposed to threatens both their physical and mental wellbeing.[16] Worse yet, a large portion of incarcerated individuals end up in jails and prisons due, in part, to their struggle with mental illness[17] or substance abuse.[18] In other words, instead of addressing the mental health needs of the individuals in its care, the American criminal legal system exacerbates existing issues and creates new ones.[19] This is even more troubling in the context of a worldwide behavioral health crisis,[20] to which the United States is no exception.[21] Of pressing concern is COVID-19's exacerbation of all these phenomena; the pandemic has created a growing gap between behavioral health

constitute a source of injustice and, possibly, social harm.").

13. Morrison et al., *What Trauma Looks Like for Incarcerated Men: A Study of Men's Lifetime Trauma Exposure in Two State Prisons*, 8 J. Trauma Stress Disorder Treatment 1, 2 (2019), https://pubmed.ncbi.nlm.nih.gov/32704504 [https://perma.cc/W2VV-BYNP].
14. *Id.*
15. United Nations Office on Drugs and Crime, Handbook on Anti-Corruption Measures in Prisons 22 (2017).
16. Morrison et al., *supra* note 13, at 11.
17. *Id.*
18. *Id.* at 3.
19. Bernadette Rabuy, *Analysis Shows People in NYC Jails Would be Better Served in the Community*, Prison Pol'y Initiative (Nov. 16, 2016), https://www.prisonpolicy.org/blog/2016/11/16/frequently_incarcerated_nyc [https://perma.cc/CF3L-DKHB].
20. Philip S. Wang et al., *Use of Mental Health Services for Anxiety, Mood, and Substance Disorders in 17 Countries in the WHO World Mental Health Surveys*, Lancet (2007), https://www.thelancet.com/journals/lancet/article/PIIS0140–6736(07)61414–7/fulltext [https://perma.cc/8R9S-7LMR] [hereinafter Wang] (There are "disturbingly high levels of unmet need for mental health treatment worldwide, even among cases with the most serious disorders.").
21. *Mental Health by the Numbers*, Nat'l All. on Mental Illness (2021), https://www.nami.org/mhstats [https://perma.cc/L57J-VWEH] [hereinafter NAMI] ("1 in 20 U.S. adults experience serious mental illness each year" and "1 in 6 U.S. youth aged 6–17 experience a mental health disorder each year").

service provision and need.[22] This gap is even starker among high-needs populations such as prisoners.[23]

II. Litigation, Settlements, and Implemented Changes

While overincarceration, generalized violence, and poor service provision[24] are widespread in the United States, this Article's analysis is driven by recent claims of inadequate service provision against prison systems ending in settlement agreements. In part, these settlements are driven by the fact that in response to consent decrees, prison management agencies have implemented changes to remedy the slew of abuses.[25] These changes provide fodder for analysis of the effectiveness of judicially mandated rules and performance standards, on the one hand, and implementation of structures and monitoring systems that engender continuous improvement toward general principles, on the other.

Regardless of which service provision model a county or state uses,[26] there are clear examples of a continued failure to provide adequate living standards and health services, especially for mental health.[27] This Part is broken into four Subparts; the first three Subparts (II.A-II.C) review the eerily similar conditions that arise in New York (direct model), Alabama (contracted model), and Louisiana (hybrid model), despite their different service delivery models. Then, Part D. looks at Texas (public university model) and notes a higher degree of success in service provision. After outlining the background of the conditions, each of these Subparts examines the litigation, settlements, and changes implemented in their aftermath and how they impacted the incarcerated's physical and

22. Vahratian et al., *Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic*, 70 Morbidity and Mortality Weekly Rep. 490, 493(Apr. 2, 2021) ("From August 2020-February 2021, the percentage of adults with recent symptoms of an anxiety or a depressive disorder increased from 36.4% to 41.5%, and the percentage of those reporting an unmet mental health care need increased from 9.2% to 11.7%.").
23. *See* James Lake & Mason Turner, *Urgent Need for Improved Mental Health Care and a More Collaborative Model of Care*, Permanente J. (Aug. 11, 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5593510 [https://perma.cc/G5MG-GPFJ].
24. Service provision refers to the ability of a system to provide services to those in need. For the purposes of this article, the service provision at stake is whether carceral facilities are able—and in fact do—provide adequate healthcare services to the individuals incarcerated in their facilities.
25. *See infra* Part III.
26. For a comprehensive analysis of the different models, their tradeoffs, and which model states implement, *see State Prisons and the Delivery of Hospital Care*, Pew Charitable Trs. (July 19, 2018), https://www.pewtrusts.org/en/research-and-analysis/reports/2018/07/19/state-prisons-and-the-delivery-of-hospital-care [https://perma.cc/27VD-FZ4T]. *See also* Micaela Gelman, *Mismanaged Care: Exploring the Costs and Benefits of Private vs. Public Healthcare in Correctional Facilities*, 95 N.Y.U. L.R. 1386 (2020) (comparing the relative merits of private- and public-run healthcare).
27. *See infra* Part A-C.

mental wellbeing regardless of whether the initial decree focused specifically on healthcare, a subset of healthcare, or general conditions. This analysis sets up Part III, where the Article considers a crucial difference in the Texas public university model that has led to sustained, albeit limited, improvements in prisoner healthcare.

