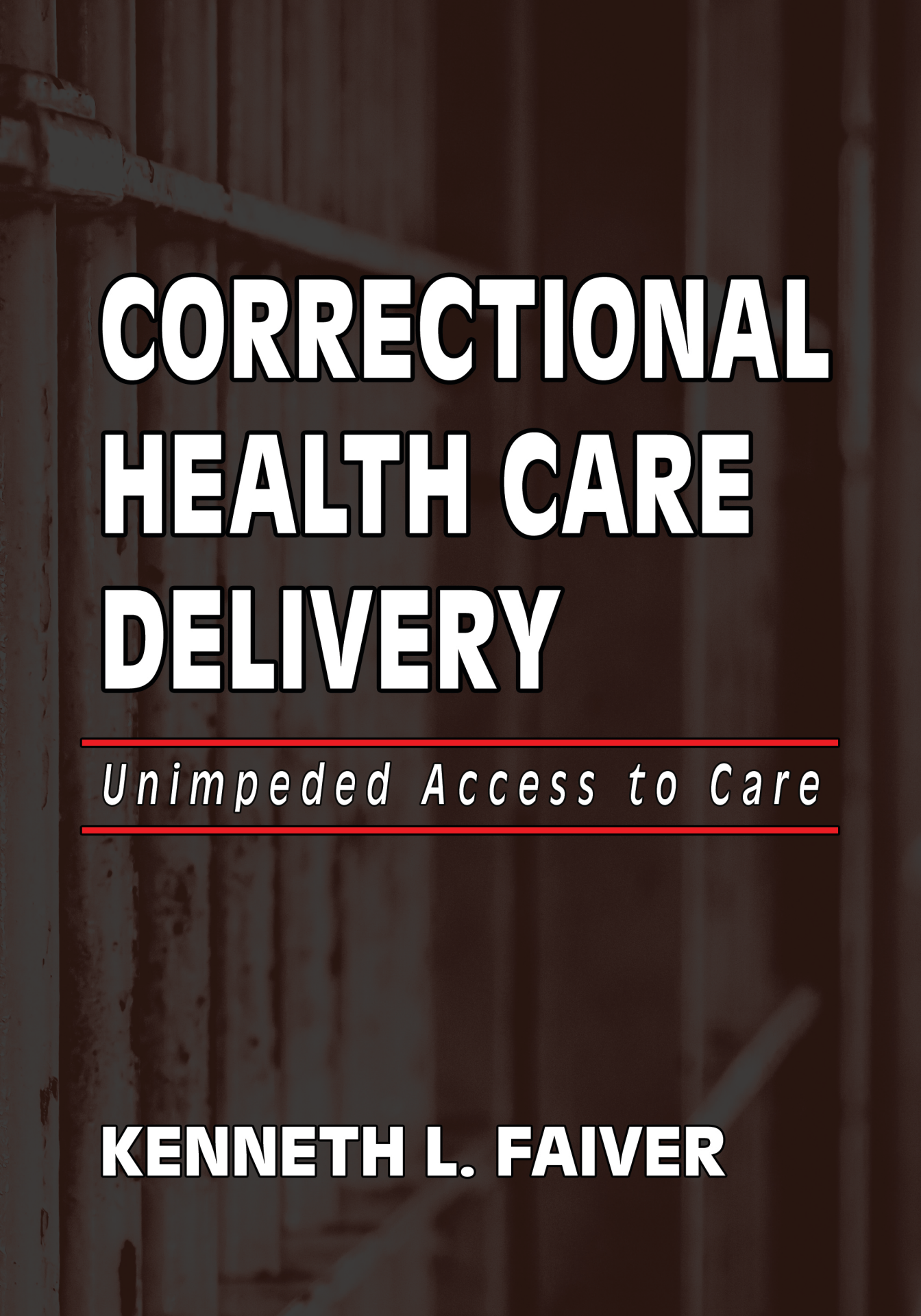

CORRECTIONAL HEALTH CARE DELIVERY

Unimpeded Access to Care

KENNETH L. FAIVER

CORRECTIONAL HEALTH CARE DELIVERY

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CORRECTIONAL HEALTH CARE DELIVERY

Chapter 1

CONTEXT OF CORRECTIONAL HEALTH CARE

GETTING STARTED

Delivery of correctional health care occurs in a context and setting quite unlike any other. Providing health care services in a prison or jail can be called many things, but is never boring. Lorry Schoenly (2015) cleverly likens it to the Wizard of Oz: "You're not in Kansas anymore, Toto!" It feels so different. You pass through security checks and gates to reach your work station. Everything (records and supplies and equipment) is kept locked. Patients sometimes appear in handcuffs. Critical tools and medications are dutifully counted and double-checked at each shift change. Tools are kept on shadow boards to spot missing items more readily. Clinic activity comes to a halt during mobilizations or daily institutional counts.

In the community, the effect of social and economic determinants of health—living environment, socioeconomic status, geographical location, and social class—has been well-documented, as has the cumulative effect of racial and ethnic disparities. For example, "The risk of dying before the age of 65 is more than 3 times greater for those at the bottom than at the top" of the income ladder (Adler and Stewart, 2007). Regardless of improvements in technology and patient care, health disparities and poor health outcomes will persist unless the social determinants of health are adequately addressed (Lathrop, 2013, 42).

