

[00:00:00:05 - 00:00:48:08]

Dr. Homer Venters:

I think that being honest about the health risks of incarceration is important, but it is hard to do because these systems, the carceral systems, prisons, jails, life detention, they do not want to be upfront and transparent about the health risks of what they do. They would generally prefer to attribute all the bad outcomes to individuals. So if you look at any press release from any death behind bars, where the sheriff's department, department of corrections, Homeland Security, what they're gonna tell you is all of the things about the person and they were sick and they had these problems or they did this or that. And you will almost never see a clear conveyance of the intersection, which is the truth between their personal health risks and the environmental risks of these places.

[00:00:50:11 - 00:01:24:07]

Intro:

Welcome to "The Skin You're In," a podcast about health and the forces that shape it. We go beyond medicine to explore how race, place, policy, and culture influence who has the opportunity to live a healthy life and what it will take to achieve health equity. From data to lived experience, from public policy to music and the arts, we connect the dots between systems and stories because health doesn't happen in isolation. It's shaped by the world around us and the skin we're in.

[00:01:27:14 - 00:02:22:10]

Dr. LaVeist:

Hello and welcome to "The Skin You're In" podcast. I'm your host, Thomas LaVeist, Dean and Weatherhead Presidential Chair in Health Equity at the Tulane University, Celia Scott-Weatherhead School of Public Health and Tropical Medicine and Principal Investigator for Partners for Advancing Health Equity. I'm also the writer and director of the documentary, "The Skin You're In." I'm excited to introduce today's guest, Dr. Homer Venters. Homer Venters is former chief medical officer of New York Correctional Health Services and currently works as a court-appointed monitored inspector of health services in jails and prison. He's also part of the adjunct faculty of the NYU School of Global Public Health. And he's the author of two books, "Life and Death in Rikers Island," and most recently, "Outbreak Behind Bars," "Spider Bites," "Human Rights," and "The Unseen Danger to Public Health." I'm honored to have you here today, Homer.

[00:02:23:18 - 00:02:28:02]

Dr. Homer Venters:

Thanks, I'm thrilled to reconnect for another discussion. Thanks for the invitation.

[00:02:28:02 - 00:02:54:09]

Dr. LaVeist:

Right, so you were recently featured at this year's New Orleans Book Festival at Tulane and we had an opportunity to have a conversation at the festival. And so I'd love for us to go over some of the things that we talked about, but first I'd like to know more about you, your background.

Where did you grow up? What influenced you to be doing the work that you did? What's your story? How did you come to be doing this work?

[00:02:56:06 - 00:03:40:06]

Dr. Homer Venters:

Well, like a lot of people, I think there probably were a bunch of stuffs along the way, but I was born and raised in Minnesota, but I was in a family that worked in international health. My dad was a pediatrician at the county hospital in St. Paul, but we worked a lot. We'd go abroad working in Central America, South America, mostly for him, but my mom, who was an epidemiologist, who was in public health also, we'd kind of follow her sometimes. And so I grew up kind of seeing them work, one in epidemiology, one in a big public hospital system and pediatrics. And even though I didn't think I wanted to be a physician, I think I took a lot away from them.

[00:03:40:06 - 00:03:47:13]

Dr. LaVeist:

Yeah, well, yeah, I can certainly see that in the work you do. And so how did you come to be doing correctional health?

[00:03:49:08 - 00:05:17:00]

Dr. Homer Venters:

Well, I think that I was interested in human rights really before I was interested in medicine. So I went to undergrad thinking I would be a human rights lawyer. I was really drawn to that world. And then in the Peace Corps, I was working as a Guinea worm volunteer and really came to love seeing people and patients. There was people in in in Togo who had Guinea worm that time with them really made me think about medicine. And then I was fortunate enough to go to a residency program at Albert Einstein in the Bronx at Montefiore, social internal medicine. And the difference between that program and the regular kind of categorical medicine programs was that you learned there was more some formal training in human rights, some formal training in public health and epidemiology, which is what drew me to it. And my project was to work with people at a legal aid services organization, Bronx Defenders, right across the street from our clinic in the South Bronx. And so I, for the whole time in my residency, I would go over there and see people and then try and get them back to our clinic or maybe just see them there. And the stories they told me about their experiences being incarcerated and the health barriers, the health problems they face, really, I think that was kind of the turning point for me in thinking about this world.

