CORRECTIONAL HEALTH CARE SERVICES

Mental Health, Infectious Disease, Dental Care, Addiction Treatment

KENNETH L. FAIVER

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HEALTH CARE SERVICES

ABOUT THE AUTHOR

Kenneth L. Faiver's educational background includes a bachelor of arts (AB) degree in psychology and Latin, licentiate (master) in sacred theology (STL) from Catholic University of America, master in labor and industrial relations (MLIR) from Michigan State University, and master of public health (MPH) in medical care organization and doctorate of public health (DrPH-abd) in health care administration from The University of Michigan.

Faiver served from 1958 to 1969 as a priest, six of these years as pastor of Cristo Rey parish in Lansing, Michigan, and was founder and co-director of the Cristo Rey Community Center. He was also diocesan director of migrant ministry and of the Cursillos in Christianity program. For several years, he chaired the Lansing Human Relations Commission. During and after this time, he was active in the civil rights movement in Michigan and elsewhere.

He was associate director of the Inner City Development Project, a multicenter antipoverty program in Milwaukee from 1969 to 1972. He then spent a year researching the process and outcomes of deinstitutionalization and community placement of the mentally ill and developmentally disabled in Michigan. In 1974, he was introduced to the world of correctional health care when he was drafted to direct a year-long study of the Michigan prison health care system. After a brief stint as research director for the Bureau of Manpower in the Michigan Department of Labor, he was called upon to implement the recommendations of the prison health study. This led to 16 years of service as associate director of health care services for the Michigan Department of Corrections, followed by three years as chief medical coordinator for the Puerto Rican prison system. Since then, his interest and passion to contribute to the improvement of the practice of correctional health care have found expression in various ways.

In 1994, Faiver became actively involved in the accreditation of correctional institutions and has visited well over 100 correctional facilities, either as lead surveyor for the National Commission on Correctional Health Care (NCCHC) or as a health care auditor for the American Correctional Association (ACA). In 1995, he formed a small company to recruit and supply qualified health care professionals for work in state prison facilities and managed the company for 20 years. For part of this time, he also directed a program to provide cognitive behavioral therapy (CBT) drug rehabilitation services in some Michigan jails. Since 1980, he has remained active as a consultant or expert witness in cases regarding prison and jail health care and has done considerable writing in the field of correctional health care—papers at national conferences, articles in journals, and now four books.

He is happily married to Rosemary. They have five children and twelve engaging grandchildren, all delightful and creative—ranging from less than one year to age eighteen. Each is a unique and truly awesome individual. He very much enjoys flying, a hobby dating back 60 years. On a good weather day you may look up and spot him in his little Cessna Cardinal "trying to get a better view of things from up there." Another hobby, short-wave amateur radio, has enabled him to communicate, usually via Morse code, with fellow hams around the world since 1951.

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By

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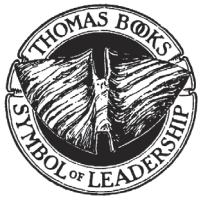

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PREFACE

ORIGINS

The origin of this volume goes back a couple of decades to my book *Health Care Management Issues in Corrections* (Faiver, 1997), published by the American Correctional Association (ACA). A decade later came an invitation for its update, but I soon exceeded the publisher's willingness to print so large a book because I had not only updated, but greatly expanded the earlier chapters and added new ones. The manuscript then lay fallow for a few years, but I couldn't forget it. It haunted me and I felt a gnawing urge to get back on it. Eventually I did. I partitioned the contents into three, found a welcoming publisher (Praeger) for the first volume, and proceeded again to update and polish the contents.