Cultural and linguistic beliefs, traditions, and practices prevail among persons of distinct ethnic backgrounds and have relevance to their ability to comprehend, trust, and properly use unfamiliar treatment methodologies. Not only do these factors bear on how much health care service will be required, they also place great demands on care providers to interact effectively with their patients. You can have all this knowledge and skill, but if you cannot communicate with a patient, it is worth little. Cultural competence of providers implies acknowledging the importance of culture, respecting cul-

tural differences, and minimizing negative consequences of these differences (Paasche-Orlow 2004). Sensitivity to the patient's perspective and culture is essential. Having a culturally and ethnically diverse clinic staff that reflects the make-up of the institution helps to reduce health disparities, since the staff will better understand the patients' culture and language and this facilitates patient-provider communication and fosters achieving a therapeutic alliance.

Each of these factors is highly relevant to the notion of access to health care and may be especially so for correctional populations. Health literacy provides a good example. It is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (IOM, 2004). Improving health literacy is both a public health goal and a determinant of health. As such, given the generally limited health literacy of many incarcerated people, time spent by staff answering questions and giving explanations can be absolutely essential if patients are to be afforded real and meaningful access to health care. Providers who fail to use appropriate interventions are negligent if they had reason to know that a lack of understanding due to poor health literacy would expose patients to unreasonable risk of harm.

Wealthier people can afford competent legal representation and so usually avoid jail time and are out on bail or their own recognizance. If imprisoned, they often go to "white collar" lockups where conditions are better, especially in the federal system. However, the patient population of typical jails and prisons derives largely from poorer, less educated, more socially disadvantaged sectors of society, racial and ethnic minorities, and the medically underserved and health illiterate. Many of these have been physically and sexually abused, are victims of violence and trauma, and have engaged in unhealthy lifestyle behaviors. Their per capita health needs exceed the average.

Other differences exist. Prisons and jails subject their occupants to confining, restrictive, punitive circumstances that can be dehumanizing—with minimal transparency or public oversight. Patients have little privacy or personal autonomy and live in an environment designed to impose total control, offering little or nothing each day to inspire or remind the occupants of their personal dignity, worth, and potential. Security is paramount. Management style is paramilitary and defined by policy and procedure. Costs have grown rapidly along with correctional census increase, reaching a level that severely competes with society's other priorities, resulting in short funding and often tight staffing. Under such conditions, staff burnout is common.

Mass Incarceration

Since 1980, the United States has adopted a practice of over-incarceration—relying on punitive and retributive methods to address control in society. We have achieved epic proportions—a census increase of nearly 500 percent in 40 years and now our one twenty-fifth of the world's population confines one-fifth of the world's incarcerated persons. We have, in fact, the highest per capita rate of incarceration among all countries in the world as well as the highest number of incarcerated persons. This cannot be sustained—and is made worse by the undeniable concentration of people of color and the poor. Our sentencing guidelines lead to unnecessarily long imprisonment. We allow political ambition and greed of elected officials to influence and determine application of clemency, pardon, and parole. Over 11 million persons cycle through 3,282 U.S. jails each year. The majority of persons in U.S. jails are awaiting trial, and "99% of the total [U.S.] jail growth in the last 15 years was in the detention of people who are legally innocent," that is, not convicted (Wagner, 2018). These issues are of paramount significance and urgently need to be addressed.

This book acknowledges current realities. Nearly 2.3 million men, women, and children are incarcerated in the United States. Over 600,000 are released each year from state and federal prisons, and 95 percent will be eventually released. The annual budget for federal, state, and local correctional agencies is $80 billion. Table 1-1 compares incarceration rates of several countries. United States is highest, with 655 per 100,000. The District of Columbia and three states (Oklahoma, Louisiana, and Mississippi) each have rates exceeding 1,000, or more than one percent of their population, as shown in Table 1-2. In fact, 23 states have incarceration rates higher than any nation in the world, and only nine countries have incarceration rates higher than Massachusetts, which has the lowest rate among all 50 states at 324 per 100,000 (Wagner, 2018). "Compared to the rest of the world, every U.S. state relies too heavily on prisons and jails to respond to crime" (Wagner and Sawyer 2018).

Except for China, the figures in Tables 1-1 and 1-2 include pre-trial and other detainees as well as persons in prison. The U.S. rate per 100,000 has declined from 739 in 2005, 731 in 2010, and 672 in 2015 to 655 in 2018. Between 2000 and 2018, the world census of incarcerated persons and the world population itself grew at about the same rate of 24 percent. However, the world increase in number of incarcerated females grew by 54 percent (464,900 to 714,417). Women and girls make up 6.9 percent of the global incarcerated population, but they represent 10.0 percent of incarcerated U.S. persons (Walmsley, 2018 and 2019).

The Rand Corporation (Davis et al., 2013, 81) underscored the positive impact of education of correctional populations over the past few decades.

Table 1-1
RATE OF INCARCERATION PER 100,000 POPULATION IN SELECT COUNTRIES
(in September 2018 [all] and September 2017 [women] or latest data available)

Country	*Rate/100,000*		*Country*	*Rate/100,000*	
	All	*Women*[a]		*All*	*Women*[a]
United States	655	65.7	England & Wales	140	6.7
El Salvador	604	58.4	China	118[c]	7.6[c]
Cuba	510	n.a.	Canada	114	7.7
Rwanda	464[b]	29.6	France	100	4.0
Russian Federation	402	33.5	Germany	75	4.5
Brazil	324	21.7	Norway	63	4.5
Iran	284	8.8	Denmark	59	2.4
Israel	236	2.7	Japan	45	8.8
Mexico	164	8.8	India	33	1.4

Source: Walmsley, 2019, Walmsley, 2018.
Notes: [a] includes girls as well as women.
[b] still includes thousands detained during genocide of 1994.
[c] includes sentenced or convicted prisoners only.