[00:05:18:17 - 00:05:38:06]

Dr. LaVeist:

It's interesting. And so, reading the book, it's clear that you come at this from a structural perspective. Was this something early in your career that led you to conclude that this was, these were structural problems and not problems of the individual patients at in rates that you were saying?

[00:05:39:18 - 00:07:07:09]

Dr. Homer Venters:

I think it took me a long time to think in the terms you just articulated. I think that, but I think there is a difference because my whole experience as a physician has been mostly with some exceptions, mostly working behind bars. And the barriers that your patients have, either you communicating with them, you even seeing them, them facing new health risks, those are all kind of intimately structural. But I'm not sure at the beginning, I was thinking in those terms. It just did occur to me that, when I started at Rikers, a lot of our patients would get injured while they were there or a lot of our patients would have trouble getting to the medication line or other things like that. And I think that as I worked my way up, the health service at Rikers doing basic medical things like quality assurance or quality improvement projects or mortality reviews. I can tell you how many mortality reviews we would come to the conclusion that something that happened behind bars really contributed to the outcome of death. But we didn't really have a way to fix it. And we started to give these a name, jail attributable deaths, and we started to measure them. But even then, I think I was still coming around to this notion that you just raised, which is these are really deep structural problems.

[00:07:07:09 - 00:07:24:23]

Dr. LaVeist:

Yeah. So as you know, I'm from New York, so I'm very familiar with Rikers Island and know a lot about that facility. But just for the audience, most of you who are not New Yorkers, can you tell us what is Rikers Island? How would you describe the place?

[00:07:26:01 - 00:09:45:00]

Dr. Homer Venters:

I think the easiest thing to say about Rikers Island is it's a penal colony. And there aren't many of those left in this nation for very good reason. In New York City, the New York City, the five boroughs of New York City, there are jails off of Rikers Island. So there's a jail in Manhattan, there have been jails in the Bronx. When I was working there, there was actually a floating barge, VCBC, where I probably saw patients more than almost anywhere else. But most of the people who are incarcerated in the city jails or in the city jail system are on Rikers Island, which is only reachable this one long bridge that goes by LaGuardia Airport. And on it, in the years I worked there, there were between, I guess between 13 and 15 total facilities and probably nine or 10 on Rikers Island. But Rikers Island, if you look at it, is an island with hundreds of buildings, different types of structures, many of them very old, fallen down. And in there, there were eight or nine or 10 jails. I think one of my first impressions, I got the first day I went to Rikers, it was a snowstorm. I was still a fellow at NYU, it was in 2008, I think in November. And I went out there in this blinding snowstorm and I was walking around, so it was very like other world. It's like being on Mars. But one of the things that struck me, and one of the first things was that there were a couple of brand new edifices, brand new buildings, five story structures on Rikers Island amidst all this like old stuff, falling down stuff. And it turned out that one of them was called the Bing, but it was, and one was, there were two jails, but one at GRVC, which is a high security jail, had this brand new five story, well, it looked like a hotel if you look zoomed out far enough, and it was brand new structure for solitary confinement. So you had five floors, maybe 500 people, I guess, locked away, you could hear them yelling through the windows, but you could kind of see right away what value was placed on that practice of solitary confinement. It really struck me that that was where a lot of money had been put.

[00:09:46:21 - 00:09:57:07]

Dr. LaVeist:

So tell me about solitary confinement, what is that like? Bring our audience into that. What is it like to actually be in solitary confinement?