A. *Direct Model: New York City Department of Corrections*

1. Initial Conditions, Litigation, and the Consent Judgment

The New York City Department of Corrections (NYC DOC) manages ten facilities, eight of which are located on Rikers Island.[28] Additionally, the NYC DOC operates two hospital prison wards, employing the direct model of service provision.[29] Over 10,000 uniformed and civilian employees manage an average daily population of nearly 5,000 incarcerated individuals.[30]

In 2012, a class of plaintiffs sued the NYC DOC for unnecessary and excessive force at the hands of correctional officers while incarcerated on Rikers Island.[31] The named defendants included not just officers and captains that allegedly engaged in the beatings, but also jail and NYC DOC supervisors.[32] The violence outlined resulted in, but was not limited to, "broken bones, perforated eardrums, and spinal injuries."[33] Obviously such practices worsen inmates' physical health. Moreover, the suit alleged insufficient investigation of and discipline for staff members' roles in the use of force.

In the preceding twenty-five years, there were "five class actions and scores of individual lawsuits" against Rikers, and particularized relief was obtained:

> That relief has included staff training as to when and how to apply physical force against inmates using methods that minimize injury; video monitoring in the jails; unbiased and thorough investigations into serious uses of force by staff; administrative discipline for staff members who violate the Department's use of force policy; staffing practices to ensure that routine violators are assigned to commands with little or no inmate contact; and personnel policies under which the very worst violators are terminated while conscientious officers are promoted to positions of responsibility.[34]

28. *Facilities Overview*, N.Y.C. Corrections Dep't, https://www1.nyc.gov/site/doc/about/facilities.page [https://perma.cc/9NW7-CD7N].
29. *Id.*
30. *See* Gwynne Hogan, *1,000 NY State Inmates to Be Vaccinated, As Cuomo Reverses Course on Ban*, Gothamist (Feb. 5, 2021), https://gothamist.com/news/1000-ny-state-inmates-be-vaccinated-cuomo-reverses-course-ban [https://perma.cc/4JR7–3EUX].
31. *See* Amended Complaint, Nunez v. City of New York, No. 11 Civ. 5845(LTS)(JCF), 2013 WL 2149869 (S.D.N.Y. May 24, 2012).
32. *Id.* at 24–39.
33. *Id.* at 2.
34. Nunez v. City of New York, No. 11 Civ. 5845(LTS)(JCF), 2013 WL 2149869 at 2–3 (S.D.N.Y. May 24, 2012).

Despite these remedies, the abuse continued, and increasingly targeted young male inmates between ages of 16 and 18, leading incarcerated people to form another class in 2012 in order to ask the court to use a "strong hand to finally put an end to Defendants' abuse."[35] The United States, after conducting an investigation, joined as co-plaintiffs in the 2012 suit, resulting in a 2015 settlement that many expected would finally lead to transformational change.[36] The 2015 Consent Judgment, detailing the settlement terms, was expansive, including 318 separate provisions.[37] The 2015 Consent Decree's requirements were rule-specific and filled with directives, record keeping requirements, and written procedures.[38] It went beyond reducing inmate violence and targeting unnecessary or excessive force by staff and included a host of other requirements, including staff management, reporting, and monitoring requirements.[39]

These reform efforts were buttressed by the appointment of a new DOC Commissioner, Joseph Ponte, a comprehensive survey of DOC and prison staff, and a thorough assessment of the Department's needs.[40] With this background, Commissioner Ponte implemented his 14-Point Anti-Violence Reform Agenda, which emphasized supporting staff by, among other things, improving leadership development and culture; designing a performance management plan; and implementing operational performance metrics.[41] Subsequently, the first few independent monitor reports graded many of the DOC's efforts in substantial compliance.[42]

2. Consent Judgment Aftermath

However, only seven years after the settlement, the most recent reports painted a disturbing picture.[43] They declared that the DOC is

35. *Id.* at 3.
36. Press Release, U.S. Dep't of Just., Dep't of Just. Takes Legal Action to Address Pattern and Practice of Excessive Force and Violence at Rikers Island Jails That Violates the Const. Rts. of Young Male Inmates (Dec. 18, 2014), https://www.justice.gov/usao-sdny/pr/department-justice-takes-legal-action-address-pattern-and-practice-excessive-force-and [https://perma.cc/48S4–2J8J].
37. Ross Sandler & David Schoenbrod, *Prison Reform: The Monitor's First Report in Nunez Case*, Cityland (Sept. 14, 2016), https://www.citylandnyc.org/prison-reform-rikers-island [https://perma.cc/7XR3-JP5C].
38. *Id.*
39. This entire list of requirements includes: modifications to staff discipline and accountability, video surveillance, risk management, staff recruitment and selection, staff screening and assignment, staff training, inmate discipline, reporting and monitoring requirements. *Id.*
40. Heidi Grossman, Deputy Comm'r of Legal Matters at the N.Y.C. Dep't of Corr., Statement before the New York City Council (Nov. 14, 2016).
41. *Id.*
42. Sandler & Schoenbrod, *supra* note 37. The remainder were in partial compliance.
43. *See* Steve Martin et al., Twelfth Report of the Nunez Independent Monitor (2021), https://www.nyc.gov/assets/doc/downloads/pdf/12th-Monitors-Report-12–06–21_As-Filed.pdf [https://perma.cc/V32F-HE6Y] [hereinafter Twelfth Report].