Table 1-2
RATE OF INCARCERATION PER 100,000
POPULATION IN SELECT USA STATES IN 2016

State (highest rates)	*Rate/100,000*	*State (lowest rates)*	*Rate/100,000*
District of Columbia	1,153	Connecticut	468
Oklahoma	1,079	New York	443
Louisiana	1,052	Utah	439
Mississippi	1,039	New Jersey	407
Georgia	970	New Hampshire	373
Alabama	946	Minnesota	364
Arkansas	900	Maine	363
Texas	891	Rhode Island	361
Arizona	877	Vermont	328
Kentucky	869	Massachusetts	324

Source: Wagner and Sawyer, 2018.

Their study demonstrated that every dollar invested in correctional education creates a return of $5.00 in the reduction of future criminal justice costs. Why, then, do we continue to invest so few criminal justice dollars in educational programs that are clearly cost-effective in reducing future crime and recidivism, while blindly continuing to pursue expensive approaches that

are demonstrably ineffective (massive incarceration and punishment)? Similarly, we need to place greater emphasis on efforts to restore a sense of self-worth and dignity to incarcerated persons by programs of health and wellness, mental health, and substance rehabilitation.

Mass incarceration is of major concern, but what can we do about it? There is abundant evidence that the prison-industrial complex actively contributes to excessive incarceration through lobbying efforts and targeted campaign contributions advocating harsher sentencing policies and further prison construction. Drug laws and the bail bond system need urgent reform. So also do harsh and mandatory minimum sentences. We should make more use of pardon and commutation. We should be looking at what works in other countries, like Germany, Denmark, Norway, Sweden, and Canada where incarceration rates are so much lower and there are very few life sentences and much shorter prison sentences. Additionally, there are sound reasons to move our criminal justice system away from the unsuccessful punitive philosophy of retributive justice and toward a policy of restorative justice. It is reasonable for correctional health professionals to challenge the status quo and attempt to influence changes that are in the best interest of the health and well-being of their patients.

A Note about Recent Detention of Immigrants in the United States

This book does not directly address the growing problem of massive detention of immigrant or undocumented children and adults by the U.S. government—a number that has grown rapidly under the Trump administration and which, according to eyewitness accounts of legislators and others, occurs under cruel and substandard conditions, marked by unsanitary, overcrowded facilities and documented patterns of abuse and brutality. Many of these people are being detained in private for-profit facilities without effective supervision by government agencies. When numbers of incarcerated persons, whether adults or children, are reported in this book, they do not include all of the persons held in permanent or temporary "immigration" facilities. These people (regardless of citizenship status) are entitled to the same standards of health care and conditions of confinement that are constitutionally guaranteed in the United States and are advocated in this series of books. The fact that they crossed the border illegally, lack documentation, or came here seeking asylum, does not excuse inhumane conditions of confinement or treatment. Therefore, the recommendations of the following chapters (and, indeed, the entire trilogy) are applicable to immigration detainees as well.

SOME ETHICAL PRINCIPLES

Definition

Ethics is a branch of philosophy that addresses morality—whether a course of action is morally right or wrong. This may or may not coincide with what is legally right or wrong in a particular country or society. Legislators and courts define what is legal, but their decisions generally reflect, albeit imperfectly, the current ethical values and norms held dear by society. But legislators can be influenced by greed and political pressure. The deliberative reasoning of courts is often akin to ethical insight as they strive to balance competing entitlements guaranteed by the constitution or laws through application of principles of "rightness" and "fairness," although these can be obscured amid the maze of finely honed distinctions, appeals to precedent, arcane procedure, and political bias (subjectivity) of some judges. In other words, legal and ethical overlap, but are not coterminous. Some things are both ethical and legal, while others may be ethical, but illegal. Still others are unethical but legal (Faiver, 2017, 6).

Source

The most basic principles of ethics are nearly universal and almost intuitively obvious. For example, we instinctively recognize unfairness to be bad. When we feel unfairly deprived of our share, our rights, or our property—we feel wronged. These principles derive from essential human dignity and are related to societal norms, ideals, and traditions. Treating others the way we would want to be treated can be a good guide—essentially the Golden Rule. Put yourself in the other person's shoes. What if my brother, my child, or I were in the situation? What would I want to happen? See also Faiver (2017, 6–20; 2019, 5–7; 1998, 219–254).

We often find a consensus among good and honorable people—and among respected civic and religious leaders—that helps to point us in the direction of what is good and ethical and moral. There are also Codes of Ethics (Faiver, 2017, 10–14) promulgated by professional societies—e.g., AMA, APA, ACHSA, ACCP, WHO, WMA, UN.

Principles

The main principles of ethics relevant to health care begin with the dignity and worth of every human person. Out of this comes respect for personal autonomy, requiring us to have due regard for the choices of the patient. Treatment must not be forced on an unwilling patient. Hence, the need for informed consent.

The basic obligation of medical practitioners is to do no harm (*nonmaleficence*). Its mirror image is to do some good (*beneficence*). Some other important principles are *privacy, confidentiality, loyalty, medical autonomy,* and *justice* (essentially fairness) "People in a free society rightly expect their physicians will care for them, carefully diagnose their illnesses, prescribe proper treatments, and serve as their advocates—always looking selflessly after their best interests" (Faiver, 2017, 7).

Over time, we have seen evidence that society continues to evolve in its degree of civilization—though not in a fully linear or uniform manner. Beliefs and practices that would appear barbaric today were common a scant few generations ago. We would like to think that we are becoming more civilized and that our norms and values continue to evolve (Faiver, 2017, 8, 131). This gives us hope.

