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PRISON HEALTH SERVICES: ABORTED FROM THE MAINSTREAM

A Critical Review of Health Service Programs for Inmates of Correctional Facilities Throughout the United States

by

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ABSTRACT

At any one time over 400,000 prisoners are incarcerated in state and federal prisons, local jails and juvenile detention facilities. Disadvantaged socio-economic classes are disproportionately represented in the populations of correctional facilities; over 40 percent of all jail inmates are Black, over 50 percent had pre-arrest incomes of less than $3,000.

Reflective of their disadvantaged backgrounds, prisoners are more likely than the general population to harbor undetected health problems of a serious nature. Alcoholics, who should be given medical treatment rather than incarcerated, make up one-third of all arrests. Despite these circumstances, jail inmates rarely receive medical examinations of any sort, and state prisoners may be held for years without medical care. While entry to care is through sick call, access to sick call is often barred by untrained guards.

A common theme running through standards for prison health care services developed by various organizations, including the United Nations and the American Correctional Association, is that medical care provided for prisoners should be equivalent to "mainstream" care in both quality and accessibility. In contrast to these standards, however, recent surveys

conducted by the Department of Justice and the American Medical Association indicate that 49 percent of all local jails lack even basic provisions for first aid, and over three-fourths of all jails have no arrangements for regular medical coverage.

The 1972 ruling in Newman v. Alabama declared that failure to provide adequate medical care is a violation of prisoners' Constitutional rights, and the health care program for federal prisoners with an annual budget of $500 per inmate indicates that adequate prison health services can be provided. In short, the abysmal state of health services in state prisons and local jails reflects lack of both motivation and resources. While yet untested, denial of inmates' rights to health care benefits previously afforded by private insurance, Medicare and Medicaid may be in violation of their Constitutional rights.

PRISON HEALTH SERVICES: ABORTED FROM THE MAINSTREAM

by

John Newport, M.H.A.

Over the past several years, a growing public awareness of the multitude of abuses to which inmates of prisons, jails and other detention facilities are subjected has become manifest. Included among these abuses are severe health hazards, mental as well as physical, which are inflicted upon prisoners by the prison environment itself. In many instances, prisoners with serious medical problems are denied access to needed medical care. What care is provided is often grossly inadequate in terms of both quality and basic considerations for human dignity.

In order to provide a framework within which problems relating to health services for prisoners can be examined, it is helpful to examine some basic characteristics of persons who are held in correctional facilities throughout the country. Tables 1 and 2, taken together, provide some basic profile data. At any one time, close to half a million individuals are held in state and federal prisons, local jails, and juvenile detention facilities across the country. This includes persons convicted and serving sentences, as well as those who are being held awaiting arraignment or trial.[1]

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The composition of inmate populations reflects the disproportionately high rates of arrests and convictions among the poor and members of minority groups. Table 2, which focuses on the aggregate census of local jails, indicates that over 40 percent of all jail inmates are Black, and that over 50 percent of all inmates had pre-arrest incomes of less than $3,000 per year. The vast majority of all prisoners, 9. percent, are male.[2,3]

Reflective of their disadvantaged backgrounds, prisoners are more likely than the general population to harbor undetected health problems of a serious nature. Alcoholics, who should be given medical treatment rather than incarcerated, make up over one-third of all arrests. Despite these circumstances, jail inmates are rarely given medical examinations of any kind, and state prisoners may be held for years without medical care.

Various organizations, including the United Nations, the National Advisory Commission on Criminal Justice, and the American Correctional Association, have set forth standards of minimal criteria for prison health services.[4] A common theme running through these standards is that medical care for prisoners should be equivalent to "mainstream" care in terms of both quality and accessibility. At present, however, these standards are merely innocuous recommendations which carry no legal sanction for enforcement.

Health Services in Local Jails

In most parts of the country, persons convicted and sentenced for relatively short terms, generally six months or less, serve out their sentences in municipal or county jails; those who are sentenced for longer

terms are generally transferred to state-operated prisons. It should be pointed out, however, that local jails do not function exclusively as short-term holding facilities, as it is not uncommon for inmates who are unable to post bail to be detained in jail for several months awaiting trial.

Actual conditions characterizing the health service programs found in local jails stand in vivid contrast to standards which call for services of a scope and quality equivalent to prevailing community norms.