trapped in a "state of disrepair."[44] Further, in 2021 an independent external monitor reported that "[t]he Department's decades of poor practices has (sic) produced a maladaptive culture in which deficiencies are normalized and embedded in every facet of the Department's work."[45] This has been greatly exacerbated by the pandemic and the resultant court delays and services and trainings being suspended.[46] The result has been described as chaos.[47] Suicides, violent incidents between inmates, and escape attempts have increased as some officers do not show up to work and others are forced to work double or even triple shifts.[48] In fact, 2021 was the most dangerous year since the Consent Judgment went into effect, as evidenced by data on fights, stabbings, and slashings.[49] Similarly, in 2021 the data indicates correctional officers used force at a historic rate.[50]

As expected, the DOC's chaotic state has translated to poor mental health protocols and service provision, as Staff have failed to respond with the requisite urgency, if at all, to self-harm gestures made by incarcerated people.[51] Additionally, individuals with mental health needs are subjected to unnecessary and excessive use of force at a higher rate than other inmates.[52] While "Department leadership, Health Affairs, and representatives from [health services] convene weekly to discuss particular individuals who have mental health concerns,"[53] "most of the follow-up notes are focused on describing the individual's problematic behavior but lack specific, targeted solutions to address those behaviors."[54]

Put simply, the NYC DOC has failed to meaningfully reform itself, despite a monitor, different commissioners, and a carefully drafted 318-provision rule-specific decree with detailed record keeping and written procedure requirements. As named above, this failure has led to unsatisfactory provision of healthcare services and the loss of human life. In that context, and until facility officials have made demonstrable changes, any supposed reform effort ought to be viewed with grave skepticism.

B. *Contract Model: Alabama Department of Corrections*

The Alabama Department of Corrections (Alabama DOC) houses nearly 20,000 prisoners across its fifteen major facilities.[55] Of these,

44. *Id.* at 9.
45. *Id.*
46. *Id.* at 2.
47. *Id.* at 17, 25, 127.
48. Steve Martin et al., *supra* note 43, at 31, 33, 119–20.
49. *Id.* at 20.
50. *Id.* at 20–22.
51. *Id.* at 18, 31, 33–35.
52. *Id.* at 45–46.
53. *Id.* at 56.
54. *Id.*
55. Liability Opinion and Order as to Phase 2A Eighth Amendment Claim, Braggs v. Dunn, 257 F. Supp. 3d 1171, 1181–82 (M.D. Ala. 2017) [hereinafter Liability Opinion and Order, Braggs v. Dunn].

between fourteen and fifteen percent receive mental health treatment, either through inpatient or outpatient care, depending on their level of need, however this low number reflects underidentification of prisoners with mental illness.[56] This service provision is overseen by the Office of Health Services within the Alabama DOC, but the medical and mental-health care services are provided by a third-party, private contractor: MHM Correctional Services, Inc.[57] Additionally, there are "psychological associates" who conduct tests and provide group sessions for "non-mentally ill prisoners."[58] The psychological associates report to the wardens at their respective facilities, not the Office of Health Services or any private contractor.[59] MHM Correctional Services' infrastructure includes a continuous quality-improvement manager who conducts informal audits of MHM's overall performance and of site administrators at each facility, in order to ensure administrative oversight.[60] Along with these management roles, there are forty-five full-time mental health professionals, four psychiatrists, three psychologists, eight certified registered nurse practitioners, three registered nurses, and approximately forty licensed practical nurses.[61]

Despite this structure and its management, the Alabama DOC mental health care system is riddled with inadequacies throughout. At the intake stage, thousands "of prisoners with mental illness are missed at intake and referrals for evaluation and treatment are neglected.[62] As a result, many [Alabama DOC] prisoners who need mental-health care go untreated."[63] Even those who are flagged as having mental illness "receive significantly inadequate care," due to staffing shortages and irregular treatment schedules.[64]

Receiving inadequate services is particularly common for individuals undergoing mental-health crises. "Mental-health staff fail to use appropriate risk-assessment tools to determine suicide risk."[65] There are insufficient crisis cells, and many individuals threatening self-harm are left to their own devices, and the "suicide-watch cells that do exist are dangerous" due to poor visibility and items in the cells that can be used for self-harm.[66] Worse yet, many individuals who experience mental health crises, in part due to inadequate mental-health care and facilities,