Eventually, the 2017 book was published. It addressed in detail the ethical and legal foundations for providing humane health care to prisoners and it delved into some of the tragic mistakes from recent history when correctional health care professionals regrettably ignored their ethical responsibilities. Next, with the able assistance of Alice Heiserman, we located a publisher (Charles C Thomas) who was willing to tackle the remaining two volumes. I worked diligently on the intended "second" volume, but again exceeded the limits specified in the publisher's contract. I mightily trimmed, sliced, and excised, but still not far enough. Then, as a last resort I decided to add a couple of chapters from the planned "third" volume and then divide this "second" volume into two: one focusing on *Services* and the other on *Access.*

So the pages you now hold constitute the "Services" volume—dealing with mental health, infectious disease, dentistry, and addiction treatment. It should be seen as a companion to the 2017 book on ethical and legal foundations and to the forthcoming (2019) book on *Access to Care.* This will likely complete the opus, but each piece is interrelated. In fact, numerous references are embedded in the text to give notice of relevant material contained in the other volumes.

A DIGRESSION—OR NOT?

Today as I sit writing this Preface, I cannot help thinking about what I was reading this very morning[1] about the current prisoner strike, which began August 21, 2018 and is scheduled to end on September 9 in at least 17 prisons across our country. To summarize: prisoners in multiple institutions are simultaneously refusing to work their institutional jobs or to buy items from the canteen, and are peacefully conducting sit-downs and boycotts and hunger strikes to express their protest—all without violence or property damage. Even 200 immigrants held in a prison in Tacoma, Washington are joining in the protest, adding their specific grievances over the recent forceful and unwarranted separation of refugee parents from infant and minor children and the tragic denial of due process to so many who came to our southern border seeking legitimate asylum from atrocities. I examined the national bill of grievances issued by one of the coordinating entities, Jail House Lawyers Speak (Arnold, 2018), and was relieved to note that none of the demands directly addresses access to or quality of health care services—perhaps a point that we should graciously acknowledge and feel some deserved pride in having collectively, over the past few decades, slowly brought prison and jail health care services out of the Dark Ages and into the twentieth and twenty-first centuries. This was no small feat, and a brief history of this progress is recounted in Anno (2001, 9–40), in Rold (2006), in Faiver (2017, 26), and elsewhere.

However, parallels to the civil rights movement are all too obvious. We did abolish the cruel slave trade and the shameful practice of slavery in our country. We enacted the 13th, 14th, and 15th Amendments. We passed a Voting Rights Act in 1965. We abolished Jim Crow laws. We even elected President Barack Obama. These are welcome signs of progress. Yet we are daily reminded that, buried just below the surface (and at times even boldly exposed on top), are signs and indicators that racial animus, hideous discrimination, and unjust bias run deep and wide across our society. There is much work yet to do. This need is urgent and must not be delayed.

Similarly, the expressed grievances of today's prisoners-on-strike must prompt us in the correctional health care professions to ponder thoughtfully. Exorbitant fees charged to prisoners (or their families) for phone calls, and, in some places, for video visitations clearly wreak severe hardship and injustice on families already impoverished by their loss of a breadwinner. Do correctional mental health professionals perceive any harmful effects on the mental health and well-being of prisoners brought on by policies that so

1. Sincere thanks to Rosemary, my wife, who discovered and sent me the URL about the strike.

effectively discourage contact with loved ones? Are there also any adverse health effects from denial of access to rehabilitation programs? What about the fallout from profit-motivated assaults on good prison management and good correctional health care?

Consider the grievance about the paltry wage (or sometimes no wage at all) paid for assigned institutional labor. Some would say that this matter is well outside the purview of doctors and psychologists, but is it? What does it to do a person's sense of self-worth and personal dignity when one's labor and effort are treated without value or recompense? Could this contribute to an unhealthy state of mind, to bouts of depression, to disinclination to cooperate in rehabilitation, or to suicidal thinking?

The grievance calling for an end to excessively long sentences and removing legal barriers to parole also touches a responsive chord for health professionals. My forthcoming volume in this series will devote chapters to the plight of the elderly and the dying in prisons. It is hard enough to die at home, surrounded by family and attended by the best medical treatment and comfort care—but in prison, the conditions and circumstances are vastly different. As a mid-level octogenarian, I can say with some authority that senescence is not fun and that it surely brings its share of hardships, but just imagine growing old behind bars and fully expecting to die there.