[00:09:57:07 - 00:12:35:05]

Dr. Homer Venters:

Yeah, I mean, I think that because we're so voracious about incarcerating people in this country, I think you could easily find people who have experience who would definitely have better reflections than I do about what the physical experience is like. My own experience as a doctor in the jails then, and really up to now, is that almost without fail, if there's a problem with a person behind bars, the solution is gonna be to lock them in a cell by themselves. And so there are a lot of terms given to that. So the term solitary confinement is a general term that refers to being locked in a cell for 22 or more hours a day. But some places might do that to punish you. Like let's say you break a rule or several rules, that's punitive segregation. Other places might look at you and say, "Geez, you're so dangerous. We think that you should always be in this kind of condition." That's administrative segregation. You might also, by the way, get a mental health label, like, "Oh, we think you're suicidal." But then the result is still, "Let's lock you in a cell by yourself." And so that practice is almost uniquely American one. It's new since the 1980s. But my experience in our data from Rikers showed very clearly that it's associated with poor health comes, including self-harm and suicide. Lots of people have documented that obviously. And I'll say the thing I really try and focus on a lot in the first book is that the corrosiveness of solitary confinement doesn't just accrue to the people who are locked in those cells, who can't talk to people, they can't get the basic services they need, their healthcare. It also comes right down on the shoulders of the correctional staff and the medical staff who work in those places. Because if you are a correctional officer, and I have a little vignette about this in the first book, and your job is to keep people detained in these cells, locked in these cells in these really inhumane conditions. And then you're supposed to once a day get them out to take a brief shower and get back, or get to recreation and get back, or get to a medical appointment and get back. That is a very fraught experience for that officer. And so almost inexorably, solitary confinements are violent. There are a lot of assaults on staff. There are assaults on people who are held there, dangerous for medical staff. It's not hard to predict the kind of physical and sexual violence that happens in these places, but the corrosiveness really reaches everybody that's involved.

[00:12:35:05 - 00:13:02:23]

Dr. LaVeist:

Yeah, I think I've kind of gotten us a little bit out of sequence in that I kind of get you talking about the prison without talking about the book first. So I'd like to talk a bit about the book, I found it a really fascinating read. It's a really quick read, really interesting stories. I think it's really eye-opening to anyone who really hasn't been thinking much about prison, but tell us about the book.

[00:13:02:23 - 00:14:48:11]

Dr. Homer Venters:

Sure, I think it's true that actually I think that maybe it's greatest virtue of what you just said, which is it's a quick read. So I've sometimes told friends, if you want credit for reading a book this year, here's your book. But yeah, I think that since COVID hit, I certainly have investigated a lot of outbreaks in different settings of all kinds, but then when COVID hit, I really exclusively kind of went on the road for a few years, go into places with COVID outbreaks. So I probably went to, I don't know, maybe 60 or 70 places around the country, driving all over to Florida, to Chicago, to Memphis, to anywhere to kind of try and help, either help with the response when I was welcomed or to help document the truth of the response in cases where I often was not welcomed. But in any event, it really got me thinking about the very common issues that I would see in that role, and that was a monitor, certainly where I've got a broader kind of court mandate to help improve health systems in these places. And I think that there are some very common and practical improvements that I've seen in places doing that save lives and help improve outbreak responses, prevent outbreaks. And then there were some pitfalls that seemed to occur over and over. And so I, in the book, go through different types of outbreaks, from COVID to scabies, to heat-related outbreaks, and have some, in each chapter, recommendations for both improvements in policy areas, but also some research ideas in each chapter for academic students, people who are interested in learning about this topic.

[00:14:49:12 - 00:14:52:08]

Dr. LaVeist:

Can you tell us about one of the outbreaks that you cover in the book?

[00:14:53:18 - 00:16:46:18]

Dr. Homer Venters:

Sure, there's a whole chapter on an outbreak at an immigration detention setting in the summer of 2020, Farmville. And that outbreak, I didn't, as I often don't know, I didn't actually know what came before I arrived, but I was there to do an inspection of the facility, and I did, and it was a facility, a private company ran this facility in Farmville, Virginia for Immigrations and Customs Enforcement use. And they went from zero cases of COVID to essentially everybody having COVID. And it happened because about 70 people were transferred into this facility. And unlike every prior transfer of people into this facility, they didn't go through all of the standard infection control practices. So this facility had a pretty good policy and practice of having people stay in a separate building for 14 days, get them cleared, make sure they were okay, then go into the main buildings. And it was also really just a handful of people at a time. But for some reason, ICE decided they were gonna take 70 people from different parts of the country, move them all in, have them all go into this main complex, not the quarantine buildings, and the outcomes quite predictable. But it was really, and the people, by the way, were coming from facilities with COVID, to a place with no COVID. So, you know, it was really, it wasn't actually very complicated to establish this sequence of events from an epidemiologic standpoint, but people obviously in the facility were enraged. There was a Canadian man who died, whose family had begging to, you know, been begging ICE to just let him come home to Canada, and they would quarantine him there. So it was really a horrible set of outcomes.