56. *Id.* at 1201.
57. *Id.* at 1183.
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.* at 1183–84.
62. Liability Opinion and Order, Braggs v. Dunn, 257 F. Supp. 3d 1171, 1185 (M.D. Ala. 2017).
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*

are put in isolation cells, where it is even harder to monitor their behaviors and mental health status.[67]

Despite "the contractor's deficient performance and inadequate quality-control process," the Alabama DOC neither fixed the problems they had control over nor found a way to monitor the third-party contractor.[68] In 2017, the Southern Poverty Law Center and the Alabama Disabilities Advocacy Program filed suit in the U.S. District Court for the Middle District of Alabama to address the deficiencies in service provision.[69] After a two-month trial, Judge Myron Thompson held that the Alabama DOC violated the Eighth Amendment rights of the plaintiff class because the Department's "mental-health care is horrendously inadequate."[70]

Shortly thereafter, Judge Thompson ordered the state to reform the system, issuing a series of remedial orders and injunctions, focusing on multiple indicators that had to be met to increase correctional and mental health staff.[71] In turn, the Alabama DOC instituted changes to remedy the situation.[72]

However, nearly four and a half years later, on December 27, 2021, Judge Thompson had to issue another order, requiring the Alabama DOC to remedy the unconstitutional mental health service provision.[73] This time, this order is buttressed by an external monitor and yearly benchmark targets, much like the NYC DOC decree.[74] However, once again, it seems unlikely that this rule and performance standard-driven order will lead to sustainable change.

C. *Hybrid Model: Louisiana Department of Corrections ("Angola")*

In 2017, prisoners at the Louisiana State Penitentiary at Angola brought a class-action lawsuit against the Louisiana Department of Corrections, seeking "to overturn a prison policy that automatically and permanently places prisoners sentenced to death in Louisiana in solitary confinement."[75] This restricted them to windowless concrete cells for 23

67. *Id.*
68. *Id.* at 1185–86.
69. *Id.* at 1179.
70. *Id.* at 1267.
71. *Id.* at 1267–1268.
72. Braggs v. Dunn, 562 F. Supp. 3d 1178, 1205–06 (M.D. Ala. 2021).
73. *Alabama Prisons Lawsuit: SPLC Urges Prompt Mental Health Remedies After Judge's Order*, S. Poverty L. Ctr. (Dec. 29, 2021), https://www.splcenter.org/news/2021/12/29/alabama-prisons-lawsuit-splc-urges-prompt-mental-health-remedies-after-judges-order [https://perma.cc/XP7G-YN9S].
74. *Southern Poverty Law Center Calls for Prompt and Effective Implementation of Mental Health Remedies Following Alabama Prison System Judicial Ruling*, S. Poverty L. Ctr. (Dec. 29, 2021), https://www.splcenter.org/presscenter/southern-poverty-law-center-calls-prompt-and-effective-implementation-mental-health [https://perma.cc/Q5JX-HMWL]; *see also supra* Part A.
75. Liam Stack, *3 Men on Death Row in Louisiana Sue Over Solitary Confinement*, N.Y. Times (Mar. 30, 2017), https://www.nytimes.com/2017/03/30/us/3-men-on-death-row-in-louisiana-sue-over-solitary-confinement.html [https://perma.cc/BZ8C-YZFK].

hours a day. During the other hour, they were permitted to walk beside their cells, use the phone, take a shower, or "sit in a small outdoor cage." This prolonged isolation puts prisoners at risk of substantial physical, mental, and emotional harm, exacerbating pre-existing mental health illnesses. "The damaging effects of prolonged solitary confinement on the mental and physical health of prisoners has been well established . . . even those with no history of mental illness were engaged in a constant, ongoing struggle to maintain their sanity."[76] Worse yet, these individuals are provided inadequate mental-health care, limited to a social worker visiting the tier periodically and moving from cell to cell. This means that prisoners are unable to have private sessions, a crucial part of mental health service provision.[77]

The settlement order by Judge Dick in 2019 mandated a number of changes, including guaranteeing at least four hours of congregate time daily, five hours of congregate outdoor recreation, at least one congregate meal per day, congregate religious worship, group classes, and contact visits.[78]

While all these changes represent moderate improvements in the lives of Angola death row inmates, which must not be discounted, such improvements remain limited. And just like the decrees issued in the New York City DOC and Alabama DOC cases above, the changes are judicially imposed "command-and-control"-type orders focusing on deadlines, quantitative measures, and specific procedural and documentation requirements.[79] Ultimately, they attempt to force action through rigid rules. At best, these rigid rules are effective when remedies require limited, discrete targets (like increasing outdoor and communal time for dozens of inmates in one correctional facility).

However, as the preceding background and Part II demonstrate, this rigid framework is inadequate to remediate structural issues like pervasive violence and inadequate healthcare provision. Instead, the following Subpart examines the public university model utilized by the Texas Department of Criminal Justice to showcase a system that has managed to make improvements by using monitoring and standard-based goals rather than sticking to a detailed judicial order and compliance plan.

