Encyclopedia of PRISONS & Correctional Facilities

SAGE reference

Health Care

SIDEBARS:
Health Care

Methods for diagnosing and treating illness are the same, whether the patient lives behind bars or in free society. No convincing legal or ethical argument can be made, on the basis of arrest, conviction, or sentence, to justify denying prisoners a level of health care that is equivalent to the community standard.

Though the principles and criteria governing medical practice for incarcerated persons are identical to community standards, the correctional context introduces important differences. Concern for safety and security is preeminent. Consequently, there may be compromises in privacy and confidentiality. **Health** care service delivery in correctional facilities is less efficient, given the need to secure all sharp items and medications from possible misuse. Movement and transport are necessarily controlled and restricted, resulting in downtime for health professionals between patients. Patients also have less freedom to choose among providers, though they remain autonomous and free to accept or reject treatment.

Caring for sick prisoners is challenging. Penal institutions were never designed for the purpose of providing health care. Their environment, regimentation, physical plant, and lifestyle are anything but therapeutic. Nevertheless, prisoners do become ill—sometimes quite seriously.

COURT-ORDERED REFORMS

Prior to the mid-1970s, prisons were virtually closed to public scrutiny, and convicts were accorded few rights. Most health care services were provided by other inmates—usually without formal training and with only rudimentary medications and equipment. Professional health care providers were few. Many of these had licensing, competence, or sobriety problems and could not find gainful employment elsewhere. As a result, abuses abounded. Sometimes medical care was denied as a form of punishment or because of the whim of an officer.

Few gave credence to prisoners' complaints. Judges ruled it was not the business of courts to meddle in the internal affairs of prisons and left these matters to the discretion of correctional managers. This state of affairs continued until the 1960s and 1970s, when white, middle-class, affluent, educated, and socially well-connected people were incarcerated for civil disobedience or other activities in civil rights and antiwar demonstrations. These activists generally had greater credibility than the typical inmate, whose only contact with a lawyer may have been with a public defender. Amid voters' rights rallies and Vietnam War protests, legal defense societies were quickly mounted to provide competent defense and advocacy.

Soon class action suits were filed, grouping similarly situated inmates together as plaintiffs seeking redress. Most were filed in federal courts and sought relief under 42 U.S.C. § 1983 of the Civil Rights Act from conditions of cruel and unusual punishment prohibited by the Eighth Amendment. In 1976, the U.S. Supreme Court in *Ruiz v. Estelle* ruled that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment."

Following *Ruiz v. Estelle*, an avalanche of litigation ensued. Some suits were successful. Many resulted in court-ordered consent agreements and required defendants to implement sweeping changes under the watchful eye of court-appointed monitors. Besides medical and mental health care, reforms addressed overcrowding, brutality,

nutrition, and access to courts. The most fundamental health arena changes required access to professional medical evaluation and prohibited interference with ordered medical treatment.

These improvements were costly, and some court-ordered reforms may have been excessive. In 1996, the Prisoner Litigation Reform Act swung the pendulum the other way, rendering access to courts much more difficult for inmate plaintiffs. These days, therefore, it is difficult for inmates to address health care problems through the court process. Instead, they must try to deal with any complaints they have at the institution where they are confined.

MEDICAL STANDARDS AND ACCREDITATION

Following public outcry over prison conditions, the American Medical Association formulated jail and prison health care standards in the late 1970s. These were subsequently adopted by the National Commission on Correctional **Health Care**. The American Correctional Association's facility-wide standards for various types of correctional institutions also addressed health care issues. Promulgation of standards was accompanied by development of accreditation mechanisms to assess voluntary compliance.

Correctional health care professionals credit the dual influence of court involvement and the standards and accreditation process for improving access to quality medical care for the incarcerated. **Prison** and jail clinics are generally staffed with an adequate number of competent health professionals; inmates no longer provide health care; treatment is documented in accordance with contemporary standards; many sites have viable quality improvement programs. The quality of health care typically available to prisoners today approximates that required by the standards and follows contemporary community practice. Glaring abuses and deficiencies are largely past.

The National Commission on Correctional **Health Care** endeavors to upgrade the quality of jail and prison clinical staff by encouraging them to become Certified Correctional **Health** Professionals and to join the Academy of Correctional **Health** Professionals. The American Correctional **Health** Services Association also sponsors programs to facilitate networking among correctional health care providers and raise their knowledge and professional awareness. Prisons and jails once were the refuge of questionably competent medical providers. Today, no stigma is attached to work as a prison doctor or nurse. Good—even outstanding—professionals are being recruited to this work.

