CORRECTIONAL HEALTH CARE
PRACTICE, ADMINISTRATION, AND LAW

Edited by
Fred Cohen, LL.B., LL.M.

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Fred Cohen, LL.B., LL.M., Yale Law School, is one of America’s foremost experts on correctional law and is generally recognized as the leading scholar and practitioner in correctional mental health law. He has served as a federal court monitor for medical, mental health care in Ohio’s prisons. Currently, he is monitoring racial and ethnic integration in the Arizona prison system. Professor Cohen received the B. Jaye Anno Award of Excellence in writing on correctional health care from the National Commission on Correctional Health Care. His articles on law and health care appear regularly in CorrectCare, the journal of the NCCHC. He serves also as a legal consultant to a national Jesuit social justice organization, working to bring human rights values to private correction organizations.

Fred Cohen is professor emeritus at the Graduate School of Criminal Justice, State University of New York at Albany, a program he helped found. He continues to lecture and consult widely while serving as executive editor of Correctional Mental Health Report and the widely respected Correctional Law Reporter. His publications number in the hundreds and range from books on sex offenders to a casebook, The Law of Deprivation of Liberty, and the treatise Practical Guide to Mental Health and the Law to numerous book chapters on correctional mental health law. He recently completed a “White Paper” titled Restricted Housing and Legal Issues for the National Institute of Justice.

Fred Cohen was involved in the widely acclaimed PBS Frontline documentary “The New Asylums” and worked closely with Jamie Fellner of Human Rights Watch on HRW’s important book Ill Equipped: U.S. Prisons and Offenders With Mental Illness.

Mr. Cohen takes pride in continuing to hold the NCAA basketball playoff record of 34 rebounds in a single game: Temple University vs. Connecticut, 1956. He notes that while records are meant to be broken, this will probably survive since more players rebound today and they certainly are better shooters.

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Steven Rosenberg is President and Founder of Community Oriented Correctional Health Services (COCHS), a nonprofit organization that works to build partnerships between jails and community health care providers. In 2006, Mr. Rosenberg founded COCHS to develop a public health approach to serving the population of people who cycle through jails, and to connect them to community-based health care. Mr. Rosenberg has over forty years of experience providing technical assistance and
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geon.
Introduction

This book is about significant aspects of the provision of health care in correctional settings (i.e., jails and prisons). It is tempting to follow the usual course and refer to this undertaking as “correctional health care,” and that term is, indeed, in frequent use but with little or no explanation of just what is meant by it.

The most obvious meaning for correctional health care relates to the health care needs of persons confined in jails and prisons and to a lesser, more distant, extent persons who are in some form of legal “at risk” status—for example, persons in community supervision (probation or parole) or halfway house residents (halfway in or out). To be clear, the most dominant reference is to those in custodial status, and that is the jurisdictional basis for this book.

Persons civilly committed to a mental hospital have been committed because of their serious mental disorder and a finding of dangerousness or helplessness (i.e., those who are gravely disabled). They are committed for treatment and yet the term “mental hospital (or civil commitment) treatment” has not found its way into the lexicon. Whether the term might be a reference to a particular modality of care (highly unlikely) or simply the setting itself, “mental hospital treatment” has not emerged as a descriptive term, nor should it.

Correctional health care (medical, dental, and mental) is referenced as a specialty—a specialty for clinicians, for security and administrative staff, and, most certainly, for lawyers as Chapter 1 of this volume makes clear. There is, of course, the highly respected National Commission on Correctional Health Care (NCCHC), which recommends standards for the management and delivery of medical and mental health care in correctional systems. Thus, the imprimatur of vital standards validates the area of concern.

These standards, however, do not embrace a new way of practicing medicine; nor do they deal with when to obtain an MRI, when to do a biopsy, when to do a hematocrit measurement in response to blood loss, how to treat carcinoid tumors, when to do an ultrasound test to determine kidney impairment, or how to perform brain surgery. rather, the standards are essentially procedural and administrative. For example, with reference to chronic disease, Standard P-G-01 calls for the identification of patients with chronic diseases, their enrollment in a program of care with the goals of symptom management, prevention of progression, and fostering improved function, and treatment protocols consistent with national clinical practice guidelines.