D. *State University Model: Texas Department of Criminal Justice*

The Texas Department of Criminal Justice (Texas DCJ), which oversees prisons and jails, houses approximately 250,000 people, a

76. *Id.*
77. Complaint, Lewis v. Cain (Angola Medical), para 42, https://www.laaclu.org/en/cases/lewis-v-cain.
78. Bobbi-Jeane Misick, *Judge Approves Settlement in Lawsuit That Challenged the Use of Solitary Confinement On Death Row*, New Orleans Pub. Radio (Oct. 1, 2021), https://www.wwno.org/news/2021–10–01/judge-approves-settlement-in-lawsuit-that-challenged-the-use-of-solitary-confinement-on-death-row [https://perma.cc/47VN-T3AL].
79. *See supra* Parts A. and B.

number that has increased by more than 400 percent in the last five decades.[80] As early as the 1970s, the Texas DCJ faced overcrowding and understaffing. The small, decentralized infirmaries across the state "were poorly equipped and maintained and were primarily staffed by medical assistants and inmate aids with little formal training."[81] Thus, those on the inside who required specialty care were transferred to a university hospital.[82]

By 1974, David Ruize and other inmates sought relief in a class action lawsuit against the Texas prison system for cruel and unusual punishment alleging, among other claims, inadequate healthcare.[83] In 1990, the District Court held in favor of plaintiffs, issuing a consent decree granting "injunctive relief and a special master to oversee and monitor compliance."[84] By 1992, the court issued a final judgment including "detailed orders and compliance plans to ensure timely delivery of adequate health care to prisoners in Texas."[85] Despite these court mandates, the reality was the Texas DCJ was still understaffed, prisons and jails were still isolated in rural pockets, and both the prison population and medical costs were soaring.[86]

In response, Texas created a novel solution for delivering healthcare to inmates: integrating the DCJ infirmaries with the state's public medical schools and affiliated hospitals.[87] The three main institutional actors other than the Texas DCJ are the Correctional Managed Health Care Committee (CMHCC), charged with integrating, developing, and managing the system; the University of Texas Medical Branch, providing service for approximately 78 percent of the inmate population; and the Texas Tech University Health Services Center, servicing the remaining population, mostly housed in western Texas.[88]

Although the Texas DCJ does not provide care to its prisoners directly, its "Health Services Division monitors the quality of care delivered by the contracted clinicians via its Health Services Quality Improvement Program. Biennial operational reviews of prison health facilities are conducted to ensure compliance with national and state standards and laws."[89] Beyond that, they review prisoner deaths, investigate medical-related grievances, and monitor communicable diseases.[90]

80. *Texas Profile*, Prison Pol'y Initiative, https://www.prisonpolicy.org/profiles/TX.html [https://perma.cc/7ABG-6MTE] (last visited Apr. 24, 2023).
81. Ben Raimer & John Stobo, *Health Care Delivery in the Texas Prison System*, 292 J. of the Am. Med. Ass'n 485, 486 (2004).
82. *Id.*
83. *Id.*
84. Raimer & Stobo, *supra* note 81, at 486.
85. Raimer & Stobo, *supra* note 81, at 486.
86. *Id.*
87. *Id.* at 486–487.
88. *Id.* at 487
89. *Id.*
90. *Id.*

Alongside the quality-assurance programs that the Texas DCJ runs, the CMHCC also monitors healthcare provision. "The CMHCC is composed of 9 appointed members, including 3 public members and 2 representatives from [the Texas DCJ, University of Texas Medical Branch, and the Texas Tech Health Services Center]."[91] Together, the committee coordinates the provision of services by contracting out to the two state university hospitals, monitors quality, resolves disputes, and implements managed care tools such as case management and utilization review.[92] The managed care system, implemented through the medical schools, has "significantly improved health care in the Texas prison system. Overall, there has been an increase in health care personnel working in prisons, and improvement in compliance for treatment of chronic diseases, and reduced mortality rates for chronic diseases."[93]

To be clear, the Texas DCJ's healthcare service provision is far from perfect. It still experiences inadequate staffing and overcrowding, and its mental health service provision is still lacking, as evidenced by a near threefold increase in suicide attempts in the last decade.[94] However, as a review of class-action litigation in Texas since 1994, the year that state university healthcare was implemented, demonstrates, health-related suits are no longer tied to the healthcare itself and instead are due to the prison conditions or correctional officers' administration of the prison.[95] This is far from a pass for the Texas DCJ; nonetheless, it further demonstrates that something about the university health model, as implemented in Texas, may be informative for how to best provide inmates appropriate healthcare.

The following Part outlines what this Article posits to be the crucial difference in the Texas public university model that has led to sustained, albeit limited, improvements in healthcare, while its peers implementing the direct, contract, and hybrid models have faltered. Notably, these differences are not specific to the public university model and could also be implemented in other service models.