Balance

Much of medical ethics is a balancing act between nonmaleficence and beneficence. Medical treatment sometimes causes pain. It might result in loss of an organ or limb or function. But if, when everything is considered, the expected good achieved for the consenting patient outweighs the expected risk of adverse consequences, the intervention is ethical and morally right. There also can be need for a balance between the good of the patient and the well-being of others.

"Ethics is often complex and nuanced, rather than clear, all-or-nothing dilemmas in which we must choose between two conflicting principles. Usually, concerns of both sides require open and candid discussion so that decisions can acknowledge all important nuances and attempt to balance the legitimate demands of both parties" (Faiver, 2018). Ethics deals with choices. Ethical practice involves a systematic approach to decision-making and behavior, considering the interests of all affected parties. Ethics is not a set of rules.

The ethical calculus is complicated in correctional health care by the ubiquitous fact of dual loyalty where, in addition to the physician's duty to the patient, competing or conflicting claims are made by the physician's employer, whether a government agency or a private corporation. The ethical principle of loyalty can be summarized as: "the well-being of my patient is my highest priority." This is consistent with the Hippocratic Oath: "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them." The principle of loyalty is of central importance, namely that the patient's well-being is always the physician's primary concern, so long as it does not bring equal or greater harm to others.

Implications

Flowing from the above medical-ethical principles are these practical implications.

- The fact of incarceration, guilt, heinousness of crime, or contributory behavior is irrelevant and has no bearing on one's entitlement to care and treatment. This principle must enlighten and guide all clinical decision making.
- Medical staff may not—as a matter of principle and ethics—ever enable, condone, or participate in acts of punishment.
- Medical decisions should always select the least restrictive means of achieving the treatment goal, considering all available alternatives.
- Correctional medical professionals cannot limit their interventions to treatment of the sick. They must also seek to prevent illness and injury, ensure patient safety, strive to improve quality of care, respect patient autonomy and dignity, advocate on behalf of patients, prevent abuse, and advise and intervene to mitigate avoidable harm and injury from prison practices and conditions of confinement.
- Medical practitioners have a duty beyond the health and well-being of their own patients. They also have a broader duty to their profession. Thus, even without an established doctor-patient relationship, a prison doctor must advocate on behalf of all persons in that prison, always attentive to the impact of conditions of confinement on health. Otherwise, patients will lose trust in the medical profession as a whole.
- Medical staff are responsible to consider the public health implications of what they do.

As seen in the themes developed throughout this book, there are significant ethical, and often medical-ethical, concerns with issues of mass incarceration, sentences of life-without-parole, housing young persons in adult prisons and jails, neglecting the adolescent health needs of detained youth, failing to meet the known needs of detained women, failure to accord elderly persons in prison with accommodations appropriate to their physical and health needs, failure to accord due care to those dying in custody, failure of staff to affirmatively advocate on behalf of these persons, and failure to respect and accommodate their ethnic, cultural, linguistic, or gender differences and needs. Additionally, there are ethical issues with unnecessary incarceration of persons with advanced dementia or housing them without due regard for their daily needs.

THE REMAINING CHAPTERS

The overarching theme of this book is the importance of ensuring unimpeded access of incarcerated persons to needed health care services. Many challenges to access exist and are discussed, including systemic problems like copayment arrangements, inadequate staff and resources, certain policies, as well as personal problems like health illiteracy, language fluency, mental illness, cultural or ethnic differences, and barriers based on gender, race, or other forms of prejudice. Some ways to combat or mitigate these barriers and challenges are discussed.

An important chapter deals with the issue of privatization of corrections or of correctional health care. While conceding that privatization and profit are not intrinsically bad, there are reasons for concern about the impact of profit motive incentives on adequacy and quality of care to incarcerated persons. Moreover, ideological and philosophical arguments can be advanced to show why it is not fitting or proper for the private sector to conduct, manage, or own the process of detention and custody of persons whom society decides to incarcerate when charging them or finding them guilty of punishable crimes. This is a function that society best handles through its governmental apparatus employing civil servants who are publicly accountable. It is not a function that should be operated for profit in the private marketplace, entrusting the care of voiceless and vulnerable persons to the lowest bidder. Beyond this, the recent history of private for-profit ownership and management of prisons in the United States has been fraught with manifold deficiencies and abuses. Even partial privatization, as in health care, food, transportation, telephone, or money-transfer services have often proved inadequate and sometimes corrupt, largely because lack of transparency shields them from public scrutiny and accountability.

Despite these reservations, the author acknowledges that some for-profit corporations that provide correctional health services are sincerely motivated to serve, not to exploit, and have set up their systems with excellent physicians and nurses, good policies and procedures, commendable staff training and supervision, and have demonstrated the ability to provide exemplary health care services—often better than the governmental agency had previously done on its own.

Therefore, the chapter on privatization is not a condemnation of the practice nor a universal criticism. However, it points out that this approach must be regarded with considerable care and caution. Slick advertising, aggressive lobbying, and covert political pressures create more demand for their services and characterize much of the industry. There is a massive correctional-industrial complex in the United States. The chapter warns states and counties of the potential risks of contracting out, and counsels that in

many instances the government entity could operate its own program at lower cost and with fewer problems than incurred by contracting. To those who have determined that contracting is their best solution, it offers advice on how to avoid common pitfalls and install reasonable safeguards. Of eminent importance is the requirement for the government agency carefully and thoroughly to monitor the program and to establish effective transparency and accountability.

