MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Physician–Public Defender Collaboration — A New Medical–Legal Partnership

Rahul Vanjani, M.D., Sarah Martino, M.P.A., Sheridan F. Reiger, M.D., M.P.H., James Lawless, M.A., Chelsea Kelly, J.D., Vincent J. Mariano, M.D., and M. Catherine Trimbur, M.D.

Mr. A., a 45-year-old man with a history of benzodiazepine use disorder, was brought to the hospital after having a grand mal seizure while awaiting trial in the holding cell of a municipal courthouse. After being arrested 3 days earlier, he had been held for 2 days in the police station, where he did not receive any medications. During that period, he developed progressively worsening withdrawal symptoms, including headache, nausea, tremors, and anxiety, culminating in a seizure. He was transferred to a local hospital, admitted to the medical service, and given clonazepam, with a plan for a prolonged taper.

Mr. A. had been hospitalized with seizures from benzodiazepine withdrawal on numerous previous occasions. Each time, he would undergo a relatively brisk clonazepam taper over the course of 1 to 2 weeks and then return to using benzodiazepines almost immediately after discharge. Understanding this pattern, the inpatient medicine team planned a prolonged taper, starting at a total daily dose of 7 mg and tapering by 0.5 mg per week. The clinicians worried, however, that Mr. A. would not be able to continue this taper in the state's prison system.

Public records showed that the patient had been incarcerated multiple times. Both Mr. A.'s self-report and his medical record indicated that his addiction, coping skills, and ability to lead a fulfilling life had deteriorated with each successive incarceration. It was clear to the medical team that an additional incarceration would be detrimental to Mr. A.'s health.

INCARCERATION AND HEALTH

The United States incarcerates people at a higher rate than any other country. There are currently 2.2 million people in prisons and jails nationwide. Research has implicated incarceration in worse health outcomes for incarcerated persons and their families and communities, both during and after incarceration. Incarcerated people have higher rates of both infectious and chronic medical conditions, as well as substance use disorders and mental health disorders.[1] Drawing on the National Corrections Reporting Program database, researchers estimate that each year served in prison translates to a 2-year reduction in life expectancy.[2] Formerly incarcerated people also have worse health outcomes, which are exacerbated by fragmented transitional care and discrimination in housing and employment.[1]

There is ample evidence that incarceration is harmful to health. For physicians and other health care providers, the urgent question becomes what role this knowledge should play in health care delivery and patient advocacy. In clinical settings, we don't routinely screen for, much less discuss, patients' involvement in the criminal justice system. Clinicians should not be surprised, however, when their patients provide personal accounts of arrest and incarceration. In fact, in a study of urban primary care clinics in the Bronx, approximately 18% of patients had been to jail or prison and more than half of the families seeking primary care had been personally affected by the criminal justice system.[3] The modern American prison system and the phenomenon of mass incarceration have been deeply influenced by the legacies of slavery and racialized economic inequality, and people from minority and low-income communities are disproportionately incarcerated.[4]

LESSONS FROM MEDICAL–LEGAL PARTNERSHIPS

Unlike homelessness, food insecurity, and other forms of structural inequality, incarceration as a determinant of poor health has not entered the standard medical lexicon. Efforts to bring the so-

cial, or upstream, determinants of health to the forefront of medicine have focused on helping patients overcome daunting issues with access and resources, such as lack of health insurance coverage, need for transportation assistance, need for income from employment or social welfare programs, and food and housing insecurity. Formerly incarcerated people are at exponentially increased risk for these problems, which makes involvement in the criminal justice system one of the most fundamental upstream determinants of health. The academic medical literature has generally focused on screening and treatment among populations with such involvement, rather than on preventing incarceration itself, as part of an achievable, or even tenable, treatment plan.

Fortunately, a model for helping patients navigate legal issues that negatively affect their health does exist in medicine: the medical–legal partnership (MLP). First created in the early 1990s, MLPs entail embedding civil legal aid experts in the health care team in order to identify lapses in protection of patients' civil rights and engage health care providers in appropriate interventions. Recognizing that the knowledge and tools to assess patients' social environments were not consistently available within traditional health system models, many health systems have welcomed MLPs and the formation of interdisciplinary care teams. The evidence in support of these collaborative efforts between lawyers and health care providers is compelling: studies have demonstrated the effectiveness of the MLP model in addressing a range of civil legal problems, including landlord–tenant disputes, divorce cases, and employment suits.[5]

MLPs have also developed tools for health care providers to advocate for patients, such as customizable form letters to judges, human services agencies, public housing authorities, landlords, employers, and utility companies to establish the health consequences of a patient's sentencing, the patient's eligibility for various benefits, or the protections afforded to the patient by housing codes, employment and workplace regulations, utility shutoff guidelines, and so on. Such letters facilitate direct advocacy by clinicians. Although clinicians increasingly understand that addressing patients' social conditions is as important as addressing medical needs, they often express a lack of confidence in their capacity to do so. As a result, they often avoid screening for social needs in the first place, worried that the answers provided by patients might highlight problems that they feel unequipped to address.[6]