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91. *Id.*
92. *Id.*
93. Sanjana Rao et al., *The Evolution of Health Care in the Texas Correctional System and The Impact of COVID-19*, 34 Baylor Univ. Med. Ctr. Procs. 76, 77 (2021).
94. *Id.* at 78.
95. *See, e.g.*, Williams v. Dretke, 306 F.App'x 164, 167 (5th Cir. 2009) (holding that officials were not deliberately indifferent to prisoner's medical needs when they refused to issue pass to allow him to go to medical department); *see also* Ruiz v. Johnson, 154 F. Supp. 2d 975, 988 (S.D. Tex. 2001); *id.* at 1001 (holding constitutional violations in areas of inmate safety, use of force, and administrative segregation but no violation with regard to provision of health care services to inmates).

III. Guidelines v. Checklists: Abating Fallibilism with Flexibility

Provision of healthcare in prisons and jails is variable, just like the populations within them.[96] To make matters worse, given a lack of a sufficient safety net in the United States,[97] American jails and prisons are tasked with taking on many of the issues that society has failed to manage elsewhere, like mental illness and substance abuse.[98] This constantly changing landscape makes properly managing an incarceration facility, which necessarily requires providing quality healthcare to inmates, an onerous task.[99] To be able to keep up with the changing individuals and trends in prisons, it is crucial that self-assessment and continuous improvement pervade the entire enterprise.[100]

To narrow down this principle, Part A looks at the Alabama-Utah model, where reforms in the welfare system "emerged from judicial decrees mandating broad institutional [re]form; yet, in each case the court and the parties avoided the rigidification and arbitrariness associated with 'command-and-control' type judicial intervention."[101] While the welfare system is certainly not the same as the criminal justice system, the historical development of the two share key characteristics, such as being large bureaucracies that provide services to a high-needs population. These similarities make it potentially fruitful to take lessons from the welfare context and consider how they might apply to penal reforms. Part B, highlighting the similarities between the circumstances calling for welfare and prison healthcare reform, comparatively analyzes why Texas was more successful in its reform than its peer states. Put simply, it is because Texas, through its public university model, avoided the rigidification of ex ante judicial rules and instead implemented management structures that allow for ongoing review and transformation.

A. *Alabama-Utah Model*

The Alabama-Utah model, much like the attempted changes in prison healthcare provision, was borne out of class-action litigation.[102] Before considering the innovative elements of the Alabama-Utah model, we begin with a very truncated history of child welfare in the United States to set up a discussion of the consent decrees and models of provision which were created.

After "[c]oncern about child abuse and neglect intensified in the 1960s and 1970s," the federal government began passing legislation to

96. *See supra* Part II.
97. Henry J. Aaron, *The Social Safety Net: The Gaps that COVID-19 Spotlights*, Brookings (June 23, 2020), https://www.brookings.edu/blog/up-front/2020/06/23/the-social-safety-net-the-gaps-that-covid-19-spotlights [https://perma.cc/P96E-696R].
98. Rabuy, *supra* note 19.
99. *See id.*
100. *See infra* Parts A, B.
101. Noonan et al., *supra* note 7, at 525.
102. *See id.* at 534–35.

better understand and remedy the phenomenon.[103] By 1980, the federal Adoption Assistance and Child Welfare Act overhauled the child protection regime.[104] However, both judicial modes of accountability and broader bureaucratic control could not root out the dysfunction of the child welfare system.[105] Lawsuits seeking injunctive relief ensued.[106]

The resulting decrees, at first, generally restricted discretion and attempted to "force action through rigid rules,"[107] focusing on "deadlines, quantitative measures, and specific procedural and documentation requirements." [108] Later decrees moved away from "command-and-control" measures and emphasized performance standards.[109] "Nevertheless, these performance-oriented regimes are sometimes experienced as just as restrictive as the rule-oriented ones," and were riddled with elements, indicators, and benchmarks.[110] It makes sense that judges that are thoroughly versed in the rule of law and have a penchant for bright-line rules may be "tempted to focus on them, while paying less attention to areas where compliance assessment will be more difficult and controversial."[111] Taken together, both the command-and-control and performance standard-driven methods were limited by devaluing amorphous, yet important norms; inhibiting adjustment in light of experience; useless indicators; and lacking sufficient outcome and diagnostic information.[112] This likely helps account "for the tendency of administrators and frontline workers to perceive consent decree requirements as a distraction from their core mission."[113] This may be especially true in the carceral setting, where moment-to-moment discretion may be the difference between a corrections officer making it home on a given day.