The rest of this book delves into some features affecting the delivery of health care to persons in jails, prisons, and juvenile detention, with special attention to five distinct categories of people: women, youth, elderly, those with dementia, and the dying. For all incarcerated persons, we will insist that diagnostic and treatment approaches and decisions be based on presenting health conditions and an evaluation of risk factors and exposures, without regard to anyone's status in the criminal justice system since this last item is fundamentally irrelevant. When we discussed infectious diseases, mental health, dental care, and substance rehabilitation in Faiver (2019), we noted that humane ethical principles and medical science do not apply differently inside prison walls In other words, the health needs of the incarcerated should be diagnosed, evaluated, and treated no differently than for free citizens.

Chapter 2

UNIMPEDED ACCESS TO CARE

UNIMPEDED ACCESS

Each person confined in jails, prisons, and juvenile detention facilities must be afforded unimpeded access to needed health care. Effectively, this is what the U.S. constitution requires. It means that such persons, without risk of interference or fear of reprisal, are always able to alert health care staff of a medical need, obtain a timely professional evaluation of that need, and receive treatment in the manner prescribed by a competent provider.

What is required is unimpeded access to an adequate *health care system,* not to any specific provider or type of treatment.[1] It must be assured that patients can, without fail, get word to health care staff when there is a need. It is then the responsibility of qualified health care staff to decide in a timely manner, based on appropriate professional evaluation and clinical skill, what is the next step in the treatment process.

As the National Commission on Correctional Health Care (NCCHC, 2018, P-A-01) points out, true access to health care cannot be assured unless the health care delivery system is adequately staffed, funded, and organized. This book explores how different correctional subpopulations require specialized focus and attention to meet essential health needs.

Simply stated, no correctional officer should ever prevent, impede, or inhibit anyone from alerting a health care provider of a perceived need for health services—even when the officer might believe the request to be trivial, fictitious, or undeserved. Officers are neither authorized nor qualified to make this type of judgment. Health professionals are well-advised to disre-

1. A jail or prison need not comply with a demand to be taken to the hospital if the patient refuses to allow a nurse to evaluate the complaint. Except where immediacy of need is obvious and apparent to any reasonable person, the facility is within its rights to designate the nurse as "gatekeeper," consistent with the practice of third-party payers in the free world that require prior authorization for hospitalization (outside of emergencies), and refuse to pay for unauthorized care.

gard opinions of this nature—namely, that the patient is manipulating or abusing the health care system—until after completing an adequate and objective evaluation of the individual's current health status. Only the appropriate clinician should determine what happens next. The right to access to care does not depend on merit or "worthiness," but on the fundamental dignity of each human person.

Health professionals who review sick call request slips may choose to speak briefly with patients during cell or medication rounds. This is called a "triage" of the request for health care. *Triage* involves a sorting by health care staff of requests, whether made orally or in writing, directly to the nurse or through an officer. Requests are sorted according to priority for attention so that the more urgent cases are seen first. They are also arranged by type of service to refer dental cases to the dentist and patients with psychological concerns to mental health staff. Some situations require urgent response; others can wait a few days. When appropriate, the health professional consults the health record to ascertain the patient's history, previously documented condition, and prior response to treatment. Certain cases warrant a face-to-face assessment to make a reasonable determination.

Sick Call Requests

From a risk-management standpoint, it is good policy to establish a method whereby everyone may, on a daily basis, transmit requests for care directly to health care staff without opportunity for interference by any correctional officer. Enacting such a policy does not imply that officers would intentionally interfere with access, but it does recognize the inherent difficulty of proving that an officer did not interfere. It is much easier to demonstrate availability of a daily means of direct contact with health care staff without any intermediary.

Specifically to be discouraged are systems that require sick call request slips to be handed to an officer to hold until delivered to a nurse, or that use a sick call sign-up sheet posted in the housing unit, kept at the officers' station, or passed from cell to cell. An obvious problem with these methods is lack of confidentiality, since unauthorized persons can read whether the person requested to see the psychologist, nurse, or dentist, or wishes to be tested for HIV. While including such information on the request form helps health care staff to determine which provider should see a given patient and with what urgency, these matters are confidential. A second problem is that the sign-up sheet could be destroyed or lost, or a name crossed off the list, thus impeding access.

Many facilities use dedicated locked boxes, strategically located, into which patients may place sick call request slips. These boxes are opened and

their contents retrieved by a nurse each day. Only health care staff possess the keys.

Once clinical staff are made aware of a patient's request and have determined the proper course of action, officers or administrators may not interfere with implementing this decision, whether by threat, innuendo, ridicule, undue delay, failure to notify, failure to escort, or unnecessarily inconvenient scheduling. If there is legitimate concern about appropriateness or need of prescribed care, or if significant delay is expected because of other pressing priorities, the officer should promptly notify health care and explain the difficulty. Often the provider can select an alternative treatment modality or change the scheduled appointment without compromising the patient's well-being. Decisions of this nature are always beyond the competence and authority of anyone except qualified health care providers.

A note of caution is in order regarding mental illness. No one would question whether a person with severe bleeding or high fever needs medical attention. Aberrant or aggressive behavior, however, can be perceived as a "bad attitude" or a disciplinary problem even when it is consequent to a mental disorder causing impaired thinking or judgment. Such matters require a professional diagnosis.

Communicating in a Language that Is Understood

Without accurate communication between patient and provider, access to care is impaired. The English language is not universally spoken and understood by every incarcerated person in the United States. Some are not fluent in English. Even among those with reasonable fluency, English may not be their first language and difficulties can arise when discussing feelings, emotions, and symptoms of mental or physical illness.