I am also mindful of the present circumstances of my much-loved younger sister who has suffered from severe dementia over the past several years and who, for the past nine months has lived in a wonderful nursing home and care center in Milwaukee. Her loving husband arrives at 7:00 to breakfast with her and remains at her side until she is fast asleep at night. He does this every day without fail, though I have relieved him as much as I could from time to time—enough to allow me to observe firsthand how very much personal care and attention my sister and all the other patients in that facility require for their own safety, well-being, and maximal possible alertness and engagement in brief, but vital social experiences each day. I watch how she and her co-patients are daily encouraged to participate in music therapy, activity therapy, occupational therapy, physical therapy, or speech therapy and how much close personal attention and gentle care they receive from the nurses and aides. Dementia, whether Alzheimer's or another type, is a progressive illness that impairs one's ability to remember, to recognize, to thoughtfully interact, and even to perform acts of self-care like walking, eating, bathing, and toileting. As the prison population becomes ever older, the number of dementia-impaired patients increases each passing month, bringing a corresponding challenge to our correctional health professionals.

Yes, I do feel a supportive response to the heartfelt pleas of these striking prisoners—and I submit that it merits serious consideration by doctors, psychologists, nurses, and other health professionals working in prisons and

jails. Clearly, this particular grievance being proclaimed by the strikers—to end excessively long prison sentences—should resonate with our professional and ethical interests.

These striking prisoners are expressing their protests at significant real personal risk to themselves. In some places, they will be punished even for peaceful protest, and inevitably some acts of retaliation will occur. While I admire their courage, I am also conscious of the objections that some readers will express. Some will say: this is not within our bailiwick; tend to your own knitting; don't lend support to rebellious inmates who refuse to obey the rules; and so forth. Then it occurs to me that the action of these strikers is not very different from that of our forebears—the American Colonists—who wrote the Declaration of Independence and fought the Revolutionary War two-and-a-half centuries ago to protest grave injustices and hardships under King George III, when they could see no other way to achieve justice. It seems hypocritical to condemn the one, but patriotically laud the other.

The intended take-away from these paragraphs about the current prisoner strike is that correctional health care is about more than bandaging a wound, treating a burn, prescribing a pill, fighting an infection, taking an x-ray, performing a surgery, filling or extracting teeth, or doing counseling and mental health therapy. These are all important and should always be done well, attending diligently to issues of quality, informed consent, patient safety, and continuity of care. Still more is nonetheless required of us. We need to expand our horizons. We should be steadfast advocates for our patients. Whenever we become aware of pernicious conditions, harmful policies, and unhealthy practices—that are damaging to prisoners' physical or mental health and well-being—each of us needs to speak up and speak out until we can bring about change. We must speak to those in authority, to those who can make a difference, and, when necessary, to their supervisors and overseers. We may also be required to take our concerns and recommendations to the public and political forum. This thought is eminently central to the theme of this series of books.

OUR PATH FORWARD

The walls and fences that surround our correctional institutions do much more than keep prisoners from escaping. They also keep the public out. They impede transparency and effective oversight. Even the courts have been largely prevented from scrutinizing the harms and injustices wrought by misguided correctional policies and inhumane conditions of confinement, due especially to the noxious provisions of the Prisoner Litigation Reform Act of 1996 (PLRA), a topic that is extensively discussed in Faiver (2017,

137–143, 147), in Schlanger and Shay (2008), and in Schlanger (2015). This law urgently needs to be repealed or radically revised.

That said, allow me to express a few more thoughts to the good readers who, as I reasonably expect, would not even have picked up the book and perused its pages unless already interested and committed to providing humane health care to incarcerated persons and unless also hoping to find in these pages some small inspiration and encouragement and a few ideas to help in carrying on happily and productively in this noble profession.

