

**HEALTH CARE
IN NEW YORK STATE PRISONS**

*A REPORT OF FINDINGS AND RECOMMENDATIONS
BY THE PRISON VISITING COMMITTEE
OF THE CORRECTIONAL ASSOCIATION OF NEW YORK*

February 2000

The Correctional Association of New York

“Because the dangers of abuse inherent in the penitentiary are always present, the work of the Correctional Association—an organization of knowledgeable experts unaffected by political forces—is so important.”

—Judge Morris E. Lasker
(Former U.S. District Court Judge for the
Southern District of New York)

Founded in 1844, The Correctional Association of New York is a nonprofit policy analysis, research and advocacy organization that focuses on criminal justice issues. It is the only independent organization in New York State with legislative authority to inspect conditions in state prisons and report its findings to policy makers and the public. Because prisons are hidden from public view and prisoners themselves are among society’s least powerful citizens, continual scrutiny of conditions is critical.

The Correctional Association’s Prison Visiting Committee monitors prison conditions, conducts research, identifies problems and works with New York State Department of Correctional Services officials to formulate workable solutions. Most recently, the Prison Visiting Committee successfully advocated for the construction of an expanded visiting room for inmates at Greene Correctional Facility; a statewide policy ensuring that inmate-patients are informed of medical test results, normal and abnormal; and special training for Fishkill correction officers who oversee inmates on psychotropic medication.

Research findings and recommendations for policy change are distributed to legislators, the public and the media to better serve the needs of inmates, correction staff and society at large.

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EXECUTIVE SUMMARY

In 1997, the Correctional Association initiated an in-depth study of the quality of health care in New York State prisons. Over 18 months, members of the Prison Visiting Committee made 25 site visits to 22 prisons representing all levels of security and including both men's and women's facilities. Interviews were conducted with over 1,300 inmates, approximately 100 prison medical personnel, several former New York State prison physicians, as well as lawyers and experts in correctional health care. Findings from the research revealed a mixed picture: Significant improvements have been made in recent years, in some cases producing dramatic results; however, systemic problems continue to compromise the delivery of prisoner health care.

Recent Achievements

Given the size of the inmate population—over 71,000 prisoners in 70 correctional facilities throughout the state—and the significant number of inmates who suffer from serious illnesses, the Department of Correctional Services (DOCS) deserves recognition for the following:

- The number of annual **AIDS-related deaths plummeted 85% in three years**, from 258 deaths in 1995 to 39 in 1998.
- The **HIV/AIDS portion of the health care budget increased 66%**—from \$38 million in 1995 to \$63 million in 1999. During the same period, the Department's overall operating budget rose only 15%.
- An expanded (voluntary) HIV testing program enabled **25,000 inmates to receive anonymous HIV tests** and counseling in 1998.
- Aggressive testing and treatment of tuberculosis—for which DOCS received national recognition—yielded a **66% decline in the number of inmates with active TB infection**, from 82 in 1994 to 28 in 1998.

- **Four of five planned Regional Medical Units** (similar to hospitals or nursing homes in the community) **have been opened** for inmates with terminal illnesses or serious, chronic medical conditions. The units replace more expensive hospital beds in the community and provide a range of outpatient specialty clinics for inmates from nearby prisons.
- **Proactive superintendents and medical staff** in some state prisons have developed **model health care procedures**. These efforts are described in the report for possible replication in other NYS prisons.

Systemic Problems

In New York, the challenge of providing health care to an inmate population as large as a mid-sized city is made more difficult by systemic problems that will require budgetary change, union negotiation and legislative oversight to overcome. These problems include:

- **Little external oversight.** Unlike hospitals and clinics in the community, prison hospitals are not overseen and regulated by the New York State Department of Health. Essentially, prison health care workers are accountable only to prison authorities.
- **Lack of a uniform, statewide quality assurance program.** Inmate health care varies greatly among state prisons because no meaningful, coordinated quality control program exists.
- **Non-competitive salaries.** Medical personnel in prison are compensated far below their community counterparts. This disparity has a snowball effect: It creates problems with recruitment and leads to attrition, which together result in long-term, hard-to-fill vacancies. Too often, the Department relies on physicians whose qualifications are questionable and for whom DOCS may be the employer of last resort.
- **Under-qualified doctors.** Neither DOCS nor the Department of Civil Service (the agency that sets the rates of pay and hiring standards for state employees) requires prison physicians to be Board-certified, or even

Board-eligible. In addition, the majority of prison doctors interviewed in the study lacked experience as general practitioners, training in primary care and the leadership skills necessary to manage a busy prison clinic.

- **Unevenness in the care of inmates with HIV/AIDS.** The New York State prison system has the highest percentage of HIV+ inmates than any other state prison system in the country. Yet, site visits to 22 prisons revealed uneven care, medical staff who lacked basic knowledge of HIV/AIDS, and inmates who reported they had “no idea how to get an AIDS test.” At only two facilities did there appear to be any adherence tracking of inmates taking complicated "drug cocktails." Non-adherence to prescribed treatment regimens, which require frequent adjustment and continual monitoring, can easily cause drug-resistant strains of HIV to emerge.
- **Use of Phone Company Commissions to Subsidize Health Care.** Since 1995, DOCS has used over \$50 million in commissions, or "kickbacks," it receives from phone companies awarded lucrative prison phone contracts to subsidize inmate health care. The problem is that these subsidies to inmate health care are paid for by the recipients of prisoner phone calls, typically friends and family members who live in New York's poorest neighborhoods, who are charged over \$1.00 per minute for collect calls from prisoners.
- **Inadequate services for Spanish-speaking inmates.** There are over 7,000 Spanish-dominant inmates in the New York State prison system. Researchers received many reports of Spanish-speaking inmates who were given medical information they did not understand, drug prescriptions they could not read and substandard health care due to the lack of Spanish-speaking medical staff.
- **Insufficient discharge planning.** Each year, the Department releases approximately 30,000 inmates into the community. With the exception of HIV+ inmates, who receive a month's supply of medication prior to release, the majority of inmates leave prison with little money and no access to health care in the community. For elderly inmates and those with