Each correctional system must ensure that health care staff can adequately understand and be understood by their patients. Where a number of persons regularly housed in the facility are known to speak a particular language, the best approach is to recruit some bilingual health professionals who can serve as primary caregivers or act as qualified interpreters for that subpopulation. It is also reasonable to use the language department of a university as a resource or to use a certified translator. Translation services[2] are available that will supply, by telephone or video conference, interpreters for virtually any language or dialect. It may also be possible to "borrow" a nurse with the requisite language skills from a hospital or clinic in the community when the need presents itself. Any of these resources is best developed and

2. Language Line is a commonly used service (https://www.languageline.com). Another is Language Translation, Inc. (https://www.languagetranslation.com). [Retrieved December 31, 2018].

researched well in advance of need, so as to avoid delay when accurate communication is required.

There are computer programs that purport to "translate" typed text from one language to another. Some are compact hand-held units. While helpful, these are prone to misinterpretation and can distort the true meaning. Misunderstanding health symptoms or medical advice could have tragic results.

A correctional facility may have employees, other than health care staff, who are fluent in the needed language. While less than ideal, the responsible health authority may deem such a person adequate to serve as translator. To protect the patient's right to privacy, outside of an emergency, the patient must provide informed consent before clinical information is exchanged,[3] and the interpreter must explicitly agree to respect patient confidentiality. Using incarcerated peers to interpret is not recommended except in emergencies. This practice seriously compromises due privacy and confidentiality and is open to abuse. Moreover, there is a potential for misdiagnosis because persons without training in medical terminology may unintentionally provide inaccurate translations.

A casual acquaintance with a language can help bridge the trust gap and engender a "friendly" relationship, but it is not enough to ensure accurate communication or in-depth understanding of feelings, fears, sensations, or instructions. Employment of qualified interpreters involves additional cost and time. Correctional administrators and health care providers must recognize its importance in the interest of ensuring proper diagnosis, effective treatment, good patient compliance, and due confidentiality. To do less does not meet the standard of care.

Unimpeded Access: The Standard

The performance standard of the American Correctional Association (ACA 2003, 1A) requires: "unimpeded access to a continuum of health care services so that their health care needs, including disease prevention and health education, are met in a timely and efficient manner." The commentary for the associated mandatory expected practice (ACI-4-4344) forbids any member of the correctional staff to approve or disapprove requests for health care services. ACA (ACI-4-4346) further requires that there be a process for everyone to initiate requests for health services on a daily basis.

NCCHC's (2018, P-A-01) essential standard specifically addresses access to care: "Inmates have access to care for their serious medical, dental, and mental health needs," and defines access to mean "that, in a timely manner,

3. There is potential conflict of interest when the prospective interpreter is the person who attests to the patient's free and informed consent to authorize him or her to serve in the capacity of interpreter.

a patient is seen by a qualified health care professional, is rendered a clinical judgment, and receives care that is ordered." The discussion makes it clear that this is the foundation on which all NCCHC standards are based, and provides examples of unreasonable barriers to access:

- Punishing persons for seeking health care
- Assessing excessive copayments that deter seeking of care,
- Creating unreasonable obstacles, such as holding sick call at 2:00 a.m.
- Having an understaffed, underfunded, or poorly organized system, or
- Having a utilization review process that inappropriately delays or denies needed care.

Importance of access to care was highlighted by the United Nations (U.N., 1982): "Health personnel, particularly physicians, charged with the medical care of prisoners and detainees, have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained," and (U.N., 1990): "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."

Enhancements to Access

Much is being learned about the social determinants of health—how social, economic, political, and other factors affect health. Social status has a dramatic influence on the health and life of individuals from birth to death. Poverty, unsafe neighborhoods, violence, unhealthy foods, and toxic and polluted air, water, and environments adversely affect health outcomes. Therefore, it is not enough to focus on the disease process and medical treatment, while ignoring the social determinants of health (WHO, 2008). Community public health advocates are making inroads into urban development, rural environments, housing, food, education policy, air and water pollution, and gun safety. So also correctional health providers must be alert and aware of harmful influences that can cause ill health to those who live and work in this environment. Examples include the stressful effects of social isolation, solitary confinement, extreme regimentation, excessive use of restraints, strip searches, mace, and restrictive visitation policies.

Health care systems in the community strive for excellence in providing the best technical and scientific quality of care—in terms of skills and dedication of providers and support staff and availability of the best and latest in technology. But effective systems also take into account concerns for several other dimensions that influence and determine access to and quality of care

services, because these can affect the receptivity of people to their care, including language fluency, health literacy, social and economic disparities in health, ethnic and cultural beliefs, traditions, and practices, and gender disparities.

Even when correctional systems provide workable mechanisms to afford patients access to necessary health care, due attention must also be given to removing or mitigating known and knowable impediments (barriers, obstacles, or disincentives) to access. These can be cultural, linguistic, faith-based, gender-based, or predicated on the unique history of an individual patient. In other words, health care services must be acceptable and available to every patient (Faiver, 2017, 15–16). Language barriers are the most obvious obstacle to access because accurate communication is of the essence. Cultural/ethnic/religious preferences and taboos are important and should be respected and, when possible, anticipated by the provider. Gender-based obstacles are particularly relevant for women, and are discussed in Chapter 4 (pp. 89–91, 114, 117–118) and in Faiver (2019, 194–196 with respect to substance abuse treatment). When a patient—particularly one from a different background than the provider, appears to express refusal, reluctance, or resistance to a procedure or treatment, take the time to tactfully inquire the reasons. If the hesitation seems to be based on ethnic, cultural, or religious reasons, demonstrate understanding and explore alternative remedies or treatments with the patient, or possibly consult with a provider of the same culture or background. Sometimes arranging a visit with a minister of the faith professed by the patient can help when religious concerns are involved. If the unacceptability of the procedure is gender-based, consider referring the patient to a same-sex provider. Sometimes the refusal may be attributable to intellectual or developmental disability, in which case the assistance and advice of a mental health professional may be beneficial.