I have referenced many books, journal articles, and other publications—as evidenced in the bibliography. Some of these are highly respected sources of authoritative and accurate information—like the Centers for Disease Control and Prevention (CDC) and the Bureau of Justice Statistics (BJS). Other sources are professional associations that speak with authority and knowledge in their respective fields, like the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA). Finally, I have cited numerous authors who have written with skill and knowledge and candor about their experiences and research findings and evidence-based recommendations concerning various aspects of correctional health care. I did so because in most instances they know more than I about the subject at hand, and they are addressing what they know both personally and professionally. Readers are encouraged to go directly to some of these sources on topics of particular interest or relevance. In surveying the available printed material on correctional health topics, I am struck by the contrast to the era when I wrote *Key to Health for a Padlocked Society* (Faiver, 1975) and even *Health Care Management Issues in Corrections* (Faiver, 1997), when the total combined published literature in the field would barely fill a small shelf in my office. Today, there is a growing abundance of relevant published material. This is progress, and bodes well for our future. As a profession, we still have much to learn. We need to ponder our past mistakes and omissions and learn from them. We need to publish our findings and insights. We need to remind ourselves (and our colleagues) of the vision and enthusiastic drive we once had to right the world's wrongs and end injustice and evil wherever we find it. We need to put our efforts where they count.

Where do we begin? I recall how I used to enjoy watching a TV serial with my engaging young grandson, Joshua. It was called *Blue's Clues* and each episode solved a mystery through discovery of various clues that needed to be examined and interpreted. Joshua (as did I) quickly learned that if we paid very close attention, we could find the answer without needing to hear a message blaring loudly from the rooftops. We need to be alert to the many clues and subtle indications that show us how we can be proactively instrumental in promoting change.

Readers are, of course, free to disagree with any of the positions espoused in this book. I have tried to make my reasoning transparent. If you disagree based on facts and logic rather than preconceived notions, you have earned my respect. I am a firm believer in working through disagreements with thoughtful dialogue and mutually respectful listening—even in such widely divergent arenas as corrections and health care.

Thankfully, correctional health care professionals now stand in an opportune place and at a pivotal moment in history. We—perhaps more than many others—can and must make a difference. We need to start by putting our ethical principles to work. No man is an island, and when any clod of earth falls into the sea, Europe (or America) is the less for it. When prisoners are treated unjustly, or when their lives are rendered unhealthy—each of us is also thereby affected.

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Among others who deserve mention are my children: Daniel, Michelle, Rebecca, Christa, and Maleika, who have always encouraged me in my writing and have, each in his or her unique way, provided support and helpful feedback. Sometimes they reviewed chapters or portions thereof and offered suggestions. It only seems like yesterday when, as elementary or junior high school children, they approached me with the question: "Dad, what can we tell our friends about your work? How do we explain why you are always going to prisons?" Let there be no doubt—they are still capable of asking hard questions and making me think.

I thank them especially for the dear grandchildren whom they have given us. In order of age, these are: Cameron, Marrianna, Savannah, Lauren, Caleb, Joshua, Galaxy, Isabela, Daniel, Elia, Victoria, and Calais. I solemnly declare them all to be really "great," although it is they who will someday supply us with great-grandchildren. To me they are eager, enthusiastic, innocent, inquisitive, creative, and energetic examples of their contemporaries all across this country who will take our places and inherit the world we leave for them. This is a powerful lesson urging us to make the world a better place, conserve its resources and safeguard its environment and biosphere, strive for peace and understanding, and work to achieve justice and freedom and happiness for all human beings. Sadly, our generation has displayed and emphasized too many of the wrong values and priorities. I continue to derive satisfaction and hope and enjoyment as I watch and love these dear grandchildren, and I thank them for their support, kind words, wonderful smiles, and loving time together. Maybe they will read these books someday, but even more likely they will write better ones. I earnestly wish them well in whatever they do in life and will enthusiastically continue to observe their growth and progress as long as this boon is given to me.

Then there are my friends, coworkers, mentors, and sources of inspiration. Many of them were mentioned in the *Acknowledgments* section of the first book of this series (Faiver, 2017). I just want to say that I have learned much from people like Dean P. Rieger, MD, Craig Hutchinson, MD, Robert S. Ort, MD, PhD, William Byland, DDS, Dennis M. Jurczak, MD, Jay K. Harness, MD, and Perry M. Johnson—with whom I worked closely for many years in the Michigan Department of Corrections and was inspired by their constant and passionate dedication to the improvement of health care of the incarcerated. I have also admired and learned much from people like Catherine Knox, RN, B. Jaye Anno, PhD, Armand Start, MD, and Glenn Johnson, MD, to name a few.