In the National Jail Census conducted by the Department of Justice in 1970, close to one-half of the nation's 4,037 local jails (49.0%) reported that they maintain no medical facilities of any form.[5] As a follow-up from this survey, in 1972 the American Medical Association conducted a nationwide survey to assess more precisely the medical resources and types of care available in U.S. jails.[6]

The A.M.A. survey, conducted by mail, yielded a total of 1,159 usable responses -- representing slightly less than 30 percent of the nation's jails. It appears reasonable to assume that those jails which <u>did</u> return usable responses were likely to have more "adequate" medical programs than those which did not. With this caveat in mind, the A.M.A. survey findings are all the more striking in terms of the paucity of medical care resources which the data reflect.

Highlights of the A.M.A. survey findings include the following:

(1) Over 80 percent of the jails reported that medical facilities, if available at all, were limited to basic provisions for first aid.

(2) Only six percent of the jails reported that inmates are given medical examinations upon entry. Most likely this is an overstatement, as in many instances these "examinations" are conducted by jail attendants without health care training.

(3) Over three-quarters of the jails (77.8%) reported no formal arrangements for medical coverage or surveillance. While virtually all jails reported that prescription drugs are dispensed, they also reported that these drugs are dispensed by personnel without health care training. Illicit drug traffic is a major problem in most large jails.

(4) A sizeable number of jails reported no arrangements for hospitalization, and less than one-quarter reported that inmates requiring psychiatric care are referred to psychiatric facilities.

In-depth studies conducted in certain locales shed further light on the dearth of medical services in jails in relation to inmates' needs. For example, tuberculosis case rates of seven to 16 times the rate among the general population are not uncommon.[7] When the County Health Department in Albany, New York initiated a screening program at the County Jail, 22.6 percent of the first 500 prisoners screened were found to require immediate medical attention. Seven percent required hospitalization.[8]

State Prisons

State prisons, which collectively held over 175,000 prisoners as of 1970, are the furthest removed from any semblance of "mainstream" medical care. Typically set in isolated locations, these facilities house inmates convicted of serious offenses and sentenced to long terms -- often several years and even life. While as yet there have been no nationwide surveys of health services in state prisons, several localized investigations shed some light on the nature and magnitude of the problem.

Health services of state prisons in Pennsylvania, which house some 5,500 inmates, were investigated by the Health Law Project of the University of Pennsylvania Law School in 1972. Major deficiencies uncovered by the investigators -- who described the system as one of the nation's better prison systems, include the following:[9]

(1) Entering prisoners were found to be given only cursory medical examinations, with no provision for ongoing medical surveillance.

(2) Access to "sick call," the only point of entry to medical care, was often barred by untrained guards.

(3) Special diets were virtually nonexistent -- diabetics were simply told to "select their food from regular meals", without being given any instructions or assistance.

(4) Provisions for psychiatric services were grossly inadequate. For example, a convict who tried to hang himself was simply cut down, given medication, and returned to his cell without any form of psychiatric evaluation.

(5) Basic quality controls, e.g. medical audits, were lacking. Also lacking was provision for informed consent, and a mechanism through which prisoners could question care provided or voice their grievances.

(6) Allocation of health care personnel and equipment throughout the system was found to be largely unplanned and not reflective of actual needs. While serious deficiencies in terms of available equipment were noted at the system's two major medical facilities, other facilities contained equipped but unused operating rooms and laboratories. One major prison had no R.N. staffing and prisoners whose backgrounds qualified them to perform useful health care tasks were often given work assignments as janitors.

As a result of the study team's findings and recommendations, a Task Force on Corrections, with membership including both government officials and prisoner representatives, was appointed to develop a comprehensive health care system for the Bureau of Correction. Initial reforms included the hiring of two registered dieticians to implement improvements in the prisons' dietary-food service programs.

While the federal courts have traditionally assumed a "hands off" posture regarding prisoners' rights to medical care, the 1972 Newman v. Alabama ruling may well be an important turning point. In this class action suit brought by state prisoners against the Alabama correctional system, the court ruled that by failing to provide sufficient medical facilities and staff, the corrections agency had violated the prisoners' 8th and 14th Amendment Constitutional rights barring cruel and unusual punishment. Some of the more severe deficiencies brought forth and documented in the plaintiffs' testimony were:[10]

(1) Grossly inadequate health care staffing -- prisoners without formal training routinely dispensed dangerous drugs, extracted teeth, operated x-ray equipment, and even performed minor surgery. Medical coverage was extremely sparse, and nursing coverage throughout the entire system, which houses 4,000 men and women, consisted of only three R.N.'s.