RISING COSTS OF CARE

Partly because they are sicker, partly because they have little opportunity for self-care, and partly because confinement and idleness promote excessive focus on their bodies, prisoners tend to require more, rather than less, health care. The causes of their illnesses often predate their incarceration and include unhealthy lifestyles, trauma and injury, malnutrition, heavy use of drugs and alcohol, and generally poor access to the health care delivery system.

Following the huge increase in the number of incarcerated in the United States, the cost burden of health care services in corrections has reached staggering proportions. Medical costs are 9% to 12% of the total cost of corrections. In addition to the sheer number of inmates who need medical treatment, several other factors contribute to this high cost: (1) the growing number of elderly prisoners, (2) technological and qualitative improvements (e.g., new, costly medications and procedures), (3) focus of attention by courts and media, (4) communicable diseases such as AIDS and hepatitis C that are difficult and costly to treat, and (5) ravages of substance abuse. Each of these factors requires increased staffing, pharmaceuticals, hospitalization, and liability insurance.

To cope with and attempt to reduce these costs, some correctional jurisdictions turn to privatization to divest themselves of the direct burden of managing and supervising health care programs and of the responsibility for

controlling costs. This strategy has had mixed results. For smaller facilities, where acquisition of in-house expertise is often difficult, private companies bring the benefit of patterned approaches to policies and methods. Some large state systems also have gone this route, though they might do as well and at lower cost by employing competent managers and providers. On this point there are differing opinions.

KEY PROGRAMS

Correctional health care provides a number of key programs throughout a person's sentence. The most important of these are described below.

Intake Screening

Correctional facilities perform a brief health screening of each inmate immediately upon arrival to determine whether an emergent or serious health problem exists, whether there is significant risk of suicide or of alcohol withdrawal, and if medications are required. These needs should be attended to within the first few hours of arrival. Within the first 7 to 14 days, inmates undergo physical health assessment and mental evaluation to provide baseline information for their medical records.

Suicide Prevention

Health care providers and correctional staff should be trained in suicide prevention. Research indicates that individuals are most likely to try to take their own lives in the first hours of detention. Self-harm and suicide attempts can take place, however, at any time. Those determined to be at elevated risk for suicide require close supervision and, when clinically indicated, may have their property or clothing restricted. In rare instances, and despite literature criticizing this practice, brief use of restraints may occur. However, it often suffices to keep patients under observation in a setting where social interaction with others can occur, such as a day room, rather than secluding them in a cell. Isolation tends to exacerbate the loneliness, sadness, and depression already being felt.

Medication

Ensuring that outpatients receive their medications in the doses and at the times prescribed is one of the most important tasks of prison health care personnel. This is also often one of the most difficult jobs to do. Rules vary as to whether inmates are allowed to keep medications in their own possession. Prisons tend to be more lenient on this practice than jails because the inmates are better known to staff. National standards insist that medications be dispensed and administered in full compliance with state and federal pharmacy regulations.

Sick Call

“Sick call” refers to the scheduled opportunity for prisoners to see a health provider face to face. Patients generally initiate nonemergency requests by writing a note for review by a nurse, who subsequently schedules an appointment with an appropriate provider (nurse, physician, dentist, psychologist). All sick call encounters are documented in the medical record.

Segregation Rounds

The health and well-being of persons housed in segregated settings, apart from the general inmate population, pose special concerns. Standards require thrice weekly to daily visits from health care staff to ensure that health problems do not go undetected.

Emergency Response

Every correctional facility has a response plan or strategy for emergencies. If health care staff, typically nurses, are on site when a medical emergency occurs, they are summoned to the scene. However, officers are trained in First Aid and cardiopulmonary resuscitation to serve as first responders until the nurse arrives. Serious illness or

injury usually results in a call to the local ambulance and paramedic service, and the patient is taken to a hospital emergency room, accompanied by a correctional officer.

Many correctional facilities now include an automated external defibrillator in their emergency response kits and ensure that nursing staff and officers are trained in its use. This precaution enables fast response to cardiac victims among inmates, staff, or visitors.