However, a new model of child welfare reform, dubbed the Alabama-Utah Model, avoids the pitfalls of the command-and-control and single-minded outcome focus of its predecessors.[114] The key is two innovative features: 1) a diagnostic monitoring system that "combines contextual decision making with systemic accountability," and 2) "a conception . . . that emphasizes a system's capacity for self-assessment and self-correction over compliance with judicially derived substantive standards."[115] Ultimately, "the Alabama-Utah model is a heuristic that

103. *Id.* at 526.
104. *Id.* at 527.
105. *Id.* at 528–30.
106. *Id.* at 530.
107. Noonan et al., *supra* note 7, at 530.
108. *Id.* at 531.
109. *Id.*
110. *Id.*
111. *Id.* at 532.
112. *Id.* at 532–33.
113. *Id.* at 532.
114. *Id.* at 533.
115. *Id.* at 534. It is important to note that the Alabama and Utah decrees has had other key features that make them effective, including infrastructure development, establishment of minimum qualifications for workers and supervisors,

explains how the integration of collaborative casework with diagnostic monitoring makes it possible for administration to learn from local practice while correcting its mistakes."[116]

In practice, this looks like a case or social worker getting called in to respond to an incident and building a team of relevant stakeholders, all with different experiences and expertise. Then, after diagnosis, that newly formed team develops and executes the plan it has constructed. Importantly, the plan is continuously revised as necessary and peer reviewed to figure out how well the process was implemented. The distinctive monitoring procedure is the Quality Service Review (QSR). Unlike the audit focus of conventional monitoring, the QSR approach goes beyond compliance and, through a random sampling of cases, tries to distill information that can improve the system as a whole. Cases are reviewed by teams of two, who, after reviewing the file and interviewing relevant stakeholders, score the case numerically through a number of indicators. These indicators measure the well-being of the clients and overall system performance. "After preliminary scoring, the reviewers meet to discuss their cases and particularly to surface and resolve any issues of scoring," before "reviewers meet with the caseworker and supervisor to discuss their findings and the scores."[117] Then cases are aggregated and reviewers try to generalize important takeaways from their findings.[118] Through this process, the QSR serves multiple purposes: It trains caseworkers and supervisors, elaborates norms throughout the system, and serves as a diagnostic tool for systemic reform.[119]

One crucial aspect of the Alabama-Utah model is that it creates both internal and external accountability. Decisions are to be "collaborative and explicit. Key judgements are made by a team, and the team is so cognitively diverse that its members must often articulate assumptions that would remain unstated in more homogenous settings."[120] In the criminal justice context, this would include the corrections officers, healthcare workers, administrators, a lawyer representing the state and another representing the needs of a specific inmate, and the incarcerated individual. This can help make norms in the system explicit and help ensure that there is consistent terminology and understanding on what each group believes is necessary for proper healthcare provision. It also helps ensure that the numerous actors involved in these bureaucracies are on the same page and nothing and no one slips through the

commitment to monitoring compliance with certain norms. *See id.* at 535–36. Other features "developed with district emphasis [are]: (1) a repudiation of rule-bound authority in favor of contextual understanding of norms; (2) a distinctive understanding of the relation between the administrative center and local units; and (3) an incrementalist approach to reform." *Id.* at 536.

116. *Id.* at 538.
117. *Id.* at 544.
118. *Id.* at 545.
119. Noonan et al., *supra* note 7, at 545.
120. *Id.* at 541.

cracks. Moreover, "peer review that engages all levels of the system, as well as outside experts" helps ensure that reviewers "formulate their judgements in ways sufficiently precise to permit comparisons across cases."[121] This also "facilitates outside review of the team's work, and it makes it easier for new members of the team to acquire understanding of the team's prior work."[122] This "facilitates the team's internal functioning. Having to articulate their views forces each member to think them through as clearly as possible."[123] This necessarily limits the discretion of actors throughout the system since they will not simply be deferred due to in-the-moment calculations.

Moreover, the Alabama-Utah model allows courts to fulfill the function they are best suited to—adjudication—without having to steer too deeply in policy concerns of day-to-day operations of an executive branch bureaucracy. Courts traditionally "decide intractably contested high-stakes issues" and "intervene structurally in response to persistent, systematically inadequate administrative performance . . . courts seem to perform these roles relative well, and they could perform the first better if they were relieved of much of the burden of routine supervision they must now perform when administrative systems malfunction severely."[124] As Noonan et al. described:

> The Alabama-Utah approach enables the court to induce an agency that has persistently failed to meet its responsibilities to reform in collaboration with injured stakeholders in a way that is both accountable and transparent. Far from imposing the kind of rigid and arbitrary regime that some critics of structural remedies fear, it inhibits administrative rigidity and arbitrariness by inducing the agency to develop its capacities to assess itself and respond to experience.

Paradoxically, there is a sense in which the broadest remedies are the least intrusive. The ideal structural decree requires no more than what good management and democratic accountability would require in the absence of judicial intervention. The Alabama-Utah approach comes much closer to this ideal than its command-and-control predecessors. In cases that have taken this direction, there are fewer complaints from defendants that court-imposed monitoring is a burdensome distraction.[125]

B. *What the Alabama-Utah Model Can Tell Us About Prison Healthcare Reform*

This Part outlines how Texas' relative success with the state university method of healthcare delivery is not inherent to the model itself, but instead can be attributed to sharing the broad guidelines, collaborative casework, and diagnostic monitoring that make the Alabama-Utah

121. *Id.* at 545.
122. *Id.* at 555.
123. *Id.*
124. *Id.* at 558–59.
125. *Id.* at 559–60.

model a success. In doing so, this Part suggests two things. First, regardless of their chosen model for healthcare delivery in prisons, states should look to the principles of the Alabama-Utah model to improve their outcomes. Second, when tasked with settling class-action lawsuits relating to prison healthcare reform, judges should avoid both command-and-control decrees and performance-oriented decrees that emphasize indicators and benchmarks at the expense of allowing the requisite flexibility to allow for continuous improvement. To that end, this Part explores whether the Texas DCJ, NYC DOC, and Alabama DOC incorporated the two core innovations of the Alabama-Utah model in their decrees and reforms: a diagnostic monitoring system and a capacity for self-assessment and correction.