(2) Substandard hospital facilities -- which consisted of an 80-bed unit with no full-time medical staff, and no nursing coverage on nights or weekends, regardless of the severity of patients' conditions. Accommodations for pregnant women consisted of a delivery table with no restraints, located beneath a ceiling with peeling paint.

Flagrant abuses in individual treatment included the case of a 19-year-old epileptic who unsuccessfully petitioned for treatment, and died due to lack of regular medical supervision, and a quadriplegic who died in the hospital unit without receiving any intravenous feeding during the last three days preceding his death.

Ruling in favor of the plaintiffs, the Court ordered major reforms, including greatly augmented health care staffing by physicians and other qualified personnel, a requirement that all prisoners be examined by a licensed physician at least once every two years, and an order that the hospital unit be brought into compliance with HEW regulations for Medicare participation.

Discussion

While most health service programs for prisoners are grossly inadequate, mention should be made of some notable exceptions. The medical care program of the Federal Bureau of Corrections, which operates at an annual budget of $500 per inmate, is far ahead of most, if not all, state and local correctional systems in levels of care provided. This health care program, serving 23,000 prisoners, includes 17 JCAH-accredited hospitals and an intensive outpatient program. In some areas, such as dental care, the per capita volume of service is well above that provided to the general population.[11]

Another noteworthy innovation is the New York City Department of Corrections-Montefiore Hospital affiliation, which became effective in 1973. In this program, the City has contracted with a major teaching hospital to provide comprehensive medical services for 7,000 prisoners at the Rikers Island facility. On-site services provided under auspices of the hospital include a 24-hour emergency service, entry medical examinations, a medically staffed daily sick call, and primary care and specialty clinics. In addition to a salaried medical staff, resident physicians are rotated through the prisoner health service.[12]

In other parts of the country, such as Cook County, Illinois and Dade County, Florida, specially trained nurse practitioners and former military medical corpsmen are being employed to provide a more adequate range of primary care services for prisoners.

While innovative programs such as those cited above indicate that adequate prison health service programs can be developed when the needed commitment is present, health service programs of most prisons and jails are abysmally poor. This is indeed ironic, for as most prisoners come from socio-economically disadvantaged backgrounds and tend to lead rather transient life styles when not behind bars, they are more likely than the general population to harbor undetected health problems of a serious nature.

In most areas, inadequate financial support has been a major deterrent blocking the development of adequate and humane health care services for prisoners. Officials of city, county and state governments claim that their treasuries are caught in a crunch on account of limited revenue-producing capabilities, combined with increasing demands for public services of many forms. Realistically, funding for correctional facility programs ranks quite low in terms of overall priorities, and a conscientious health services administrator who is attempting to upgrade levels of service is likely to run up against a pervasive, below the surface mind set in which prisoners are viewed as "bad people" who consequently should be "punished".

In most state and local prison systems, allowable rates of reimbursement to physicians for services rendered to prisoners are substantially lower than comparable reimbursement for the same type of service provided under Medicare or Medicaid or in a federally-assisted neighborhood health center program. Even before the present malpractice insurance crisis, allowable reimbursement for performing surgery on a prisoner has often not been high enough to pay the proportionate cost of malpractice insurance needed to cover the operation.

In short, in most instances doctors who are willing to work in prison settings are provided rock bottom remuneration for rendering care to a group of patients who are generally extremely difficult to treat. From the prisoner's standpoint, prison health services can right fully be called a "third class" level of care, for in terms of both accessibility and general levels of quality, our country's health care system essentially breaks down into three levels or classes of care:

> First class -- "mainstream" or private sector care, available to private paying patients.
>
> Second class -- public programs for the indigent, including public hospitals and clinics and services subsidized through public assistance programs, e.g. Medicaid.
>
> Third class -- health service programs for "captive populations" who have no recourse, e.g. prisoners and patients committed to mental institutions.

One can safely state that in most instances, mental health services available to prisoners are grossly inadequate by any standard. Even in the relatively well-funded medical care program of the Federal prison system, officials report that existing mental health services are inadequate in relation to the needs of the estimated 15-20 percent of prisoners requiring psychiatric treatment. In the Newman v. Alabama case, plaintiff's testimony indicated that 10 percent of all state prisoners in that state were judged as psychotic, and another 60 percent were seriously disturbed and in need of psychiatric treatment.[13]

The very environment or milieu of the correctional institution often, if not in most instances, poses severe threats to the inmate's psychological well-being. Quoting from the report of the University of Pennsylvania's Health Law Project:

> General prison conditions expose an incarcerated person to daily boredom, loneliness, frustration and tension. The threat of sexual assault weighs heavily; there is no opportunity for heterosexual fulfillment... Privacy and self-determination end at the prison entrance...Educational and work-training programs generally fail to hold promise for good jobs upon release.[14]

Ironically, while a person on the outside may be arrested for drug abuse and sent to prison, in many prisons various forms of mood-altering drugs are prescribed quite freely in a surface attempt to counteract the very real problems of intense frustration, anxiety, boredom and tension which inmates experience as part and parcel of the prison environment.