Chronic Disease Management

When the number of patients with chronic illness is sufficiently large, it becomes efficient to schedule weekly or monthly chronic disease clinics apart from the times acute and new patients are seen. The appropriate provider calls chronic patients to the clinic for routine testing and follow-up according to the treatment plan. Especially in systems with multiple providers, use of approved chronic disease guidelines can help ensure consistency in treatment and avoid substandard care.

Contagious Disease Control

Close living quarters present elevated risk for spread of contagious illness. Consequently, correctional authorities must take systematic precautions to minimize transmission of infectious disease. AIDS, hepatitis B, hepatitis C, and tuberculosis are major concerns. These diseases abound among prisoners because of previous lifestyles, including needle sharing and substance abuse.

Mental* Health *Services

Since the 1970s, state mental hospitals have systematically deinstitutionalized (discharged) their patients to receive care in the community. Many of these women and men have been reinstitutionalized into prisons and jails. Such people generally cope poorly under the conditions that prevail in general prison populations. Many require a special intermediate-level mental health unit where antitherapeutic stimuli are minimized.

***Dental* Care**

Prisoners are entitled to basic dental care. Such treatment usually provides them with fillings and routine endodontic and periodontal services. Gold crowns and extraordinary prosthetic or restorative measures are usually not allowed.

Detoxification and Withdrawal

Jails, especially, must identify new arrivals at risk of serious consequences of overdose or withdrawal from alcohol or drugs. Each new inmate is questioned about recent use of intoxicants and whether difficulty was previously experienced when discontinuing these substances. Mild to moderate symptoms can often be managed in the correctional facility, but severe symptoms of withdrawal nearly always require prompt admission to a hospital.

***Off-Site* Care**

While smaller facilities refer all complex and specialty care to off-site providers, large correctional systems find it cost effective to schedule certain specialty clinics on site. Some even provide minor surgeries, dialysis, and inpatient care within the walls. When a prisoner requires medical care beyond the level available in the facility, services are arranged with a community provider or medical specialist. If necessary, the prisoner is admitted to a local hospital. Unless the hospital has a secure unit staffed by a cadre of officers, a correctional officer is assigned to remain by each prisoner's bedside to prevent escape or harm to other persons.

Pregnancy

Many pregnant prisoners are at high risk due to drug abuse, lack of prenatal care, AIDS, recent trauma, and other factors. They require close and specialized monitoring and care. Accommodations may be needed in diet,

living conditions, and work assignments. Every effort is made to ensure delivery in a community hospital. Very few correctional facilities in the United States permit incarcerated mothers to be accompanied by their infant and small children, though this practice is more common in other countries.

The Elderly and Disabled

To meet the special needs of the growing number of elderly and disabled inmates, some larger correctional systems are establishing dedicated housing units. These are barrier free, readily accommodate wheelchairs, and afford a more leisurely and less regimented and stressful routine. Like community homes for the aged, they make life more tolerable. Some chronic illness conditions can also be cared for in these units.

***End-of-Life* Care**

Prison systems find it increasingly necessary to cope with dying inmates. Until recently, all but the most sudden and unexpected inmate deaths occurred in community hospitals. Wardens and jail administrators went to extreme lengths to ensure that nobody died in the institution. Instead of peaceful and reassuring surroundings, patients were unnecessarily subjected, during their final days and hours, to frightening sounds, commotion, and unfamiliar faces.

Dying prisoners experience the same kinds of disability, pain, anxiety, fear, confusion, incapacity, and needs as do free citizens who face old age and death. They, too, want closure, need to say farewell, desire to forgive and to be forgiven, appreciate kind words, crave companionship, require assistance, and fear dying alone. Separation from family and friends only exacerbates these problems. A few prisons have established special policies and programs to cover the final phase of life, relaxing visitation rules and other restrictions and utilizing the services of specially trained inmate volunteers to sit at the bedside, assist with activities of daily living, and provide companionship during the last days. Demonstrable benefits of this practice include redemptive and rehabilitative effects for the inmate caregivers themselves. Prisoners in these programs are allowed to die peacefully in a familiar environment and are appropriately permitted to refuse unwanted life-prolonging rescue methods.

Transitional Case Management

Transitional case management approaches have been successfully employed to assist terminally or seriously ill and disabled inmates to cope in the community after release from jail. Using case managers to prepare living and support arrangements prior to release and to afford follow-up guidance and assistance afterward, these programs can reduce recidivism and promote humane living conditions and should be implemented in collaboration with other agencies.