chronic conditions such as mental illness, heart disease or hepatitis, the 45-day wait for Medicaid poses serious problems to their well being and to the public health and safety of the community.

Recommendations

The improvements the Department has made in recent years indicate that change is possible. The following recommendations can serve as a blueprint for rectifying remaining deficiencies in the inmate health care system.

- **Increase external oversight and accountability.** Far too many taxpayer dollars are spent on health care within prison walls (\$175 million in FY 1998-1999) for there not to be external review and higher standards of accountability. The Correctional Association urges the Governor and State Legislature to appoint and fund an oversight committee charged with assuring quality health care in state prisons. Such a committee might include correctional health care experts and practitioners, individuals with public policy, public health and fiscal management experience, the Commissioner and chief medical officer of DOCS, and senior Department of Health officials. The committee would monitor the quality of medical services in state prisons and have the authority to direct facility-level and system-wide change. It would report its findings and recommendations annually to state officials and the public.
- **Strengthen quality assurance mechanisms.** A detailed quality assurance protocol, similar to those used in hospitals in the community, should be developed and articulated by the Department's chief medical officer, carried out by facility health services directors and evaluated regularly by regional medical directors.
- **Increase salaries of medical staff.** The quality of health care in prison will remain as is unless the Governor and State Legislature increase the salaries of medical staff to make them commensurate with community rates of pay.

The rates of compensation among regional medical directors, facility health services directors and prison physicians must also be stratified so that there are incentives to advance and retention of valuable physicians improves. Because of noncompetitive salaries, the Department's efforts to recruit qualified health care providers are limited.

- **Raise qualifications of physicians.** The Department of Civil Service and DOCS should require higher qualifications for facility health services directors and for prison physicians generally. A minimum standard of Board eligibility (which requires completion of an approved residency training) and a preference for Board certification in internal medicine or primary care should be endorsed.
- **Augment training of medical staff.** DOCS, the Department of Health, the State University of New York and teaching hospitals throughout the state should administer and require training for prison health care providers in the clinical management of HIV/AIDS, hepatitis C, and addressing the psychosocial needs of inmate-patients.
- **Expand HIV/AIDS testing, tracking, education and prevention.** Every inmate should be encouraged to take an HIV test throughout the period of confinement. Inmates who are diagnosed HIV+ should be strongly encouraged to begin life-prolonging treatment and counseled on dosage information and side effects. It is also essential that an HIV-experienced physician direct treatment for HIV/AIDS, since complicated anti-retroviral regimens must be tailored to individual patients and knowledge in the field is advancing rapidly. In addition, the use of peer educators should be expanded throughout the system. Finally, the Department should follow other correctional systems in preventing contagion by making condoms available.
- **Increase language translation services.** Written and oral instructions should be provided with all new prescriptions and made readily available in Spanish when needed. At least one member of the medical staff, and more in facilities with high percentages of Spanish-dominant inmates, should be

fluent in Spanish. The Department should also make more use of AT&T's telephone interpretation service, which provides translation in 17 languages and is currently used by reception staff at Downstate Correctional Facility.

- **Address inmates' long-term health needs in discharge planning.** The appropriate federal, state and city agencies should work together to ensure that at-risk inmates—particularly the elderly and those suffering from chronic illnesses—have access to health care in the community upon release and until Medicaid coverage is available.
- **Take more proactive steps to manage hepatitis C.** Recent prevalence studies indicate that 40% of state prisoners nationwide may be infected with hepatitis C, a long-term disease that is easy to transmit and difficult to treat. DOCS should work with the Department of Health and the Center for Disease Control to expand testing, explore treatment options and provide preventive information to inmates and correction staff throughout the system.
- **Expand social services for female inmates.** Given the higher rates of HIV infection, substance abuse, sexual abuse and clinical depression among female prisoners, DOCS and the Office of Mental Health should expand social services in women's prisons. In addition, a family reunion program should be opened at Albion Correctional Facility (the state's largest and most remote prison for women) so that female inmates can better cope with separation from their children and strengthen important family ties prior to release.
- **Stop subsidizing health care with Family Benefit Fund monies.** The Department's practice of charging exorbitant fees to the recipients of inmate phone calls in order to subsidize health care should be ended. Because inmates have no way of obtaining medical services on their own, the cost of inmate health care is clearly a state responsibility. The Department should solicit bids for new telephone contracts that offer no "kickbacks" to the state and more affordable rates.