[00:16:46:18 - 00:17:26:00]

Dr. LaVeist:

Wow, yeah, that's horrific. And so, but COVID was a unique period, right? With the pandemic. And that's an example of how public health challenges from the broader community come into the prison. But the health problems go in the other direction as well. They come from the prison out into the community. And one of the things that I found particularly fascinating in the book was the story about scabies, which, you know, is not something that we, you know, health professionals generally associate with gaffe. Can you tell us about that story?

[00:17:26:00 - 00:19:53:23]

Dr. Homer Venters:

Sure, I think scabies is a great example of something that affects many people behind bars. And just as you said, it doesn't get a lot of attention because it doesn't contribute to that much mortality. Although I will say there have been cases that I've reviewed where, and this is people, imagine somebody is locked in a cell for mental health reasons, and then nobody checks on their physical health. There have been cases where people have died of ectoparasite infection and really infestation, I think, and also dehydration, things like that. So that in extreme cases can occur. Scabies is also an example of something where there are, especially in a county jail that has a lot of people coming in and out all the time, there may be certain physical places where lice and scabies and other, both ectoparasites and also mold and other things are just allowed to persist. So a jail intake pens are a good example where you may have dozens of people coming in every day where there might be an effort to clean them once in a while, or the mental health cells where people are locked in solitary for mental health reasons. Those are places where these problems can persist, but the experience with scabies, I think, is really telling because you can have an outbreak going on for months. And I talk about a couple of outbreaks that went on for months in correctional settings, where there's kind of sporadic treatment offered to some people, it could be evidence-based treatment, but it's not treatment that people can renew or repeat with an adequacy to keep them free of infestation. And then, especially in jails, people go home. And when they go home, they have a thousand things to worry about when they're going home from parole, probation, jobs, family, all these things. And I add up to today, except for where I'm a monitor, where I have some agency and working with a system, I haven't come across discharge planning that it involves checking this box, which is, geez, there's a scabies outbreak. Let's make sure people have in their hands the medication they need to go home and treat themselves. And if they don't, that could be 30 bucks, 40 bucks that they simply don't have or aren't gonna be able to use. So then now you've taken this thing that seems like an annoyance, but you've introduced it to their home.

[00:19:53:23 - 00:20:10:18]

Dr. LaVeist:

Yeah, so as health professionals, we have ethical standards, guidelines to live by, oaths that we pledge to provide standard of care. Why don't those things work in prisons?

[00:20:12:21 - 00:21:37:05]

Dr. Homer Venters:

Well, I think that the easiest, simplest answer, and this doesn't account for all of it, I think the biggest single reason that I've seen is that the structures we use to monitor the adequacy of care or to introduce accountability when there are problems with adequacy of care, those

structures don't exist behind bars. So the Joint Commission, the State Department of Health, the people that check to see, did you go do a good job getting to the cath lab on time? Did you do a good job with your IVs? Did you do a good job with whatever the, the part of the healthcare processes, those organizations and structures are purposely cut out of correctional health. And then you have, and there are a few exceptions, but generally that's the case. And so then you have sporadic oversight, and oversight is often by law enforcement, not by these actual true health structures. And so it makes, and there's also some legal constructs that I'm not an expert in, but I think that generally speaking, if you don't use the health experts that you use in a hospital to also look and see if you're getting the right care or the timely care behind bars, then the product is kind of predictable, which is that one that only will notice the most egregious violations.

[00:21:38:23 - 00:21:55:22]

Dr. LaVeist:

So, you've been doing this work for decades now. You've seen a lot of different facilities around the country and is it possible to incarcerate people in a humane way? Is that possible? And if so, how do we get there? What would that look like?