I thank in a special way Alice Heiserman, who must own some responsibility for all of this writing since it was she who first suggested that I write *Health Care Management Issues in Corrections* and served as its editor leading to publication by ACA in 1997. She continues to prod me and guide me through the publications thicket and serves as my agent.

And I thank God—the source of all our blessings—who has given me the longevity and strength to continue in this effort, and in countless ways provided me the opportunities to enjoy the challenges and rewards of a career in correctional health care.

CONTENTS

CORRECTIONAL
HEALTH CARE SERVICES

Chapter 1

ETHICAL FOUNDATION FOR CORRECTIONAL HEALTH CARE

FOCUS OF THIS BOOK

Delivering health services to incarcerated persons involves the use of nearly every type of care that is commonly practiced for patients in the free world, even though the more sophisticated levels of care may be obtained off-site from non-correctional sources. This book will focus on four specific branches of health care services: mental health, infectious disease, dentistry, and addiction rehabilitation. Several reasons account for this selection.

Mental health care is critically important in correctional populations because the prevalence of mental illness is so high—a fact partially explained by a policy decision made several decades ago to close most of the nation's mental hospitals. In their place, a new and highly touted community mental health service was established. Although this latter program serves the needs of many, it is unfortunately widely underfunded and unable to reach effectively the poorer and most needy segments of society. Many thousands were deinstitutionalized—often people with only marginal ability to function by societal norms. Those whose behavior violated the law were thrown into jail or prison because there was nowhere else to put them. Numerous others are among the homeless. As will be seen, corrections has by default largely assumed the role of state mental hospitals. Yet, the correctional milieu and methods are tragically antithetical to the treatment needs of mentally disordered persons.

Chapters 2 and 3 of this book are devoted to the special care needs of mentally disordered persons in prisons and jails, and emphasize the usefulness of special therapeutic environments or intermediate level care units for housing these patients. They also detail important contemporary professional standards of mental health care. Other topics covered include intake screening, suicide, self-injury, crisis intervention, diversion programs, and post-release continuity of care. Issues with use of restraints and segregation, punitive disciplinary measures, and malingering are discussed. Chapter 6 of Faiver (2017) explains the importance of conceptualizing mental illness as a chronic condition.

Prevention and care of *infectious diseases* also occupy a high priority in correctional institutions. One reason is that disease transmission is facilitated by the close proximity of living arrangements. Another reason is that so many prisoners come from poor and deprived sectors of the population where communicable diseases are rampant and too little treatment is available. Additionally, most prisoners lack adequate health education and knowledge about how to prevent spreading infectious diseases. Chapters 4 and 5 are devoted to blood-borne and other communicable diseases commonly encountered in prisons and jails and juvenile facilities.

The topic of *dental care* is taken up in Chapter 6. Dental programs in correctional facilities are sometimes undervalued and have little voice in planning and arranging the health services. Too often, dental care is viewed as "unnecessary" except for obvious dental emergencies. Scant attention is paid to prevention—either by way of teaching good dental hygiene practices or in terms of providing professional prophylaxis on a regular basis.

Chapter 7 covers *substance abuse rehabilitation* services precisely because this topic is so conspicuously absent from discussions about correctional health care. Substance treatment programs are rarely operated under auspices of the correctional health care system. They are usually assigned to the facility's "program director," who also directs education, counseling, recreation, and chaplaincy programs. This is not wrong or unreasonable. What is unfortunate is the routine lack of direct, ongoing, or meaningful coordination with the medical and mental health programs of the facility. Yet comorbidity is very common—persons having a substance abuse addiction and also mental illness or a chronic medical illness at the same time. Topics discussed include the failed War on Drugs, stages of change, the mecha-

nism of addiction, various rehabilitation programs, gender responsive treatment, cognitive behavioral therapy (CBT), comorbidity, how to set up a program, and the role of medications.