The protocols should be informed by the compliance indicators scattered throughout the standards and they, in effect, should form a base point from which to elaborate further. With regard to oral care, Standard P-E-06 states, “Extractions are performed in a manner consistent with community care. . . .” The standards do not address when an extraction is the preferred dental intervention. However, when an extraction is to be done it should not be done in a fashion that would be unacceptable in the outer community.

This distinction is one that pervades correctional health care. That is, when a “correctional dentist” extracts a tooth that would have been salvageable by filling the cavity, that would likely violate community standards as well as the more forgiving legal
norm of “deliberate indifference,” which is the constitutionally required standard of liability when a federal lawsuit challenges the standard of health care in a correctional setting.

Correctional health care should not be viewed as implying some relaxed standard of care for inmates confined in correctional settings. The term focuses on the setting, not on the quality of care provided. The setting, of course, is unique. First, health care for serious health conditions is constitutionally mandated and in its provision, or absence, the operative normative term is “thou shall not be deliberately indifferent.”

Second, there is the omnipresence of security needs in correctional settings. The patient will need a pass to access care, will need an officer or nurse to authenticate the need for medical attention, and will need to overcome a pervasive, cultural norm that often equates an inmate’s request for health care with a desire for secondary gain.

Thus, the inmate too often is viewed as a captive receiving/seeking health care. That is, patient status is not easily conferred on the medically compromised inmate. The inmate is disbelieved and objectified, and thus compromised in his or her humanity.

Correctional health care, as noted, deals with the medical needs of those in penal confinement. There is a legal rights–based framework for correctional health care. Health care in the outside world is insurance based and commodified. While correctional health care has a constitutional, litigation-driven basis—a detainee or convicted inmate has no access to freely chosen providers—the constitutional right to care is quite limited.

As we shall see in the body of this work, a prisoner’s condition must be serious and deliberate indifference is the measure of health care failures.

Along with the need for custody, seriousness, and the deliberate indifference standard, another defining feature of correctional health care is the terribly compromised health of a large percentage of persons in jails and prisons. Lifestyle decisions regarding exercise and diet, inability to access health care in the community, and pervasive substance abuse problems characterize this population.


- In 2011–2012, an estimated 40% of state and federal prisoners and jail inmates reported having a current chronic medical condition while about half reported ever having a chronic condition.
- Twenty-one percent of prisoners and 14% of jail inmates reported ever having tuberculosis, hepatitis B or C, or other sexually transmitted diseases (excluding HIV or AIDS).
- Both prisoners and jail inmates were more likely than the general population to report ever having a chronic condition or infectious disease. The same finding held true for each specific condition or infectious disease.
- Among prisoners and jail inmates, females were more likely than males to report ever having a chronic condition.
- High blood pressure was the most common chronic condition reported by prisoners (30%) and jail inmates (26%).
• The majority of prisoners (74%) and jail inmates (62%) were overweight, obese, or morbidly obese.

• While female prisoners and jail inmates were less likely than males to be overweight, they were more likely to be obese or morbidly obese.

• About 66% of prisoners and 40% of jail inmates with a current chronic condition reported taking prescription medication.

• The majority of prisoners reported having been tested for HIV (71%) and for tuberculosis (94%) since admission. Among jail inmates, 11% had been tested for HIV and 54% for tuberculosis.

• Seventeen jurisdictions reported testing all inmates for HIV during the intake process, eleven reported opt-out-testing, and ten reported opt-in-testing.

• Forty-four percent of prisoners and jail inmates reported a chronic condition compared with 31% of persons in the general population. High blood pressure is rife along with asthma and arthritis.

Access to a facility’s chronic care clinic is vital and also demanding, with so many inmates needing ready access. In higher-security prisons the escort system is so burdensome that some clinicians tell me that they can see only half the inmates-patients they would see in minimum- and medium-security facilities.

What follows is, we believe, a wonderful, perhaps idiosyncratic, series of chapters dealing with some of the most significant issues in correctional health care. These are valuable sources prepared by outstanding experts designed to expand the readers’ information base and provide practical guidance and a legal-ethical framework.

Fred Cohen
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References