[00:21:55:22 - 00:25:15:22]

Dr. Homer Venters:

Well, I think that for me, the first step is to be honest about the health risks of these places. I think that, I think that actually this is where human rights and epidemiology are a very good match with each other, even though they often are at odds with each other professionally, if you look at who does what, but I think that being honest about the health risks of incarceration is important, but it is hard to do because these systems, the carceral systems, prisons, jails, license, detention, they do not want to be upfront and transparent about the health risks of what they do. They would generally prefer to attribute all the bad outcomes to individuals. So, if you look at any press release from any death behind bars, where the sheriff's department, department of corrections, homeland security, what they're going to tell you is all of the things about the person and they were sick and they had these problems or they did this or that. And you will almost never see a clear conveyance of the intersection, which is the truth between their personal health risks and the environmental risks of these places. And so I think that, I believe in undoing our American misadventure of mass incarceration. I think there are lots of ways to prevent people from going into these places, but where I stand with the work I do is to try and start with being honest. Like this place has these specific health risks to people. So, if you're a jail or prison and it gets hot there and they don't have air conditioning, you are conferring a health risk to people that for some people could lead to their death and we should be honest about that. And I mentioned that metric we developed at Rikers Island, jail attributable deaths, where in a given year, it wasn't that we found all of the deaths were jail attributable. Well, we would find, I think probably like 10 to 20% most years of the deaths were jail attributable. Something that happened here made a significant contribution to the outcome of death. But that measurement and metric has not taken off, believe it or not. And so it's not, I think that these systems are just, because they're paramilitary, they're built to kind of voiced all of the responsibility or blame for the bad outcomes onto an individual person there. And also we don't really have an accountability structure. It screws up over and over and over with healthcare. It's

the opposite of what happens. In the community, if a transplant team has a bunch of patients develop infections, guess what, that hospital stops being a transplant service or there's this CMS can send out a letter of, I think it's imminent harm or imminent jeopardy, something. They could send a hospital, a health system, a single letter that says, these problems could lead you to lose all of your Medicaid reimbursement. The opposite happens with jails and prisons. And I think that that's fundamentally the problem. But from a human rights standpoint, I think the first step is to tell the truth about the health risks of these practices.

[00:25:15:22 - 00:25:22:08]

Dr. LaVeist:

To be clear, you say the opposite happens in jails and prisons. What specifically are you referring to as the opposite?

[00:25:23:15 - 00:26:37:06]

Dr. Homer Venters:

Yeah, I think that the jail and prison, when they get in trouble, nobody's going to take away their ability to be a jail or a prison. I think that probably in the most robust response, they're going to get more resources and hopefully they get more resources to provide more care. That's what you would hope. But I'm just not aware of, and it's an extreme example, like in New York City, you could go into kind of a receivership. California prisons went into this where control gets taken away from the state or the city. But it's just the opposite. The two sides of this human rights coin, the transparency and the accountability. The transparency you can see in some places where you get to the truth in some cases of what's happening, but the accountability, which is like, is this place going to stop being a jail or a prison, or they're going to be forced to have fewer people in there or meet some standards? It doesn't happen very frequently. So then you could have lawsuits. In a big case, you might have a class action lawsuit. And that could lead to some changes, but those changes are difficult and they take time.

[00:26:39:14 - 00:26:48:23]

Dr. LaVeist:

That's interesting. So if you could implement one structural change, what would that be? Or is there anything that you would suggest?

[00:26:48:23 - 00:28:30:22]

Dr. Homer Venters:

I think my role now, most of my work is as a federal monitors. So where both sides have kind of said, like people have identified a problem or a set of problems with healthcare, and a judge has said, okay, we need somebody to come in and try and not force, but help ensure that things with healthcare go in a different direction. And for me, one of the first things that I want to establish is that whatever's happening inside the box, let's say it's a jail, that whatever we do to improve, and it could take a few years to improve it, we're going to connect all of that outside local health department. And so in places where I'm the monitor for a jail health service, early on I talked to everybody involved, all the parties, the plaintiffs, the defendants, the people in the jail. And I say, look, who's the local health department? How can we get them involved? They're probably involved a little bit in things like HIV, TB, they might've helped out with COVID for instance, or hep C. But what the goal for me as a monitor is that when the monitoring is done, we improved,

let's say there's 25 things that the court said, try and fix these things. When we've improved those things over a few years, that then what you're leaving behind is a structure of a local health department that is doing very similar type of review of the adequacy of care, the timeliness of care, that they've trained up and built those structures. Because the goal with these legal cases is that they're done. You get to compliance and they're done. But you want to know that when you leave, you've built a structure that involves real independent health and public health people outside of that box, helping and monitoring the adequacy of care.

