Chapter 4. Improving Correctional Health Care: A Unique Opportunity to Protect Public Health

This chapter reviews the extent to which prisons and jails provide prevention, screening, and treatment programs for communicable disease, chronic disease, and mental illness. The chapter then examines whether current correctional prevention and treatment efforts for selected communicable diseases and for mental illness meet accepted national standards for correctional health care. The findings suggest that there is a tremendous opportunity—as yet, largely unexploited—to protect public health by improving current correctional prevention, screening, and treatment programs.

Current State of Correctional Prevention, Screening, and Treatment Programs

Chapter 3, "Prevalence of Communicable Disease, Chronic Disease, and Mental Illness Among the Inmate Population," documented that communicable disease, chronic disease, and mental illness are prevalent in prisons and jails. Many specific conditions are more prevalent among inmates than among the general population. The discussion below suggests that many correctional agencies are not doing enough to address most of these medical conditions.

Communicable disease

Data suggest that many prisons and jails are not adequately addressing three communicable diseases—human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), syphilis, and tuberculosis (TB).[1]

HIV/AIDS. Although rudimentary HIV education programs are becoming more widespread in correctional facilities, few prison or jail systems have implemented comprehensive HIV-prevention programs in all of their facilities.[2] Most correctional systems provide HIV antibody testing only when inmates ask to be tested or have signs and symptoms of HIV disease. Testing is not aggressively "marketed" in most correctional systems. Some correctional systems, however, are beginning to implement an integrated continuum of care for inmates with HIV and AIDS.

Syphilis. Very few correctional systems routinely screen inmates for syphilis. Despite the availability of fairly inexpensive diagnostic and treatment modalities for syphilis, a national survey conducted by the Centers for Disease Control and Prevention (CDC) found that fewer than one-half of all jails (46–47 percent) offer routine laboratory testing for the disease as a matter of policy. Even jails that report aggressive screening policies actually screen fewer than one-half of inmates (48 percent). As a result, on average fewer than one-quarter of jail inmates undergo laboratory testing for syphilis while incarcerated. In jails that offer testing only to patients with suggestive symptoms or signs, only 2–7 percent of inmates are tested. Continuity of care for inmates released with syphilis and other sexually transmitted diseases (STDs) is also inadequate.

Tuberculosis. Although more prisons and jails screen for TB than for STDs, too few conduct TB screening. According to a 1997 survey conducted for the National Institute of Justice (NIJ) and CDC, more than 90 percent of State and Federal prisons, and about one-half of jails, routinely screen at intake for TB. In part, however, because of short inmate stays in jail, TB skin test results—which require 48–72 hours before they indicate infection—may not be read.[3] Ninety-eight percent of State and Federal prison systems and 85 percent of jails report that they isolate inmates with suspected or confirmed TB disease in negative pressure rooms. Some facilities, however, do not test the rooms to ensure that they are working properly, or they use the rooms even when they are known to be out of order.

Directly observed therapy for latent TB infection (watching patients swallow each dose of medication) is the reported policy for all patients in 91 percent of State and Federal prisons and in 85 percent of jails. Correctional systems may have appropriate policies in place related to TB, but implementation of those policies may be inadequate.[4]

Chronic disease

As part of *The Health Status of Soon-To-Be-Released Inmates* project, a survey was conducted examining prevention, screening, and treatment services for chronic disease offered by State departments of corrections (see chapter 2, "History of the Project").[5]

Treatment protocols for chronic diseases in corrections systems. As shown in table 4–1, only 24 to 26 of the 41 States responding report they have systemwide treatment protocols for diabetes, hypertension, and asthma. Departments of corrections with systemwide protocols tended to be those with the largest average daily population and the largest number of annual releasees. Eighty-four percent of inmates and 78 percent of annual releasees covered by the 41 departments of corrections that responded to the survey were in correctional systems that report they have protocols for the treatment of asthma. Seventy-three percent of inmates and annual releasees from systems that responded to the survey are from systems with protocols for the treatment of diabetes. Seventy-seven percent of inmates and annual releasees from systems that responded to the survey were from systems with protocols for treating hypertension. These figures may be overestimates, however; a content analysis found that most of the clinical "guidelines" addressing chronic disease that correctional systems submitted were incomplete or out of date, making them useless for screening or treating inmates or for measuring quality of care. In addition, although the policies and procedures in place may be acceptable, actual services may be inadequate.