HOW MUCH CARE?

Medical care of inmates is subject to limits, just as it is in the community. Those whose care is paid by public funds or insurance policies cannot demand every expensive procedure, regardless of need. Cost must always be balanced with need so that there are sufficient resources for all.

Inmate status and nature or gravity of the crime—such as gender, race, color, creed, or ethnicity—have no bearing on such decisions. Even expensive procedures such as organ transplants ought not be denied solely because of inmate status. Age and expected years of life remaining, general health condition (including comorbidity), likelihood of successful response to treatment, and patient's wishes are relevant.

A jail or prison ought not deny or withhold a necessary treatment or diagnostic procedure because of lack of funds. Previous failure to access health services while in the community does not justify denial of care. Jails or prisons may defer treatment of short-term inmates until released from custody, provided a determination is made that this will not pose undue risk to the patient.

CONCLUSION

A healthy tension should exist between correctional authorities and the responsible health authority. If open and constructive discussion is repressed or discouraged, the differences in approach, policy, and mission can result in imprudent decisions. There is no real contradiction between the principles and practice of good correctional programs and good health care programs. Each party needs to be familiar with the content and rationale of the other's policies. **Health** care professionals should never fail to be their patients' advocates.

—Tara Frechea

—Kenneth L. Faiver

Health Care

I have been incarcerated for close to five years now and have been in four different institutions. I was in a serious motorcycle accident when I was sixteen. I broke my left leg in three places, shattered my left ankle, suffered many internal injuries, and injured my back, which caused complete paralysis from the knee down on my left leg. I have had several operations because of these injuries. Since I have been in the federal prison system I have had to beg and plead with the medical staff to get even basic needs met.

I started my time at Carswell's Federal Medical Center in Ft. Worth, TX. I had three surgeries there, two on my back and one on my left leg and ankle. My back surgery was successful. The surgery, which was a fusion of my left leg and ankle, was a whole different story. The orthopedic surgeon that performed the surgeries set my cast crooked after the surgery.

Later, when I was transferred to FCI Dublin, still in my cast, the cast was removed. I was horrified because my foot was permanently crooked, turning inward. It looked deformed and remains that way today. I was devastated, as I still am. Before surgery I wore a leg brace (from the knee down), but my foot was straight. If I wore pants you could not even tell that anything was wrong with me. Now even with pants on it is quite evident that my leg is crippled. I am very self-conscious about it, but at this point there is nothing that can be done. I will try to get it corrected when I get out. I asked medical in Dublin if they could fix it. The head of medical there, told me that I would have to go back to Carswell for a procedure like that because they could not provide the aftercare necessary. Plus they did not want the liability. Needless to say, I decided not to go back to Carswell.

I do have to give credit, where credit is due. The physical therapy department in Carswell was real good, and I had a very caring and competent physical therapist. They also made sure I got my medications, my leg brace, and special shoes.

After FCI Dublin I went to Phoenix **Prison** Camp, and now I am currently at the Victorville **Prison** Camp in California. For the most part, with all the prisons I have been in it has been the same old story. There is no order and they are incompetent, with Phoenix and Victorville being the worst. I have been going to doctors for years before my incarceration, and I have never seen nothing like this. You rarely ever if at all, see a doctor. It is usually a physician's assistant or a nurse who cares for our medical needs; anything from a headache to terminal cancer, and it is usually the same treatment—Ibuprofen. I never once saw a doctor the whole time I was in Phoenix, which was over one year. I did write them up for negligence to their regional director, and I did win.

I have been in Victorville for three weeks now and have not yet seen a doctor. It is a task just to get your prescriptions filled here. When I asked the physician's assistant what the problem was, she told me that they were just overwhelmed with work because there are so many inmates. And that, I believe, is exactly it. They are all short staffed and don't have the time to spend on our individual medical needs. I am sure our medical care would improve considerably if there was enough medical staff for the inmate population. But until that happens, we will go without.

The Bureau of Prisons's sole function is not to simply warehouse inmates, but while in their custody, we have the

right to receive health care in a manner that recognizes our basic human rights. Our eighth amendment right states that we are not to be subjected to cruel and unusual punishment. To be left sick or in pain is cruel and unusual punishment.

Tara Frechea, *Federal* **Prison** *Camp Victorville, Adelanto, California*

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