[00:28:30:22 - 00:28:55:07]

Dr. LaVeist:

Yeah, I think I mentioned to you when you were down here in New Orleans that during the pandemic, I chaired the Governor's COVID Task Force. And one of the challenges we had was really getting eyes and ears into the prison and really accessing what was happening there. It was really a separate system of the way the things are done in a prison versus... Do you find that's common around the country?

[00:28:55:07 - 00:30:05:06]

Dr. Homer Venters:

Sure, I think that, you know, imagine you just allowed some hospitals to be like, "We're not gonna be involved in the Joint Commission or JACO or whatever, and we're gonna do our own thing." You know, prisons are built that way. And they have this, because they have a security mandate, they're built as really paramilitary structures and organizations. And so it's very, I think that it's difficult in the context of outbreaks. I just had a great webinar, the CDC, myself, and the National Association of County and City Health Workers yesterday, NACCHO. We had a great webinar yesterday about how to build these connections with outside health departments. And I think that, you know, building those relationships, just like you observed, it is very difficult in a moment of crisis to go into a jail or a prison and get anything except what they want you to see. And what they want you to see is kind of the, I often talk about this, it's the numerator, right? They're gonna tell you, "We did this many things. We gave this many band-aids or this many medicines." But there's a pretty big denominator out there, and getting to the truth of that denominator, I think really requires ongoing relationships.

[00:30:07:09 - 00:30:16:20]

Dr. LaVeist:

So let me end here on hopefully something positive. What gives you hope, if anything, that we can actually make change and do better?

[00:30:18:08 - 00:32:08:12]

Dr. Homer Venters:

I think that there are a couple of areas that I think are very promising. One is that there are many local health departments that are, you know, with some resource help, are eager to get involved in this area. I think that COVID was a really stark lesson about how connected health inside these facilities and in the community is. So I think that that's probably an area where you find not all, but many local and state health departments are thinking about these areas and they're getting engaged in improving care. The other part of it is that we have a lot of great alternatives to incarceration. So we have about 3,000 counties in this country. We probably have

almost as many drug courts and mental health courts. So people have thought about how can we do things differently. I think the difficulty with that approach is that some states have really eviscerated their community resources for mental health or for substance use treatment, but some haven't. And I think that figuring out these alternatives and how to fund them is really an important priority because to be fair to anybody who works in a jail or a prison, you know, having people who are put into a jail or a prison who are floridly psychotic or who are going through withdrawal, potentially fatal withdrawal is a deadly path for that person, but it obviously is also very corrosive and difficult for everybody who's asked to supposedly provide medical care or custodial care. And so I think these alternatives and how to build them in an evidence-based way is another area where I see some promise.

[00:32:09:19 - 00:32:30:01]

Dr. LaVeist:

You know, one of the big revelations I had in reading a book was the extent in which we've separated the public health system out in the community from the public health system in prison and how dysfunctional that is because the populations are not separated and the diseases do not respect the boundaries that the prisons create. Thank you so much for this important work that you do. You know, I think this is an important aspect of health equity that we really don't give enough attention to and it really should become central to the topic of health equity and something that we should always be talking about that the people in prison are going to come back out into the community and potentially with them those diseases and that they are members of our community and as such are deserving of the same care and respect as everyone else. And we need to be thinking about that and making sure that we're holding government accountable as well. So thank you so much for joining us for this conversation.

[00:33:07:06 - 00:33:08:20]

Dr. Homer Venters:

Thank you so much. It was really a thrill.

[00:33:08:20 - 00:33:22:15]

Dr. LaVeist:

And a big thank you to our listeners. We hope you found this episode insightful. If you have any thoughts to add to the discussion, feel free to comment on our podcast platforms or connect with us on the skin you're in in social media. Thanks for listening.

[00:33:24:09 - 00:34:09:00]

Outro:

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