A NEW KIND OF MLP

Development of the MLP model stemmed from the understanding that in the United States low-income people have no guarantee of assistance in civil matters. In 1974, Congress established the Legal Services Corporation, a private 501(c)(3) organization that distributes federal funding to civil legal aid organizations in all 50 states. These agencies provide free legal assistance to low-income people in noncriminal matters. There is not enough funding, however, to meet the high demand for civil legal services; the Legal Services Corporation estimates that because of resource limitations, the agencies they fund can fully address only 28 to 38% of the needs brought to their attention.[7] In short, though we place some value on offering free civil legal assistance to low-income Americans, there is no mandate regarding the accessibility of these services.

In contrast, low-income people charged with criminal offenses are guaranteed the right to representation by an attorney, regardless of their ability to pay — a right that was upheld by the Supreme Court in *Gideon v. Wainwright* in 1963.[8] For people who are indigent, this representative is often a public defender. Charged with obtaining the best possible criminal justice outcomes for their clients, public defenders may not appear to be obvious allies and collaborators for health care providers. However, given the complexity of medical and social needs that an indigent patient may present with while facing criminal charges, information and participation from clinicians can be invaluable for public defenders as they investigate, litigate, and try to address the underlying issues that led to contact between their clients and the criminal justice system.

For public defenders, medical information can be valuable evidence supporting a client's receipt of community-based rehabilitation and treatment in lieu of incarceration. Judges often request documentation or medical records to confirm defendants' claims that they are currently engaged in medical or mental health treatment or that they require such treatment. Without collaboration between the public defender and the

health care provider, arguments for releasing clients from custody so that they can receive treatment are significantly weakened. Judges can draw only on their knowledge of patients' criminal history and their own instincts in assessing the legitimacy of defendants' self-reports and the potential impact of a prison sentence on defendants' health.

Despite a shared mission of caring for people at their most vulnerable, collaboration between public defenders and health care providers in aiding low-income people has not historically been formalized in MLPs. Whereas it is relatively easy to see why a public defender might need a clinician's cooperation, clinicians may not understand why and when they might call on a public defender. In Rhode Island, a growing partnership between the office of the Public Defender (RIPD) and the Lifespan Transitions Clinic (LTC) — a primary care program that is part of the nationwide Transitions Clinic Network and is located at the Rhode Island Hospital Center for Primary Care, an academic primary care clinic that serves patients involved with the criminal justice system — demonstrates how both professions can benefit from collaboration in their efforts to preserve their clients' and patients' health.[9]

The RIPD–LTC partnership was born out of a growing awareness on the part of LTC primary care providers and community health workers that incarceration and community supervision hinder our patients' attainment of stable housing, meaningful employment, medication adherence, and other determinants of health. In response, representatives from the RIPD Social Services Unit and the LTC team convened a meeting to brainstorm ways of coordinating more effectively while respecting the boundaries of each profession. Though the relationship has grown organically as new collaboration opportunities have emerged, a few deliberate steps were taken.

First, it was clear that obtaining patients' consent to our communication would be critical. We changed our standard practice so that the information-release form that all patients sign at their first appointment includes release to the RIPD. Patients are asked explicitly whether they give us permission to contact the RIPD if they are currently facing charges or have an issue in the future, and they can opt out of this communication entirely at any time. This practice has enabled seamless two-way communication between the RIPD and LTC, which is important for both sides. For example, LTC clinicians reach out to RIPD social caseworkers if a patient is rearrested or violates the conditions of probation or parole. The caseworkers can then review the case with the patient's attorney and facilitate a discussion about the potential disposition of the case. These interactions allow LTC clinicians to alter their care plans and provide relevant support. In addition, they enable LTC community health workers to regularly attend court dates with their clients to offer peer support and demonstrate to the court that the patient has sources of community support. Similarly, the relationship opens a line of communication so that the RIPD can ask for supporting documentation from the LTC as appropriate — for instance, when there is a case to be made for residential substance use treatment instead of incarceration.

Second, we discovered new ways that medical documentation can be used to advocate for our patients' improved health. One relates to the substantial debt many of our patients have incurred from court fines and fees. If they miss a court date when they were supposed to make a payment, a warrant can be issued for their arrest and they can be reincarcerated if picked up by law enforcement. Many of our patients report substantial stress about their inability to pay and the threat of incarceration.[10] The LTC, in consultation with the RIPD, generated a customizable form letter highlighting the impact that court debt is having on a patient's health (see the Supplementary Appendix, available at NEJM.org). This letter can be submitted to a judge, who can reduce or waive court fines and fees.

Third, an additional customizable form letter was created outlining the impact that incarceration might have on a patient's health (see the Supplementary Appendix). When a patient faces criminal charges, this letter can be submitted to the judge, providing information to be considered in sentencing. Such information is most relevant when substance use and mental health problems contributed to the events behind the new arrest, as in the case of Mr. A.