Status of discharge planning programs for chronic diseases. Discharge planning is designed to facilitate an inmate's transition into the community. In the case of health care, discharge planning means that, at a minimum, arrangements are made for inmates to have a contact from whom they can get needed services for any medical or mental condition they may have when they are released into the community. Sixteen of the 41 responding States, housing 61 percent of the total inmate population in the responding States, had policies and procedures for discharge planning for inmates with chronic diseases. Once again, however, the policies and procedures may not be followed, especially in jails; as a result, services may be inadequate.

Twenty-nine of the 41 responding States, accounting for 84 percent of total annual releasees in these States, indicated that inmates with chronic diseases

Table 4–1. States Reporting Systemwide Treatment Protocols for Chronic Disease* (*n* = 41)

	Average Daily Population			Total Annual Releasees		
Chronic Disease	*n*	%**	Mean	*n*	%***	Mean
Asthma (*n* = 26)	692,295	84.2	26,627	338,695	78.4	13,706
Diabetes (*n* = 24)	606,878	73.8	25,287	316,686	73.3	13,195
Hypertension (*n* = 25)	660,520	80.3	26,421	336,320	77.8	13,453

*As discussed in the text, the clinical guidelines from a large proportion of corrections systems that reported that their protocols were incomplete or out of date.

**Percentage of all inmates housed in the prison systems covered by the protocols.

***Percentage of all releasees housed in the prison systems covered by the protocols.

Source: Hornung, C.A., B.J. Anno, R.B. Greifinger, and S. Gadre, "Health Care for Soon-To-Be-Released Inmates: A Survey of State Prison Systems," paper prepared for the National Commission on Correctional Health Care, Chicago, Illinois, 1998. (Copy in volume 2 of this report.)

were given a supply of medication when they were released. Even when a discharge policy provides for a supply of medication upon release, the policy may not be followed because of logistical barriers.[6] Security staff responsible for preparing an inmate's discharge may not inform health care staff that the inmate is leaving, so the inmate does not receive medication.

Mental illness

Surveys have documented that jails and prisons provide inadequate services to inmates with mental illness.

Jails. A study of mental health services in U.S. jails having rated capacities for 50 or more detainees found that few jails provide a comprehensive range of services.[7] Approximately 83 percent of all U.S. jails provide intake screening, but only 60 percent provide full mental health evaluations. Forty-two percent provide psychiatric medications. In response to emergencies, 43 percent of jails provide crisis intervention services and 72 percent offer access to inpatient hospitalization. Although 73 percent of jails report they have suicide prevention programs, the content of the programs is not known.[8] Release planning may be the most important service a jail can provide to reduce the probability of mentally ill releasees returning to jail. Only 21 percent of jails, however, provide case management or discharge planning.[9]

Prisons. Among State adult prisons, 83 percent provide screening and assessment for mental illness, 80 percent provide medication and medication monitoring, 87 percent offer some form of counseling or verbal therapy, and 77 percent have access to inpatient care. Only 36 percent of prisons have specialized housing for individuals with stable mental health conditions.[10]

Corrections' Mixed Record of Compliance With National Guidelines

The information above suggests that many prisons and jails fail at least in part to conform to nationally accepted health care guidelines. Illustrations of this mixed record follow.

Communicable disease

A significant minority of prisons and jails do not adhere to CDC standards with regard to screening for and treating TB.[11]

- About one-fourth of corrections systems do not follow CDC recommendations regarding universal TB screening. About 10 percent of State and Federal prisons and about one-half of jails do not have mandatory TB screening for inmates at intake and annually thereafter. CDC acknowledges that screening may be infeasible in short-term facilities because most inmates are released before the skin test can be read.
- Nearly all (98 percent) of State and Federal prison systems and 85 percent of jail systems have a policy to isolate inmates with suspected or confirmed TB disease in negative pressure rooms. However, 16 percent of State and Federal prison systems and 74 percent of jails report they do not conform to the CDC guideline that respiratory isolation be maintained until patients have tested negative for TB on three consecutive sputum smears.
- Ten percent of State and Federal prison systems and 15 percent of jails do not have policies for directly observed therapy for treatment of latent TB infection. (Only 2 percent of prisons and 5 percent of jails do not have policies for directly observed therapy for TB disease.)

Chronic disease

A significant number of prisons and jails do not appear to adhere to national standards for screening for and treating chronic disease.