The next volume in this series will deal with the special health concerns of selected correctional subpopulations—specifically of women, juveniles, the elderly, and the dying. Largely because these each represent a relatively small percentage of the correctional population, they garner too little attention in planning and design of programs, and consequently also in terms of resource allocation. They have different needs than do the young and middle-aged men who constitute the vast majority of incarcerated persons. These smaller segments of the population warrant special attention and consideration. Clearly, one size does not fit all. Gender-specific and age-specific policies and programs are, therefore, crucially important. Ensuring unimpeded access to health care for all prisoners will be a major theme.

ETHICAL PRINCIPLES AND CONCERNS

The earlier book, *Humane Health Care for Prisoners: Ethical and Legal Challenges* (Faiver, 2017), summarized the ethical and legal principles that undergird and inspire the kind of care prisoners should receive and lays a foundation for this present volume. These principles stem from a recognition of the inherent and fundamental dignity and value of each human person. There follows a corresponding obligation to respect the worth of every individual. Autonomy, privacy, and confidentiality are entitlements of all people. The caregiver is duty-bound and pledged to do no harm (non-maleficence) and to place the patient's health and well-being (beneficence) as the highest concern and priority (loyalty). Dual loyalty situations, however, are problematic, because providers may not ethically act in accordance with the goals of an employer or the government if this is contrary to the best interest of the patient.

The United Nations (U.N., 1948) declared that "All human beings are born free and equal in dignity and rights. . . ." (Article 1); "Everyone has the right to life, liberty and security of person. . . ." (Article 3); "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. . . ." (Article 5); and "Everyone has the right to . . . food, clothing, housing and medical care. . . ." (Article 25).

"It is the privilege of the physician to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, and to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use is to be made of any medical knowledge contrary to the laws of humanity."—words from the Preamble to the *Declaration of Tokyo* (WMA, 2016).

The Declaration of Geneva (WMA, 2017) binds physicians with these words: "The health of my patient will be my first consideration." The International Code of Medical Ethics (WMA, 2006b) declares: "A physician shall act in the patient's best interest when providing medical care."

Ethical obligations deriving from the dignity of the human person are also found in such timeless documents as the *Declaration of Malta* (WMA, 2006a); *Declaration of Helsinki* (WMA, 2013); *Madrid Declaration of Ethical Standards for Psychiatric Practice* (WPA, 2011); *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (U.N., 1991); *Principles of Medical Ethics Relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (U.N., 1982); *Position Statements* of the National Commission on Correctional Health Care (NCCHC, n.d.); *Code of Medical Ethics* (American Medical Association, n.d.); *Code of Ethics* (American Correctional Health Services Association, and American College of Correctional Physicians (ACHSA, 2016 and ACCP, 2016)); and *Ethical Guidelines for the Practice of Forensic Psychiatry* (American Academy of Psychiatry and the Law, 2005). Perhaps the simplest and most intuitively obvious statement of ethical guidance is the *Golden Rule* (Matthew 7:12 and also stated in the teachings of other world religions): "Do unto others as you would have them do unto you."

We subscribe to these principles, having learned from a fairly recent history of mistaken priorities and tragic abuses, including regrettable biomedical experiments that used incarcerated human subjects without respect for human dignity; repeated failure to provide prisoners access to necessary care and treatment; and numerous instances of ill-resolved role conflict such as medical clearance for punishment, use of medication for behavior control, physician participation in executions and in torture, and failure to report abuse or neglect of prisoners.

"Whenever a correctional system denies prisoners access to necessary and adequate health care, it perpetuates a collective crime against the prisoners that is equally as wrong and abhorrent as their heinous crimes against society" (Faiver, 2017, 173). There can be no justifiable reason to provide a lesser quality of health care services to prisoners than to patients in free society. Details of their criminal history or institutional behavior are not relevant to the treatment decisions of health care providers. We are ethically bound to foster access to quality care and must be concerned about issues of informed consent and patient safety, focusing on systematic avoidance of errors, omissions, injuries, accidents, and infections.

Moral Imperative

When society confines a person for reasons of public safety, thereby rendering that person unable to obtain sustenance and care, then society must supply, at a humanely adequate level, the needed sustenance and care. If we lock them up, we are obliged to care for them.