- **Expedite computerization of medical records system.** While some states are experimenting with such innovations as inmate “smart cards” that store a patient’s entire medical history and future appointments on a memory chip, many New York prison clinics still operate with manual appointment logs. State budget officials should allocate the funding necessary to complete the computerization of the Department’s medical records system.
- **Improve care of the chronically ill.** Inmates suffering from chronic illnesses such as HIV/AIDS, heart disease, diabetes and asthma are insufficiently monitored by prison health care providers. Important follow-up appointments are often missed because no single doctor examines and treats the same patient regularly. The Department should formalize and expand its pilot practice of assigning inmate-patients with chronic conditions to a single primary care physician. These physicians oversee and coordinate complicated medical services, and monitor adherence and response to medication during the inmate's stay the facility.
- **Provide alternatives to incarceration for elderly prisoners.** The cost of health care for geriatric inmates is triple that of younger inmates. In addition, the propensity for criminal behavior wanes significantly with age. New York lawmakers should follow other states in offering geriatric parole and electronic detention for elderly inmates who no longer pose a threat to society.

ACKNOWLEDGMENTS

This report is the result of prison visits, interviews and research conducted by the Prison Visiting Committee of the Correctional Association of New York. Numerous people contributed to the effort. Jennifer R. Wynn, director of the Prison Visiting Project, served as principal author of the report. Robert Gangi, executive director of the Correctional Association, and Ralph S. Brown, Jr., chairman of the Prison Visiting Committee, guided the project from inception to completion. Gail Goodman, former director of the Prison Visiting Project, played a key role in developing and initiating the research. Mishi Faruqee, director of the Women in Prison Project, wrote the section on health care for female prisoners.

The following members of the Prison Visiting Committee volunteered many hours of their time conducting research in prisons, writing reports of observations and helping to shape the report that follows: Heather Barr, Safiya Bandele, Michael Cuenca, M.D., Betty and Rudy Cypser, William J. Dean, Nancy Duggan, Ph.D., Lourdes Falco, Carol Ferry, Barrett B. Frelinghuysen, Gail Goodman, Clay Hiles, Marcia Hurst, William Marino, M.D., Cara Marshall, M.D., Anthony Ortiz, Elizabeth Osborne, Barbara Lee Perlmutter, M.D., John S. Prescott, Jr., Marjorie Schlitt, James Silbert, Barbara Stanton, Colin Starger and Ethel Virga. The Committee is grateful to Drs. Nereida Ferran, Peter Meacher and Esther Schumann, whose knowledge of correctional health care and compassion for inmate-patients informed and inspired our work.

Glenn S. Goord, Commissioner of the New York State Department of Correctional Services, and Lester Wright, M.D., Associate Commissioner and Chief Medical Officer, cooperated fully with the gathering of information for this report. Members of the Department's Counsel's Office, in particular Donald Matusik, former Assistant Counsel, are acknowledged for their efficiency and graciousness in arranging prison visits. The Visiting Committee also extends its appreciation to the many superintendents, medical personnel and correction staff who were consistently courteous and accommodating during prison inspections.

The work of the Prison Visiting Project is made possible through the generous support of the Irene Diamond Fund, the Pforzheimer Foundation and the Prospect Hill Foundation.

INTRODUCTION

“Felons are sentenced to prison as punishment, not for punishment. Once they are incarcerated, we are obligated to provide them with medical care that is the equivalent of that found in the community.”

—Governor George E. Pataki,
in *DOCS Today*, October 1998 edition

Inherent in the nature of confinement is that prisoners cannot obtain medical services on their own. Along with food and shelter, health care is a component of prison life that inmates must rely on correction officials to provide. Prisoners’ loss of liberty is essentially a loss of choice: Inmates cannot choose the physicians who treat them or the types of medical services they receive. All inmates can be denied medical treatment that prison officials deem unnecessary, and some inmates can be medicated against their will if prison authorities consider it necessary.* It is only ethical, then, that the state ensures access to health care, and that inadequate treatment is never a condition of punishment.

The delivery of health care in correctional settings is fraught with challenges. Correctional health care workers must contend not only with the grimness of the prison environment, but the inconveniences of practicing medicine in locked institutions governed by strict security procedures. In addition, prisons are rarely located near major cities, and inmate-patients generally have far greater physical and psychological needs than non-confined patients. Fundamentally, the difficulty of providing health care in prison can be traced to the profound differences in the purposes, training and clients of the medical and correction professions. For example, doctors are called upon to treat and to heal a largely law-abiding population. Correction officials are called upon to maintain and confine

* *Washington v. Harper*, 494 U.S. 210, 227 (1990). The Supreme Court held that: "Given the requirements of the prison environment, the Due Process Clause permits a State to treat a prison inmate who has serious mental illness with anti-psychotic drugs against his will, if the inmate is dangerous to himself or to others and the treatment is in the inmate's medical interest."

convicted felons. Good medical practice encourages informed choice and taking responsibility for one's health. Correctional practice—the very nature of incarceration—restricts free will and choice. Training in the medical community is based on academic study and clinical treatment. Training in the correction profession is based on security practices and paramilitary protocol. A physician's highest obligation is to the patient. A correction officer's highest obligation is to society.

To many people, prisoners represent a hidden population. Locked away in distant correctional facilities, prisoners are easily and often forgotten. Yet the average length of stay for New York prisoners is 27 months, and the Department of Correctional Services (DOCS) releases nearly 30,000 inmates annually. When prisoners return to society, the health care they received while confined will affect the public health of the community at large. For example, every inmate who enters prison HIV+, or who becomes HIV+ during incarceration and remains undiagnosed, returns to the community posing a threat to public health. For as many years as the disease goes unnoticed, it also goes untreated. If life-prolonging HIV medications are not administered in prison, then local communities must pay for the ex-offender's more advanced and costly medical needs upon release. On the other hand, if an inmate is tested, counseled and treated while in prison, and arrangements are made before he leaves to see a doctor in the community and continue his medical treatments, significant personal and public health costs are avoided.