Although including protected health information in a criminal legal proceeding may be new for some of our patients, we have yet to have a patient reject the collaboration or express discomfort with it. Having their physician involved in the process affords patients additional oppor-

tunities to discuss their case and share any concerns or anxieties about the potential outcomes. Most of our patients with substance use disorder have a long history in the criminal justice system, and their substance use is already well known to the court. However, we trust our RIPD colleagues to consult with the patient about the risks and benefits of disclosing health information and to determine when introducing information about behavioral health may in fact be detrimental to their client's case.

Establishing a partnership with a local public defender agency undoubtedly takes time, relationship building, and careful attention to protocol, but our experience in Rhode Island indicates that it should not necessarily require outside funding. The MLP model integrates attorneys into the health care setting to provide robust consultation on civil legal matters. Fortunately, nearly 350 health care organizations have succeeded in financing this work with a combination of funds from the Health Resources and Services Administration, philanthropy, and their own operating budgets.[11] The RIPD–LTC partnership built on the health care team's positive experience with an MLP, and it was designed to enhance communication between providers and social caseworkers who were already serving the same people; we did not add a new direct service to patients or new staff members.

Physicians and other health care providers have no business moonlighting as amateur attorneys, and we don't suggest that clinicians can or should determine the appropriate sentence in a given criminal case. But if we accept that involvement in the criminal justice system has important negative effects on patients' health, we should seriously consider what we can do to reduce its harm.

After Mr. A. signed an information-release form, the medical team contacted the local public defender's office to discuss the case with Mr. A.'s attorney and caseworker. The attorney convened a meeting with the judge, the prosecutor, and the police department. She shared the letter produced by Mr. A.'s health care providers explaining the medical rationale for finding an alternative to incarceration. The judge and prosecutor agreed that incarceration was not in Mr. A.'s best interest. His probation violation was withdrawn, his bail was waived, and the police officers released him from custody by uncuffing him from his hospital bed. A few days later, Mr. A. was discharged from the hospital to a residential treatment program, where he completed the medically appropriate gradual benzodiazepine taper as prescribed and received comprehensive treatment for his substance use and mental health diagnoses.

Disclosure forms provided by the authors are available at NEJM.org.

From the Division of General Internal Medicine, Warren Alpert Medical School of Brown University (R.V., S.F.R., V.J.M., M.C.T.), the Center for Prisoner Health and Human Rights, Miriam Hospital (S.M.), and the Rhode Island Public Defender's Office (J.L., C.K.) — all in Providence.

1. Wildeman C. Incarceration and population health in wealthy democracies. Criminology 2016;54:360-82.
2. Patterson EJ. The dose-response of time served in prison on mortality: New York State, 1989-2003. Am J Public Health 2013;103:523-8.
3. Shah MP, Edmonds-Myles S, Anderson M, Shapiro ME, Chu C. The impact of mass incarceration on outpatients in the Bronx: a card study. J Health Care Poor Underserved 2009;20:1049-59.
4. The color of justice: racial and ethnc disparity in state prisons. Washington, DC: The Sentencing Project, June 2016 (https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/).
5. Tobin Tyler E. Medical-legal partnerships in primary care: moving upstream in the clinic. Am J Lifestyle Med 2017;13:282-91.
6. Health care's blind side: the overlooked connection between social needs and good health: summary of findings from a survey of American physicians. Princeton, NJ: Robert Wood Johnson Foundation, December 2011 (http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2011/rwjf71795).
7. The justice gap: measuring the civil legal needs of low-income Americans. Washington, DC: Legal Services Corporation, June 2017 (https://www.lsc.gov/media-center/publications/2017-justice-gap-report/).
8. McKoy JM. Obligation to provide services: a physician-public defender comparison. Virtual Mentor 2006;8:332-4.
9. Shavit S, Aminawung JA, Birnbaum N, et al. Transitions clinic network: challenges and lessons in primary care for people released from prison. Health Aff (Millwood) 2017;36:1006-15.
10. Harris A, Huebner B, Martin K, et al. United States systems of justice, poverty and the consequences of non-payment of monetary sanctions: interviews from California, Georgia, Illinois, Minnesota, Missouri, Texas, New York, and Washington. Seattle: Laura and John Arnold Foundation, November 2017 (http://www.monetarysanctions.org/wp-content/uploads/2018/01/Monetary-Sanctions-2nd-Year-Report.pdf).
11. Trott J, Peterson A, Regenstein M. Financing medical-legal partnerships: view from the field. Medical-legal partnership fundamentals. Issue brief two. Washington, DC: Robert Wood Johnson Foundation, April 2019 (https://medical-legalpartnership.org/wp-content/uploads/2019/04/Financing-MLPs-View-from-the-Field.pdf).

DOI: 10.1056/NEJMms2002585