As discussed above, the survey of State departments of corrections conducted as part of *The Health Status of Soon-To-Be-Released Inmates* project found that many departments report that they lack systemwide protocols for screening for and treating diabetes, hypertension, and asthma. Analysis of the existing protocols found that most do not meet American Diabetes Association and National Institutes of Health standards for treating these diseases.[12] Correctional health care experts who have visited many prisons

conclude that, although it is relatively easy to provide services that meet national standards, it is rarely done in the absence of any or appropriate treatment protocols.

Mental illness

Most prisons and jails do not conform to nationally accepted health care guidelines for mental health screening and treatment.

Screening. The American Psychiatric Association,[13] the American Public Health Association,[14] and the National Commission on Correctional Health Care[15] have established principles for the delivery of mental health care services in prisons. All of these organizations' standards emphasize that mental health screening and evaluation should be provided by qualified personnel for all inmates as part of the admission process to jail or prison.

The American Psychiatric Association describes the following procedures for identifying inmates requiring mental health treatment:

- Screening newly arriving inmates at the correctional facility immediately following admission.
- Comprehensive evaluation in response to referrals from a screening examination or from other staff, or in response to a self-referral.[16]

As noted in the previous section, 17 percent of jails and prisons do not screen for mental illness at intake, and 40 percent of jails and 17 percent of prisons do not provide mental health evaluations.

Treatment. Professional standards also call for comprehensive mental health treatment. According to the American Psychiatric Association,[17] the essential components of a comprehensive mental health care system include:

- An acute care program.
- A crisis intervention program with infirmary beds for short-term treatment and 24-hour availability of a psychiatrist for clinical evaluations and emergency medications.
- A chronic care program or special needs unit within the correctional setting that can house 30–50 inmates with chronic mental illness who do not require inpatient treatment, but cannot function adequately in the general population housing.
- Outpatient treatment services.
- Consultation services.
- Transfer and discharge planning.

The fundamental policy goal of the American Psychiatric Association guidelines is to provide the same level of mental health care to patients in the criminal justice system as is available in the average community.[18] As noted above, a significant proportion of correctional systems do not provide all the called-for services. In particular, few jails provide comprehensive services. The mental health treatment available to inmates in jails is often limited by inmates' short stays and the small size of most facilities. The Center for Mental Health Services argues that it is impractical for jails to provide therapy and that—

> only four services should reasonably fall within the purview of the jail. . . . Realistically, [jail inmates] . . . should be assessed, provided with emergency treatment, and linked to the [community] mental health care system. Thus, the essential jail services are intake screening, evaluation, crisis intervention, and discharge/transfer planning.[19]

As noted above, few jails provide the "essential" service of discharge planning.

Implications: A Significant Opportunity to Intervene

The previous chapter documented the high prevalence rates—disproportionately high, in some cases—of communicable diseases, chronic diseases, and mental illnesses among inmates. This chapter establishes that many prisons and jails are doing too little to address these conditions. Failure to prevent or treat these conditions is likely to have significant adverse effects on society.

- Released inmates who are not treated for communicable diseases may transmit these diseases to members of the general community.

- Many inmates who are released with untreated communicable or chronic diseases, or with mental illness, are likely to become a much greater financial burden on their local health care system or, if indigent or elderly, a much greater burden on State and national health care insurance systems (Medicaid, Medicare) than if they had been treated while still incarcerated and in an earlier stage of their disease.

By providing comprehensive prevention, screening, and treatment services in prisons and jails, communities can take advantage of a tremendous opportunity to improve public health by reducing the problems associated with untreated inmates returning to the community. The following chapter documents that preventing, screening, and treating communicable disease, chronic disease, and mental illness in prisons and jails would be cost effective. The benefits of prevention and treatment would outweigh the expense.

Notes

1. Hammett, T.M., P. Harmon, and L.M. Maruschak *1996–1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities,* Issues and Practices, Washington, DC: U.S. Department of Justice, National Institute of Justice, July 1999, NCJ 176344.

2. A comprehensive HIV-prevention program provides HIV counseling and testing, instructor-led education, peer-based programs, and multisession HIV-prevention counseling in each correctional facility.

3. Valway, S.E., R.B. Greifinger, M. Papania, J.O. Kilburn, C. Woodley, G.T. DiFerdinando, and S.W. Dooley, "Multidrug Resistant Tuberculosis in the New York State Prison System, 1990–1991," *Journal of Infectious Disease* 170 (1994): 151–156.