Incarceration presents an opportunity for correctional health care workers to test, treat and educate a population that suffers disproportionately from a host of medical problems. Countless studies show that the majority of inmates come from medically underserved communities plagued by high rates of disease and low rates of immunization. Compared to their counterparts in the community, they have less access to health care, are more likely to be victims of violence and abuse, and

engage more frequently in high-risk behaviors. In the New York State prison system, for example:

- Approximately 7,500 inmates (over 10% of the prison population) are HIV+;
- 25% of prisoners entering the system are infected with tuberculosis;
- Nearly 70% of male inmates, and over 80% of female inmates, are self-reported substance abusers; and
- 15% of all state inmates have been diagnosed by the New York State Office of Mental Health as “significantly, seriously or persistently” mentally ill.

In addition to the moral and public health reasons for providing prisoners with adequate medical services, there is also a legal requirement. The U.S. Supreme Court ruled in 1976 that prisoners have a constitutional right to health care that people on the outside do not have. The landmark case, *Estelle v. Gamble*, established that deliberate indifference to inmates’ serious medical needs constitutes cruel and unusual punishment, and therefore is a violation of the Eighth Amendment. In *Estelle*, the Supreme Court noted:

The government [has an] obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs. It is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself.

As a result of *Estelle* and subsequent rulings, health care in American prisons and jails improved dramatically. Court intervention—or the fear of court intervention—provided a catalyst for improving correctional health care across the country. Indeed, it was court intervention in the late 1970s that prompted health care reforms in New York’s Bedford Hills and Green Haven correctional facilities, the former of which is recognized in this report for its model practices. However, there is yet to be a single federal court decision applicable to all prisoners in all states that outlines the specific medical services that must be provided. Another problem is that in 1991 the Supreme Court restricted *Estelle's* rulings in *Wilson v.*

Seiter, essentially making it more difficult for inmates to successfully challenge inadequate medical services. In order to demonstrate “deliberate indifference,” inmate-plaintiffs must show that correction officials intended to cause the alleged inadequate health care. This narrowed standard is much more difficult to meet.

Ultimately, the tremendous responsibility of providing adequate prisoner health care rests with individual state governors and legislators. Only they can ensure that necessary budget appropriations are made and sufficient oversight exists. This effort demands wisdom and compassion from all New Yorkers, and the recognition that public health is threatened when we forfeit our constitutional and humanitarian imperatives to care for the sickest and least powerful among us.

Background of the Study

In the approximately 1,000 letters and phone calls the Correctional Association receives each year from prisoners, their family members and lawyers, inadequate health care is the single most common complaint. During prison inspections, inmates typically identify medical services as the area most in need of reform. Anecdotal evidence reported to the Correctional Association is consistent with findings and observations from other organizations that have examined health care in New York State prisons over the past decade.

An audit of DOCS’ health care system conducted by the Department of Health in 1993 revealed weaknesses in quality assurance, the testing and treatment of inmates with HIV/AIDS and access to specialty care. In 1990, the Legal Aid Society filed a class action suit (currently in the later stages of discovery) against DOCS for the substandard treatment of inmates with chronic illnesses, particularly those with HIV/AIDS. Reports critical of the Department’s health services were issued by The New York State AIDS Advisory Council’s Subcommittee on Criminal Justice in 1989 and again in 1998. Members of the New York State Assembly introduced a bill in July 1999 calling for Department of Health oversight

of health care in state prisons. Most recently, the Office of the State Comptroller initiated an audit of the Department's health care system, the findings of which will be published in early 2000. According to a Comptroller's Office representative, "Health care in state prisons has been identified as a high-risk area." In other words, this office of state government determined that prison health care likely involves some waste of taxpayer dollars.

To better understand the concerns of inmate-patients and the quality of care they receive, the Prison Visiting Project launched an in-depth study of health care in New York State prisons in 1997.

Research Methods

Members of the Prison Visiting Committee conducted a total of 25 site visits to 22 state correctional facilities, three of which included Regional Medical Units (RMUs)—secure hospital-like settings for chronically ill inmates. The sample of prisons was designed to represent all levels of security, a range in population size and both male and female institutions. Specific prisons were identified to support or reject anecdotal evidence alleging inadequate health care. Correctional facilities visited by the Committee are listed on the following page.

<u>Correctional Facility</u>	<u>Security Level</u>	<u>Population</u>
Albion*	Medium	1268
Arthur Kill	Medium	978
Attica	Maximum	2181
Bayview*	Medium	175
Beacon*	Minimum	228
Bedford Hills*	Maximum	792
Coxsackie	Maximum	1067
Coxsackie RMU	Maximum	60
Downstate	Maximum	1384
Eastern	Medium	1199
Elmira	Maximum	1813
Fishkill	Medium	2103
Great Meadow	Maximum	1668
Greene	Medium	1610
Green Haven	Maximum	2159
Marcy	Medium	1469
Orleans	Medium	1300
Southport	Maximum	919
Sullivan	Maximum	810
Walsh RMU	Maximum	112
Wende	Maximum	831
Wende RMU	Maximum	80

* denotes a women's facility

On each visit, researchers included one to three doctors (sometimes including a former DOCS physician), two paid staff members and up to eight volunteer citizens with backgrounds in criminal justice, law, psychology, mental health and public health. The group conducted field research during full-day, on-site visits. Researchers used two questionnaires—one for inmates and one for medical staff—that were designed by physicians to probe health care policies, procedures, problems and progress. In addition, the Committee conducted semi-structured group interviews at each prison with:

- all levels of the medical staff;
- the Inmate Liaison Committee, a leadership group representing the concerns of prisoners;
- a small group of self- or facility-selected correction staff; and
- the superintendent and senior administrators.