Likewise, provision for emergency medical services is often grossly inadequate if these services are available at all. Even in the larger prisons that do maintain hospital units, nursing coverage may not be provided on a 24-hour basis. A prisoner in a cell block who is suffering a heart attack may be able to gain the attention of a sympathetic guard, if he is lucky. Even when this is the case, however, bureaucratic encumbrances or lack of an arrangement for emergency medical services may make it impossible to get the prisoner to the care which he needs.

Health service programs for prisoners are also sorely lacking in the area of health education. If realistic attempts were made to match resources with needs, one would expect to find fairly extensive health education programs in operation behind prison walls. For here one is dealing with a captive population where life styles outside of prison are often quite transitory. While prisoners are more likely than the general population to be afflicted with serious health problems, they are far less likely to have sought medical attention. Yet in the greater majority of prisons and jails, even rudimentary provision for health education in such areas as personal hygiene and nutrition is generally lacking. Indeed, one wonders how many prisoners even have access to a tooth brush and tooth paste.

As documented in the A.M.A. survey findings, the greater majority of local jails do not have adequate arrangements for medical coverage. Realistically, it is probably not practical to expect that everyone who is arrested and booked at a local jail should be given a medical examination by a licensed physician. Persons arrested for minor offenses are often released in a few hours.

It might be more realistic for standards to require that all prisoners should be given a medical screening by a skilled nurse or paramedic upon booking, and that prisoners held for more than 48 hours should be examined by a physician. In small jails which do not have arrangements with physicians for daily sick call, arrangements could be made to take prisoners to a private doctor's office or a hospital outpatient department for

medical evaluation. Initial medical screening of newly arrested prisoners might be conducted by R.N.s or other skilled personnel, e.g. former medical corpsmen, who might be retained on a part-time or on-call basis or, in the case of metropolitan jail systems, deployed as circuit riders from larger jails in the system which maintain medical informaries.

In some parts of the country, significant improvements in jail health services have been effected through transferring authority for operation of the health service program to the local public health agency. Such an arrangement can be highly advantageous through opening up health department resources, including clinical staff and hospital facilities, for provision of care to prisoners. Also, the fiscal and administrative separation between health and security staffs can allow physicians to exercise greater objectivity in medical decisions to protect the health of inmates.

While desirable, arrangements for operation of jail health programs by public health authorities are by no means free of problems. In Cook County Illinois, for example, which maintains one of the largest and most over-crowded jail complexes in the country, the Health and Hospital Governing Commission's medical director in charge of health services for the 5,500 inmates held in county jails reports that he has not been able to develop arrangements to ensure that inmates with special dietary requirements due to their medical conditions receive the special diets they require. While the health service agency has authority over medical services for inmates, the food service program is operated by corrections agency staff.

Conclusion

Despite the emphasis over the past decade on the right to health care, this right is by no means a reality for the close to half a million persons incarcerated in correctional facilities throughout the country. While as yet untested, denial of prisoners' rights to health care benefits which had previously been available through private insurance, Medicare and Medicaid and other sources may well be in violation of Constitutional rights barring cruel and unusual punishment.

Where do we go from here? Conceivably, if problems of inertia and legal and bureaucratic hurdles could be overcome, an effective attack could be brought to bear on the problems of prison health services through development of "correctional facility HMOs". Such organizations could be created to provide comprehensive health services to prisoners, tapping funding which would need to be pried loose from such sources as private health insurance, Medicare and Medicaid, and supplemented by governmental funds. Basic components which should be included in a "correctional facility HMO" developed to serve the inmate population of a relatively large jail or prison are outlined below:

A full-time, adequately salaried health care staff, including physicians, nursing staff, technicians, and other needed personnel.