However, the reluctance might also be personal. As mentioned in Chapter 4 (pp. 87, 115) for women, (pp. 138–139, 145–146) for youths, (p. 170), for elderly, and in Faiver (2017, 37–39); and Faiver (2019, 47, 50–52, 194–196), many of the people in correctional facilities have experienced repeated and severe trauma and abuse and are consequently vulnerable to being re-traumatized by certain legitimate and necessary medical procedures. If this is suspected to be the case, the provider must avoid all haste or brusqueness. Perhaps a psychologist can help to identify the problem or prepare the patient, or can elicit clues as to how to make the procedure acceptable. Above all, do not belittle, disregard, negate, or ridicule the patient's concerns. They should be listened to, validated, and treated with respect. There should always be a same-sex chaperone for intimate exams or treatments—both for the provider's own protection and also to help put the patient at ease. Be sure that the treatment itself does not reveal the diagno-

sis to others (as can happen if there is a separate pill line for HIV or TB medications, or when patients are being obviously called out to see the HIV counselor following a test for AIDS). See Chapter 4 (pp. 92–93), Faiver (2017, 15–17), and Faiver (2019, 65, 114, 129).

It is well to foster and encourage a holistic and integrated approach to care. Many physicians trained in a narrowly focused area of medicine see their role as repairing the broken human machine. They need to look at the whole person from a biopsychosocial perspective, and not just at the diseased organ or tissue. There are mind-body links and there are also influences from the environment and social context in which people live. The correctional environment can, without doubt, be profoundly and powerfully relevant and must be taken into account in the diagnosis and treatment of illness and in the promotion of health (Faiver 2017, 212–215). Ensuring both visual and auditory privacy is vitally important (284–285). Be soft-spoken. Loud talking—especially in the segregation setting or anywhere if others might overhear—should be avoided. Cleanliness and orderliness of the diagnostic and treatment areas is reassuring and comforting. Take time to get to know patients and put them at ease.

Stress Reduction

Stress is one of the biological pathways linking social status to health. For example, "The body is designed to respond to stress and maintain homeostasis, but chronic stress results in system overload and disease." Chronic psychosocial stress (from poverty, unemployment, inadequate education) results in maladaptive physical response like cardiovascular disease, premature birth, and hypertension (Lathrop, 2013, 42). "The body responds to almost any event or challenge by releasing chemical mediators . . . that increase heart rate and blood pressure—that help us cope with the situation; on the other hand, chronic elevation of these same mediators . . . produces chronic wear and tear on the cardiovascular system that can result, over time, in disorders such as strokes and heart attacks" (McEwan, 2006, 368). McEwan also says that good self-esteem and a positive outlook can bring long-lasting health consequences, and that this is positively enhanced by having good social support in contrast to loneliness, which is associated with greater system overload (376).

It should be no surprise that occupants of prisons and jails often experience health deterioration from exposure to institutional stresses like isolation, cramped space, overcrowding, excessive noise, separation from family, lack of privacy, limited autonomy, and negation of dignity and self-worth.

Health Literacy

The Institute of Medicine (IOM, 2004) reported that "nearly half of the American adult population may have difficulties in acting on health information." These difficulties occur in accessing, understanding, appraising, and applying health-related information (Sørensen et al., 2012, 2). Literacy level among incarcerated persons is limited. Others may have difficulty with technical terms commonly used in health care, or may require assistance in processing this information and making meaningful application to their life situations.

Health illiteracy can lead to "poor health outcomes, such as difficulty recognizing and reporting symptoms, inability to self-administer medications correctly and self-manage medication side effects, inability to understand and concord with treatment plans, and inappropriate use of health care services with associated unnecessary health care costs and greater mortality risks" (Lambert and Keogh, 2014, 34). "Enhancing health literacy is increasingly recognized as a public health goal and a determinant of health" (Sørensen et al., 2012, 11).

Rectifying this problem will require correctional providers and nurses to take more time to simplify, explain, answer questions, and confirm patient understanding.

Culture/Ethnicity/Religion

We can expect better patient compliance and cooperation if providers try to understand and appreciate the health-related traditions and beliefs prevailing among different cultural groups. This helps bridge the trust gap between patients and providers. "Broadly speaking, cultural competence assumes an inclusive approach to health care practice that enables a health care professional or a health care system to provide meaningful, supportive, and beneficial health care that preserves every client's and every community's human rights and dignity" (Soulé, 2014, 48). She further states that a single way of thinking or acting based on a single set of cultural norms is unethical (48). "Relational aspects of care, such as compassion and empathy, are far more related to affect than to cognition" (56).

"Clinicians have a responsibility to develop a deep understanding of their patients to ensure they provide high-quality care. . . . Ultimately, knowledge about a patient's own preferences should guide decision making. . . . Culturally competent care is a moral good that emerges from an ethical commitment to patient autonomy and justice" (Paasche-Orlow, 2004, 348, 349). Whenever possible, providers should alter their practices rather than place the burden of adaptation on patients. They should think proactively and seek culturally appropriate options, making members of different cul-

tures feel welcome. "Cultural competence goes beyond cultural sensitivity and must replace it" (349).

Douglas et al. (2011, 320) speak of the importance of culturally competent assessment skills for facilitating communication and inquiring into sensitive questions about beliefs and practices that providers need to consider when delivering health care. Cultural competence is required by the principles of social justice (Douglas et al., 2014, 109). Clinical institutions should enhance staff competency in cross-cultural practice by affording "ongoing educational workshops as well as mentoring and training geared toward the continuous development of . . . cultural knowledge and skills for effective cross-cultural practice" (113). Evidence-based practice derives from three sources of evidence: "the best available research findings, clinical expertise, and patient values" (115).