Committee members also spoke informally with prisoners over lunch in the mess hall and during unmonitored conversations in cellblocks, dormitories and infirmaries. In total, formal and informal interviews were conducted with over 1,300 inmates and approximately 100 prison health care providers.

At each prison, medical staff (sometimes accompanied by officials from the Department's Health Services Division) provided tours of the clinic, infirmary, examination rooms, medical records office and dental area. At prisons with Special Housing Units (SHUs)—disciplinary cells where prisoners are locked in 23 hours a day—the Department permitted two Committee members to spend an hour in the unit, interviewing inmates behind cell bars or metal doors.

Researchers took detailed notes during site visits and submitted reports of findings to the project director. Additional information was gathered through interviews with physicians and lawyers specializing in correctional health care,

former prison doctors, members of the New York State AIDS Advisory Council’s Subcommittee on Criminal Justice, the Department’s chief medical officer and several regional medical directors, as well as recently released ex-offenders. The Department supplied data when requested and available. A review of the literature on line and in print was conducted.

With guidance from Committee physicians, the project director analyzed the data, which were mainly qualitative in nature and collected over an 18-month period, for system-wide patterns and trends and for similarities and dissimilarities among individual prisons. Throughout this report, the names of prisons where substandard practices were observed have been omitted. The Committee reported this information in writing to the commissioner, chief medical officer and superintendent after each visit. (Attribution to sources is also omitted throughout the report to protect privacy and to prevent the possibility of reprisals.) Through an analysis of the data, a mixed picture of recent and substantial improvements, as well as systemic problems in need of immediate and sustained attention, emerged.

How the State System Works

New York State—the third largest prison system in the country—has a vast and complicated health care system that serves over 71,000 inmates in 70 correctional facilities across the state. In 1998, medical staff saw over one million inmate-patients and provided nearly two million “medication call-outs.” Three large state agencies (the Department of Health, the Office of Mental Health, and the Office of Alcohol and Substance Abuse Services) each play a role in prisoner health care; however, primary and routine health care is provided mainly by DOCS’ medical staff, which is comprised of approximately 1,500 employees. Acute care and specialty care are provided by outside contractors to DOCS, such as Albany Medical Center, under coordinated specialty care contracts. HIV/AIDS services are provided by personnel employed by DOCS, by the Department of

Health's AIDS Institute (AI), or by outside organizations under contract to DOCS or AI.

All inmates receive a medical evaluation at a reception/classification center when they enter the system, and another assessment when they arrive at their assigned prison. At Downstate Correctional Facility, for example, the main reception/classification center for maximum-security inmates from New York City, inmates undergo a number of medical tests, including full blood work, chest x-rays, tuberculosis screening, a dental exam, a liver function test, urinalysis and hepatitis B screening. HIV tests are not conducted at reception but at the assigned correctional facility on a voluntary basis. Classification personnel consider inmates' medical needs when determining their prison assignment.

Inmates are treated for routine health problems in prison clinics and infirmaries. Medications are supplied mostly through a formulary (a catalog of state-approved medications) and, in about 20% of prisons, through outside contractors. In 1997, the Department introduced telemedicine—interactive teleconferencing connecting physicians in the prison with community medical centers. Currently, 27 facilities have telemedicine, which is used on a limited basis to enhance emergency triage, broaden specialty services and minimize the costs and security risks of inmate transportation to off-site providers. A pilot program in teleradiology is under way, whereby x-rays can be read immediately at distant sites to provide rapid feedback.

The Department's chief medical officer oversees all aspects of health care in New York State prisons. Reporting to the chief medical officer are five regional medical directors and five regional health services administrators, who oversee care in their designated areas. At each prison, a facility health services director serves as the prison's highest medical authority. Facility health services directors report directly to the superintendent and indirectly to the regional medical director. They supervise all aspects of inmate health care and medical staff, and are

involved in budget decisions, clinic mortality and morbidity reviews, and scheduling medical coverage.

Portrait of the Inmate-Patient

According to Department figures released in January 1998, approximately 95% of state inmates are male. Fifty percent are black; 33% are Hispanic; 16% are white. The average age is 33 years. Approximately 68% are from New York City; 13% are foreign-born. The Department classified 10% of state inmates as “Spanish-dominant,” meaning that Spanish is their primary and preferred language.

Nearly 65% were classified as never married; 60% have one or more living children. The median minimum sentence is 48 months, but the average length of stay is 27 months. A little over half of the inmate population (52.4%) is serving time for violent offenses. The majority of inmates (69%) served previous jail or prison terms.