4. Ibid.

5. Hornung, C.A., B.J. Anno, R.B. Greifinger, and S. Gadre, "Health Care for Soon-To-Be-Released Inmates: A Survey of State Prison Systems," paper prepared for the National Commission on Correctional Health Care, Chicago, IL, 1998. (Copy in volume 2 of this report.)

6. This was the consensus of *The Health Status of Soon-To-Be-Released Inmates* project expert panels. (See chapter 2, "History of the Project," for a discussion of the composition and role of the panels.)

7. Steadman, H.J., and B.M. Veysey, *Providing Services for Jail Inmates With Mental Disorders,* Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, 1997, NCJ 162207.

8. NCCHC Jail Standard on Suicide Prevention (J–51) requires jails to have a program for identifying and responding to suicidal individuals. Program components include identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing. National Commission on Correctional Health Care, *Standards for Health Services in Jails,* Chicago, IL: Author, 1996.

9. Steadman and Veysey, *Providing Services* (see note 7).

10. Manderscheid, R.W., and M.A. Sonnenschein (eds.), *Mental Health, United States, 1998,* Rockville, MD: United States Department of Health and Human Services, 1999.

11. Hammett, Harmon, and Maruschak, *1996–1997 Update* (see note 1). The CDC guidelines at the time this report was written may be found in "Prevention and Control of Tuberculosis in Correctional Facilities: Recommendations of the Advisory Council for the Elimination of Tuberculosis," *Morbidity and Mortality Weekly Report* 45 (RR–8) (June 7, 1996): 1–27.

12. American Diabetes Association, "Standards for Medical Care for Patients With Diabetes Mellitus," *Clinical Practice Recommendations 2000, Diabetes Care* 23 (supp. 1) (2000): 1–23; American Diabetes Association, "Management of Diabetes in Correctional Institutions," *Clinical Practice Recommendations 2000, Diabetes Care* 21 (supp. 1) (2000): 1–3; National Institutes of Health, National Asthma Education and Prevention Program, *Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma,* Bethesda, MD: National Heart, Blood, and Lung Institute, February 1997; National Institutes of Health, *Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure,* Bethesda, MD: National Heart, Lung, and Blood Institute, November 1997.

13. American Psychiatric Association, *Task Force Report No. 29: Psychiatric Services in Jails and Prisons,* Washington, DC: Author, 1989.

14. American Public Health Association, *Standards for Health Services in Correctional Institutions.* Washington, DC: Author, 1976.

15. National Commission on Correctional Health Care, *Correctional Mental Health Care: Standards and Guidelines for Delivering Services,* Chicago, IL: Author, 1999.

16. Screening is a form of assessment that seeks to identify risks for various diseases, conditions, or behaviors in ways that are quick, inexpensive, and relatively accurate. Essentially, a screen is a form of probability estimate. Diagnostic assessments (or evaluations) need to be thorough and definitive. An example of the distinction between screening and assessment taken from the detection of breast cancer would be the difference between a mammogram and a biopsy.

17. In 1982 the American Psychiatric Association (APA) created a Task Force on Psychiatric Services in Correctional Facilities, and in 1983 APA became officially represented on the board of directors of the National Commission on Correctional Health Care (NCCHC). Henry Weinstein, a board member of both organizations, chaired APA's most recent revision of its guidelines, *Psychiatric Services in Jails and Prisons* (1998), and NCCHC's comprehensive *Correctional Mental Health Care: Standards and Guidelines for Delivering Services* (1999). Jails also have a constitutional obligation to provide minimum care. Custodial facilities have both the duty to protect and the duty to treat serious medical and psychiatric conditions. See Cohen, F., and J. Dvoskin, "Inmates With Mental Disorders: A Guide to Law and Practice," *Mental and Physical Disability Law Reporter* 16 (3–4) (1992): 39–46, 462–470; and Metzner, J.L., "An Introduction to Correctional Psychiatry: Part III," *Journal of the American Academy of Psychiatry and the Law* 26 (1) (1998): 107–115.

18. American Psychiatric Association, *Psychiatric Services in Jail and Prisons.* (see note 13).

19. Goldstrom, I., M. Henderson, A. Male, and R.W. Manderscheid, "Jail Mental Health Services: A National Survey," in R.W. Manderscheid and M.J. Henderson (eds.), *Mental Health, United States, 1998,* Rockville, MD: U.S. Department of Health and Human Services, Center for Mental Health Services, 1999, p. 182.