There are obvious advantages to a culturally diverse staff. Their shared values and life experiences enable them to better understand the patient's culture, effectively communicate, and establish a therapeutic alliance for improved patient outcomes.

Complementary and Alternative Medicine (CAM)

There is value in respecting patient preferences and encouraging patient participation in treatment planning. This can improve compliance and good outcomes. While many correctional providers will face time constraints that prevent researching alternative therapies, and may also feel ethically bound to adhere to evidence-based practice within their own conventional medical tradition, there are circumstances when CAM practices may be worth considering, namely: if patient preference is strong, there is no evidence that the practice is unsafe, and there is some reason to believe that it may be beneficial. The IOM (2005, 184) states that Adams et al. (2002) offer a helpful framework: "in the absence of significant evidence, when there is no standard efficacious treatment or when conventional therapy has failed, and when the patient's intention to use a CAM therapy is strong and persistent, . . . it may, indeed, be unethical for the physician to withhold either treatment or an appropriate referral" because generally the personal beliefs and choices of patients should be respected if they pose no threat to other parties.

Social and economic determinants of health bring two important benefits: a better understanding of the plight of the patients and perhaps an improved means of meeting their needs, and second, an awareness of some parameters signaling need for meaningful change in prison conditions.

INTAKE HEALTH SCREENING

Point-of-Entry Health Screening

Ensuring access to health care begins with intake health screening. Even before a new arrival actually initiates a request for health care, the agency has an affirmative obligation to discover any obvious and urgent health needs, commencing the moment the arresting officer's squad car or the prison transportation bus arrives. This can be called "point-of-entry" screening. Typically, the first representative of the correctional facility who bears this responsibility is the officer who meets the transporting vehicle. This person must be able to recognize an obvious medical emergency from signs such as profuse bleeding, impaired consciousness, physical weakness, intoxication, disorientation, evidence of pain, or an urgent request for help. Officers accompanying new arrivals in the transport vehicle also have a duty to report immediately any suspected health problems, complaints, or indications of distress they have observed.

No one with a serious illness or injury should be accepted at a jail; instead, policy should require the receiving officer to direct the vehicle driver to take the person to an appropriate hospital or emergency room until medically cleared to return. Otherwise, the resulting delay could risk even greater injury or complications.

Division of labor between correctional and health care staff for point-of-entry screening can be handled in various ways. The net result must include a prompt and competent assessment followed by an appropriate response and timely referral when indicated. If a nurse is present during the off-loading of new arrivals, the principal responsibility belongs to the nurse; but if the nurse is not likely to see them until an hour or more after arrival, the responsibility of the officers to observe and inquire about urgent health problems becomes significantly greater. Hence, officers require in-depth training to perform this function competently. In large systems with a central reception center where intake health assessments are completed prior to transfer, the responsibility of receiving officers is limited to:

- Observing symptoms of any apparent medical or mental disorder as new arrivals disembark the transporting vehicle and enter the facility, and being alert for signs of trauma or mishap which may have caused injury or illness *en route*. It is always appropriate to ask the transporting officer whether any such event has occurred.
- Promptly referring any suspected serious health problems.
- Ensuring that any accompanying health record or medication is confidentially handled and promptly given to designated health care staff.

Receiving Health Screening

If a nurse does not conduct a face-to-face screening immediately upon arrival, officers' responsibility increases with the time interval before the nurse does so. As a rough guideline, if it will be more than one hour before the new arrivals are seen by a nurse,[4] the health-trained officer should ask each individual whether there are any urgent health problems or needs and promptly refer anyone who is or appears to be ill. In addition to what the officer does, the receiving screening nurse must:

- Review documentation of any findings by the officer at point-of-entry.
- Process each patient using an approved screening form that addresses health condition, communicable diseases, mental health, suicidal ideation, legal or illegal drug use, allergies, special needs, and medications; perform a detailed health history; and screen for active TB. Vital signs are generally obtained.
- Carefully evaluate each person's risk for withdrawal symptoms or suicidal behavior (Faiver, 2019, 12–13, 35–37, 188–189). Arrival health screening presents an ideal opportunity to screen also for substance use disorders. When such a finding is made, it is appropriate, with patient consent, to make a referral to the facility's substance rehabilitation program. NCCHC (2018, P-E-02) requires the receiving screening process to inquire about drug use and history of withdrawal symptoms to assess need for detoxification or medication-assisted treatment.
- Review the medical record from any previous incarceration and provide appropriate follow-up where indicated. When time does not permit, this function may be postponed for a few days. Some facilities do this in connection with the intake health assessment. It should not be deferred further.
- When indicated, place a call to the provider; submit a prescription to the pharmacy; administer prescribed medications or treatments in a timely way; schedule an appointment with a provider, dentist, or mental health professional; or hold the patient in a medical observation or infectious disease isolation setting.

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4. This time frame is not a hard and fast rule and must be reasonably interpreted and applied. When many individuals arrive together on a transport bus, it would be imprudent for a nurse to wait an hour before beginning health screening. This could mean that some would not be seen until several hours after arrival. To avoid this, arrangements should be made for using multiple nurses, beginning the screening process as soon as the transport vehicle arrives, or using a phased strategy that begins with rapid triage of all, followed by more detailed screening and assessment soon after. Individuals should not be released from the intake area until the receiving screening is completed (NCCHC, 2018, P-E-02).