Almost 60% of state inmates do not have a high school diploma or equivalent degree. Of this 60%, nearly 25% read below the fifth grade level, and 33% read at less than the eighth grade level, the eligibility level required for the high school equivalency exam. According to the Department’s 1998 report, *The Hub System: Profile of Inmates*, “56.7% of the inmates without a high school diploma needed educational services simply to help them read at the level necessary to earn a G.E.D.”

As noted previously, inmates suffer disproportionately from a host of medical conditions. Approximately 9% of the state’s male inmates and 18% of female inmates are HIV+. Almost 25% of inmates entering the system are infected with tuberculosis. Fifteen percent have been diagnosed as “significantly, seriously

or persistently” mentally ill. Nearly 70% of male inmates and over 80% of female inmates are self-reported substance abusers.

These data and Visiting Committee interviews with over a thousand prisoners reveal this composite portrait of the inmate-patient:

He is a male of color in his early 30's, born and raised in poverty, unmarried, with children, and lacking a high school diploma. His educational deficiencies have likely resulted in low-paying or menial jobs. His history of substance abuse, parental neglect and high-risk behavior has compromised his physical and mental health as well as his ability to find and keep a job. Chances are strong that he supported his drug dependence by entering the neighborhood drug trade, which further exposed him to a life of violence and instability and prompted his decline into homelessness, joblessness and addiction.

He enters prison in poor health and withdrawing from drugs. Once the reality of his situation becomes clear, he will likely grow angry at “the system,” frustrated by the rigidity of prison life and the remoteness of the facility that confines him, and depressed by the prospects of his life upon release.

In the daily grind of prison life, the clinic may appear as a bright spot, a place where he will be cared for by nurses rather than confronted by “guards.” Is it any wonder, then, that he might “play sick call” (inmate jargon for faking illness) because he is lonely and seeking attention? (More than likely, however, he is suffering from any of a host of ailments: asthma, diabetes, depression, high blood pressure, rotting teeth, migraine headaches, hepatitis, cancer or HIV.) Is it any wonder that his social and coping skills are not as developed as those of his counterpart from a stable home and community? Is it any wonder that the abruptness of an overworked nurse—likely untrained in the psychosocial needs of inmates—is particularly distressing to him?

Cost of Inmate Health Care

As in the community, the cost of health care in prison has risen dramatically over the past decade. According to the National Institute of Justice:

The costs of prison health care have risen faster than other correctional costs. Upward pressure on spending comes from several sources: growing numbers of inmates; rising costs of health care in the larger society upon which offenders rely for services; the threat of litigation and federal court demands to improve services; aging inmate populations; and the higher prevalence of HIV/AIDS, tuberculosis, hepatitis and other infectious diseases among prison populations.

New York's mushrooming inmate population, the soaring costs of health care in the community, and the twin challenges of tuberculosis and HIV/AIDS have caused the prison health care budget to more than triple in the past 12 years. In fiscal year 1986-1987, the health care budget was \$50 million. By fiscal year 1998-1999, it had risen to \$175 million. In keeping with the rate of medical care increases in the community during the same time period, annual per-prisoner health care costs nearly doubled from \$1,250 in 1986-1987 to \$2,465 in 1998-1999. (The total cost of maintaining a New York State prisoner for one year is \$32,000.)

Notably, the HIV/AIDS portion of the budget has risen by two-thirds in the past four years alone,* from \$38 million in fiscal year 1994-1995 to \$63 million in fiscal year 1998-1999. (During the same period, the Department's overall operating budget increased by only 15%.) The cost of treating one HIV+ inmate in 1998 was \$1,000 a month.

The Department's increases in health care spending are laudable. However, it is troubling that DOCS prides itself on the fact that "\$41 million of the \$200 million in inmate AIDS spending since 1995-1996 has come from the Family

Benefit Fund,” as was written in the state-issued magazine, *DOCS Today* (October, 1998). Actually, a closer look at Department expenditures indicates that the Department has used over \$51 million from the Family Benefit Fund since 1995-1996 to subsidize inmate health care.

The Family Benefit Fund was created to help the families of inmates maintain important ties with loved ones behind bars, not to pay for health care—clearly a state responsibility. It should be noted that DOCS supplements the Family Benefit Fund, but it does so with monies from commissions (“kickbacks”) it receives from phone companies for awarding them with lucrative prison phone contracts. In its current contract with MCI, DOCS receives a 60% commission. State officials project a telephone commission income of \$21.5 million in this fiscal year alone.

The problem is that it is essentially prisoners’ family members and friends who pay, not the inmates. Only collect calls are allowed from prison. Recipients of prisoners’ collect calls are saddled with surcharges and per-minute costs, which amount to over a dollar per minute for long distance calls. Therefore, it is the friends and family members of inmates, the majority of whom live in New York City’s poorest neighborhoods, who are subsidizing inmate health care. A *New York Times* editorial (“When Johnny Calls Home, From Prison,” 12/6/99) described the state’s practice as “cruelly exploitative,” and stressed that “it is wrong to penalize and profit from the families of inmates.”

The Correctional Association agrees with the *Times* and other organizations, such as the AIDS Institute’s Subcommittee on Criminal Justice, that the practice of using Family Benefit Fund monies for health care is unjust and may also be illegal. Neither inmates nor their families have any choice in the medical services they receive or influence over funding decisions. More pertinent is that funding for inmate health care is clearly a state responsibility.

* Coincident with the development of anti-retroviral therapy.