Moreover, because our patients are frequently incapable of effectively speaking up for themselves, we are obliged to advocate affirmatively on their behalf. This responsibility falls to correctional doctors and nurses and other caregivers. One who becomes aware of an unmet potentially serious health need is obligated to take effective steps to remedy that need or to promptly report it to those able to do so. For example, a nurse who learns that a patient's supply of prescribed medication is depleted should initiate appropriate action to renew the order and obtain the medications. A psychologist who discovers mental health deterioration consequent to extended stay in segregation should advocate for proper and timely relief.

Health care providers are also obliged to report any suspected abuse or mistreatment of inmates. The one reporting the incident need not have absolute certainty of the abuse, but only sufficient evidence to warrant a review. This topic is addressed in Faiver (2017, 58, 78–81, 288–289) and in Allen, Cohen, and Rold (2006).

Public Health Implications

Correctional health care does not operate in isolation. Providers of health care to prisoners should understand the ways in which their interventions can also affect the public health. To cite some obvious ex-

amples, prisoners returning to society can carry untreated infection, such as tuberculosis, sexually transmitted diseases, and hepatitis C to those whom they encounter after release. Moreover, the fact of incarceration presents a unique opportunity to be taught good health and hygiene habits that can minimize disease transmission. It also affords an opportunity to treat mental illness and teach effective ways of managing anger and other destructive behaviors, so as to reduce episodes of violence in the community. Finally, because incarcerated persons constitute a significant reservoir of persons with certain communicable diseases, aggressive case-finding and proactive treatment intervention strategically carried out in prisons and jails may have the potential of enabling virtual extinction of the disease. One such instance within reach by virtue of newly discovered cures is the eradication of hepatitis C.

HOW IS DELIVERY OF HEALTH CARE DIFFERENT IN CORRECTIONS?

Given all that has been said, correctional health care providers may have even greater responsibility than do community providers, because prisoners do not get to choose their doctor. The prison or jail controls access to health care, to health information, to medications, and even to OTC remedies, healthy foods, fresh air and exercise, healthy and non-stressful social interactions, and environmental hazard exposure.

Therefore, health care and correctional systems must function smoothly and without error. In the chronic disease program, primary responsibility for regular and timely follow-up is yours, not the patient's. If a diabetic or other chronic patient is lost to follow-up and does not receive regular check-ups and periodic treatments, you may be found liable. Should you fail to speak up responsibly when you become aware that the practice of isolation and segregated housing of mentally ill persons in your facility is severely exacerbating their condition, you become an accomplice. This has serious ethical, moral, and potentially legal consequences for health care personnel.

An Opportunity and a Caution

But what an opportunity to serve! There is value in serving "the least of our brethren"—a designation that aptly describes those in our

care whom society has judged and largely discarded. While we do not decide their situation or legal status—this was the province of the law and the courts—it is ours to oversee and provide care of their bodies and minds and thus to ease, insofar as we can, their burden. This is noble work—generous, dedicated, and committed. Medical professionals who have never worked in correctional settings cannot imagine it accurately. But for most who have tried it, correctional health service becomes a life-long commitment, carrying intrinsic rewards and satisfactions that make it worthwhile.

There are, on the other hand, some who should not be in this profession. Those who view prisoners as unworthy, evil, depraved, or less than human, should not work in corrections. Those who feel that "prisoners deserve whatever they get" and "don't have anything coming to them" should seek work elsewhere.

In Faiver (2017, 81–85), we spoke of those who, after some years in corrections, find themselves falling victim to the corrosive effects of prolonged immersion into the correctional environment. They experience a gradual erosion of their ethical principles and sensitivities. They notice how certain situations easily provoke them to angry or even punitive responses. They realize that this is not the kind of nurse or physician or psychologist they started out to be when they first entered the profession. For them, it is time to pause and take counsel with seasoned dedicated colleagues, take a break, and refresh their principles, ideals, and commitment. Perhaps they can request a change in assignment to help gain a better perspective. What is happening is not unusual or unexpected. It is a form of burnout. But being forewarned can help minimize the effects. Good peer support helps, as can regular attendance at national professional conferences.

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