Much like the Alabama-Utah model, the Texas DCJ utilizes an operational performance evaluation system (OPES). OPES provides "[r]egular review and feedback for clinicians regarding compliance with disease management guidelines, adherence to pharmacy practices, and quality issues."[126] This allows for individuals with different skill-sets to discuss their understanding of system failures, allowing them to upgrade their approach to ex-post issues. This process is exemplified by the development of a performance evaluation system by the pharmacy department within the University of Texas Medical Branch. OPES required them to "determine quality indicators and develop measurement systems to evaluate departmental and employee performance."[127] Instead of top-down metrics, the pharmacy department formed a working group of the director, supervisors, and a practice resident to develop a draft of the criteria, before the entire pharmacy staff reviewed, discussed, and updated the criteria. The criteria developed, and their metrics, are very compliance-focused. For example, the metric "clinical intervention" is measured by number of clinical interventions added to the number of consultations completed by practice specialists.[128] However, the model still creates interdependence, teamwork, and cooperation, and the incentive to pinpoint strengths and weaknesses that can be remedied.[129] It does so by not only creating a diagnostic tool, but by also creating a means by which personnel can become better service providers through review of the results of the diagnostic tool. "Results are reviewed at monthly department meetings and posted on [their] information board for personnel to review."[130] Moreover, the expectation is that indicators and standards "be reevaluated and revised annually to ensure an accurate reflection of departmental

126. Raimer & Stobo, *supra* note 81, at 489.
127. Melanie Roberts and Matthew Keith, *Implementing a Performance Evaluation System in a Correctional Managed Care Pharmacy*, 59 Am. J. Health-Sys. Pharmacy 1097, 1098 (2002).
128. *Id.* at 1101.
129. *Id.* at 1103.
130. *Id.*

goals and activities."[131] Another interesting element not present in the Alabama-Utah model is a pay-for-performance structure which ties salary increases to overall team performance, pushing all members to continuously experiment to improve their overall effectiveness.[132]

Unlike the Alabama-Utah child welfare model and the Texas prison healthcare service provision model, the NYC DOC and Alabama Department of Corrections, mirroring their judicial decrees, modeled their reforms around rule- and performance-orientation. In the case of NYC DOC, the monitor noted that "simply articulating the desired change is not sufficient to actually *catalyze* the change in practice."[133] Instead, the "issues plaguing the Department are systemic and deep-seated and have been passed down and accepted by all levels of Staff across the Agency."[134] The three main problems outlined in the most recent monitor report all stem from issues with facility leadership and staff. In turn, the administrators would greatly benefit from a monitoring review system that incorporates their knowledge, as those closest to the issues, gives them the time to review each other's work, and incentivizes them to change as much as the jail population does in short periods of time. Similarly, the Alabama DOC did nothing more than what was required by the court's decree, and has found no improvement in its staffing and mental health provision. The Alabama DOC similarly can be greatly aided by a peer review system that brings in the perspectives of those on the front lines, in pursuit of having a shared understanding with facility and DOC leadership about how to improve conditions.

In short, incorporating measures that allow for ongoing monitoring and correction has worked in child welfare service provision and the Texas DCJ's success suggests that it may work for prison healthcare service provision as well. In turn, judges and advocates alike should take notice of how this approach can save millions behind bars a great degree of pain and suffering.

IV. Conclusion

There is an uptick in general and mental health illness around the world. This is particularly true in prisons and jails, where a large proportion of individuals enter with behavioral service needs. Yet, prisons and jails have been incapable of meeting this need. In turn, several class-action lawsuits have been filed and judges hoping to use their power to mete out justice have ordered highly rule- and performance- orientated requirements. However, much like in the child welfare space, these have failed to produce tangible results. This Article suggests that instead of

131. *Id.*
132. *Id.* at 1098.
133. Steve Martin et. al., Eleventh Report of the Nunez Independent Monitor 5 (2020), https://www.nyc.gov/assets/doc/downloads/pdf/11th_Monitor_Report.pdf [*https://perma.cc/Q44F-S5BH*].
134. *Id.* at 6.

these rule-based requirements, judges and policymakers should opt for principles similar to those the Alabama-Utah model employ: a diagnostic monitoring system and an emphasis on self-assessment and correction. If it has led to positive results for the Texas Department of Criminal Justice, it may do the same for its counterparts across the country, thereby effectively using taxpayer money and significantly decreasing unnecessary suffering. Perhaps if the Alabama-Utah model can revolutionize prison healthcare provision, all hope is not lost after all.