RECENT ACHIEVEMENTS

The Department has made a number of system-wide improvements over recent years, yielding meaningful and in some cases dramatic results. The number of AIDS-related deaths, for example, has plummeted 85%, and the Department's strategies for controlling tuberculosis have gained national recognition. In addition, DOCS has constructed state-of-the-art Regional Medical Units, which provide comfortable settings for terminally and chronically ill patients while reducing statewide costs, and has renovated a number of prison clinics throughout the state.

Decline in AIDS-Related Deaths

Between 1995 and 1998, the number of annual AIDS-related deaths dropped from 258 to 39. This 85% reduction was largely due to the state's commitment to offering the newest HIV medications (anti-retroviral therapy) to control HIV infection before more serious symptoms emerge. Health services officials report that collaboration between DOCS and Department of Health's AIDS Institute also contributed to the decrease in AIDS deaths. In 1989, the AIDS Institute and DOCS initiated a joint project in which DOCS funded positions in the Institute to form regional teams to provide HIV counseling and testing for inmates and educational programs for inmates and correction staff. This effort was closely coordinated by the central offices of both agencies. In 1990, DOCS and DOH established the Criminal Justice Initiative (CJI), which provides training for inmate peer educators, anonymous counseling and testing, support services for HIV+ inmates, and transitional planning for parolees.

Currently, approximately 1,400 state inmates have been diagnosed with AIDS. According to Department officials, approximately 2,800 inmates who are

infected with HIV and/or AIDS receive anti-retroviral therapy. Officials report that they “will spend more money than ever [in 1999] for voluntary inmate HIV testing, a process that gets inmates into treatment earlier, prolongs their lives and reduces treatment costs for taxpayers.”

In addition, the Department recently developed courses for registered nurses to help them identify symptoms associated with HIV infection. With knowledge of these “triggers,” nurses can recognize opportunistic infections that might otherwise be discounted as colds or flu.

Construction of Regional Medical Units and Renovation of Clinics

Inmate health care has also improved through the consolidation of medical services into Regional Medical Units and through major renovations of prison clinics throughout the state. Regional Medical Units (RMUs) are secure facilities that provide a range of medical services for inmates who are too ill to be treated in regular prison infirmaries but who do not require acute care. The units not only replace more expensive hospital beds in the community for inmates requiring long-term care, but provide specialty clinics for inmates from nearby prisons. RMUs provide step-down care for inmates returning from a hospital stay, rehabilitation care, chronic disease care, long-term care and hospice care. Outpatient clinics in such specialty areas as ophthalmology, infectious disease, endocrinology, orthopedics, dermatology, gastroenterology, podiatry and urology are offered. Specialty care is provided by physicians from medical centers such as Albany Medical Center, SUNY Health and Science Center in Syracuse, and Strong Memorial Hospital in Rochester.

Four of five planned RMUs have been opened at a total capital cost of \$130 million: a 112-bed unit at Walsh, in the central part of the state, in 1993; a 60-bed unit at Coxsackie, in the eastern part of the state, in 1996; and an 80-bed unit at

Wende, in the western region, in 1998. An RMU at Bedford Hills in southern New York opened in late 1999; a unit at Fishkill is scheduled to open in 2000.

Committee researchers visited three RMUs and were favorably impressed by the state-of-the-art equipment, the use of telemedicine, the professionalism of the staff, and the spaciousness and cleanliness of the units. The majority of the inmate-patients interviewed expressed satisfaction with the care they received.

In addition, DOCS has renovated the majority of prison clinics throughout the state. Many correctional facilities were built prior to the era of modern medicine and were unable to accommodate a significantly larger and sicker population. In fact, the leading recommendation in the Department of Health's 1993 audit was for DOCS to "modernize the physical plants...so as to provide an environment conducive to modern medical care." Auditors noted that such steps "should be implemented expeditiously," and it appears that they have been. On the majority of site visits, Committee physicians noted that physical plants were consistent with modern infection controls and often compared them favorably to clinics in the community.

Management of Tuberculosis

Relatively recently, DOCS faced a tuberculosis crisis, as cases of active infection doubled from 55 per 1,000 inmates in 1989 to 111 per 1,000 just two years later. Since then, aggressive testing and treatment have dramatically reduced the number of active cases of tuberculosis. In fact, the number of active cases declined 66% over four years, from 82 cases in 1994 to 28 cases in 1998. No staff developed active TB in 1998 and only 10% converted to positive skin tests, for a conversion rate of .03%. For inmates, the conversion rate to positive was 1.15%. Both rates are lower than the rate among most community health care workers.

The Department's success in controlling tuberculosis earned it national recognition. In 1998, a report by the National Institute of Justice stated:

Since 1988, the New York State Department of Health Bureau of Tuberculosis Control and DOCS have had extensive and, according to DOH staff, 'exemplary' collaborations in screening, treatment, case management, surveillance, outbreak investigation, discharge planning education, training of staff and inmates and technical assistance to staff. Tuberculosis cases have declined steadily since reaching a peak in 1993. No tuberculosis outbreaks have occurred in DOCS facilities since 1993.

Currently, the Department mandates annual screening for inmates and employees and requires inmates taking TB medications to do so under direct observation. Employees suspected of having TB are prohibited from working. Inmates suspected of having TB are moved to special negative pressure rooms in prison infirmaries, where transmission is mitigated and chest x-rays, sputum tests and treatment are administered. The results of these efforts show that system-wide strategies and collaboration with DOH can have a measurable impact.