Provision for medical evaluation and follow-up care for all incoming prisoners. This would in turn entail:

(1) Intake medical evaluation

(2) On-site primary care services, with provision for ready access to care

(3) Basic mental health services, which would most likely place heavy emphasis on group therapy modalities and be closely linked to the facility's rehabilitation program. The mental health program should also be directly concerned with the impact of the institution's physical and psycho-social environment on inmates' mental health status

(4) Definitive contractual arrangements for hospital care, specialized outpatient services, and other services which cannot be conveniently provided on-site on a day-to-day basis

(5) A health education program, with particularly heavy emphasis in such areas as personal hygiene and nutrition

(6) Nutritionist/Dietician services to ensure that nutritional requirements of all prisoners are adequately met, and that prisoners with health problems requiring special diets, e.g. diabetics, persons with cardiac problems, etc., receive the special diets which they require

(7) Dental services, including preventive dentistry (tooth brushes, education in oral hygiene, etc.) for all prisoners, emergency dental care, and restorative treatment for long term prisoners

(8) Follow-up services, e.g. "exit health interviews" upon the prisoner's release to impress upon him the importance of obtaining follow-up care for conditions uncovered while in prison, and to aid him in obtaining such care through resources in the community

Financing might be on a modified capitation basis, taking into account the rapid turnover of inmate population which takes place in many jails.

Finally, as we approach the passage of some form of national health insurance, we should strive to ensure that whatever program is adopted shall include provision for financing and ensuring an adequate level of health care services for inmates of prisons and jails, as well as for mental patients and other institutionalized segments of the population.

References

1. Uniform Crime Reports for the United States: 1972, Federal Bureau of Investigation.

2. Survey of Inmates of Local Jails (1972): Advance Report, U.S. Law Enforcement Assistance Administration, Department of Justice.

3. National Prisoner Statistics, Bulletins 47 and 48, U.S. Law Enforcement Assistance Administration.

4. Medical and Health Care in Jails, Prisons, and Other Correctional Facilities: A Compilation of Standards and Materials, prepared by the American Bar Association in conjunction with the American Medical Association.

5. 1970 National Jail Census, U.S. Law Enforcement Assistance Administration.

6. Medical Care in U.S. Jails: A 1972 AMA Survey, American Medical Association, 1973.

7. Whalen, Robert P. and John J.A. Lyons, "Medical Problems of 500 Prisoners on Admission to a County Jail," Public Health Reports, 77:497-502, 1962.

8. Ibid.

9. Health Care and Conditions in Pennsylvania's State Prisons, Health Law Project, University of Pennsylvania Law School, August, 1972.

10. Opinion excerpted from Newman v. Alabama, United States District Court, M.D. Alabama, M.D., as reproduced in Medical and Health Care in Jails, Prisons and Other Correctional Facilities, op. cit., pp. 229-237.

11. Federal Prison Medical Program: Bureau of Prisons, Health Services Division of the U.S. Bureau of Prisons, January , 1973.

12. "Excerpt and Descriptive Data on Agreement between New York City Department of Corrections and Montefiore Hospital and Medical Center (June 1973)," material reproduced in Medical and Health Care in Jails, Prisons and Other Correctional Facilities, pp.293-302.

13. Medical and Health Care in Jails, Prisons and Other Correctional Facilities, op. cit., pp. 229-237.

14. Health Care and Conditions in Pennsylvania's State Prisons, op. cit.

Table 1. Inmates Incarcerated in Local Jails, State and Federal Prisons, and Detention Facilities for Juvenile Offenders: 1970

	No.	Percent
Local Jails:		
Total inmates	160,863	37.1
Adults	153,063	35.3
Juveniles	7,800	1.8
State Prisons	176,391	40.6
Federal Prisons	20,038	4.6
Detention Facilities for Juvenile Offenders		
Total inmates	76,729	17.7
Training Schools	66,457[a]	15.3
Detention Homes	10,272	2.4
Total Inmate Census	434,021	100.0

Source: Statistical Abstract of the United States: 1973. Data compiled by the U.S. Bureau of the Census and the Law Enforcement Assistance Administration.

[a]Includes 10,272 juveniles incarcerated in privately operated detention schools.

Table 2. Socio-Economic Characteristics of Inmates of Local Jails: 1972

Total Inmates	141,600
Race:	
White	79,900
Black	58,900
Unknown	2,800
Education Attainment:	
0-8 years	32,200
9-12 years	94,500
Over 12 years	14,300
Unknown	600
Pre-arrest Annual Income	
Less than $2,000	61,800
$2,000 - $2,999	16,100
$3,000 - $7,499	44,400
Over $7,500	15,100
Unknown	4,200

Source: U.S. Law Enforcement Assistance Administration, Survey of Inmates of Local Jails: Advance Report.

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