Development of Policy for Communicating Medical Tests Results

A source of frustration inmates reported to the Committee was difficulty in obtaining results of medical tests. The Correctional Association reported this concern to the Department's chief medical officer, and in 1999 a policy was issued that requires medical staff to notify inmates on a routine basis of results of medical tests and x-rays. Inmates are now told of positive (abnormal) findings by a licensed member of medical staff during sick call. Negative (normal) results are reported to inmates on a written medical slip, signed and dated by a licensed member of the medical staff.

SYSTEMIC PROBLEMS

As previously noted, the Department has improved many aspects of inmate health care over the past decade—by no means an easy task. With a vast and complex system, a sicker than average patient population, difficulty recruiting qualified personnel, and thorny bureaucratic issues to resolve, the Department deserves praise for the results achieved. However, systemic problems persist and will be difficult to remedy under current budget and personnel constraints. While some of the problems observed during site visits in 1997 have since been solved, others remain and are detailed in the following section. Most appear to stem from a lack of external oversight and accountability and a lack of internal quality control. A fundamental problem plaguing the system is non-competitive salaries: DOCS medical personnel are compensated far below their community counterparts. This disparity has a snowball effect: It creates problems with recruitment and leads to attrition, which together result in long-term, hard-to-fill vacancies, and reliance on health care workers whose qualifications are questionable and for whom DOCS is sometimes the employer of last resort.

External Oversight

Because inmates cannot choose their health care providers or influence the medical decisions made in their behalf, the state has a strong ethical obligation to provide adequate health care and to establish strict standards of review. However, the delivery of health care in New York State prisons operates virtually free of external controls. Unlike hospitals and clinics in the community, those on prison grounds are not overseen and regulated by the Department of Health. Essentially, prison medical personnel are accountable only to prison authorities.

By contrast, hospitals in the community must meet a number of external standards. Nearly all hospitals are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and patients and physicians have come to expect that hospitals will maintain their JCAHO accreditation as evidence of quality care. Moreover, if a patient in the community receives substandard care, he or she can file a complaint with various oversight agencies, including the Department of Health. In addition, and perhaps even more important, community health care providers are driven by external market pressure to maintain certain standards. The federal government, for example, reimburses Medicare and Medicaid expenses only to those hospitals with JCAHO accreditation, so it is rare to find a community hospital that lacks this stamp of approval. Finally, non-incarcerated patients have some choice in their primary care provider and can “take their business elsewhere” if they are not satisfied. On the other hand, incarcerated patients must accept the health care that the state provides or prove in court through protracted legal battles that prison officials denied them adequate services.

It is important to note that no law in New York State requires that DOCS seek or achieve accreditation for inmate medical services. As stated in the 1998 publication, *Clinical Practice in Correctional Medicine*: “There is no obligation for correctional facilities to seek accreditation of any kind. Many systems have nonetheless voluntarily sought American Correctional Association (ACA) accreditation, and a smaller number have sought National Commission on Correctional Health Care (NCCHC) or JCAHO accreditation.”

In fact, all of New York State’s 71 correctional facilities have achieved ACA accreditation, and DOCS is the only correction department in the country to have earned that status. ACA-accreditation, however, does not guarantee a consistently high level of care, as was evidenced during prison visits. Committee physicians identified practices in several prison clinics that violated ACA standards, such as correction staff involvement in accessing sick call as well as

insufficient and/or inaccurate instructions given with prescription drugs. When the ACA evaluates a facility, its assessment covers the entire spectrum of prison operations. By contrast, the NCCHC and JCAHO focus exclusively on a facility's medical services. Perhaps the best distinction between NCCHC and ACA standards was made by an employee of the ACA itself: "Our standards are merely minimal requirements—certainly not measures of excellence."

Quality Assurance

Quality assurance is a critical component of health care delivery. It is practiced in a number of ways and evaluated on many different levels. While external oversight and regular audits by outside agencies are a part of quality assurance, more important are internal controls and self-assessments including weekly staff meetings, utilization and morbidity reviews and patient chart analyses. As a correctional health care expert at Montefiore Medical Center in New York City explained, "Quality assurance is a process of always looking at ways to improve the system. Most hospitals have a quality assurance or Continuous Quality Improvement (CQI) committee that meets weekly, that collects data regularly and makes decisions based on that data." In fact, JCAHO and NCCHC require, as a condition of accreditation, that correctional facilities have a CQI program in place.

On the majority of prison visits, medical staff's knowledge of CQI as a concept, or of actual procedures for assuring quality care in the prison clinic, was vague. Most described quality assurance as a discrete event that occurred when the regional medical director visited the prison rather than an ongoing program. When asked if these visits were random or anticipated, a nurse at one prison aptly replied, "There are no surprises in prison. Clearances need to be arranged. We always know when they're coming."

Health service officials also pointed to regional medical directors as the guarantors of quality. However, it was clear to that regional medical directors do not have the necessary staff or resources to spearhead, coordinate and oversee quality assurance in their prison districts. “Regional medical directors do problem solving,” said a Legal Aid attorney familiar with prison health care in New York, “not oversight.” It should be emphasized, however, that the regional medical directors whom the Committee met seemed knowledgeable about the medical practices and problems in their designated facilities. They appeared to be professional and energetic individuals, who are compensated, as discussed later, far below their level of responsibility.

Quality assurance requires adherence to articulated internal controls and hands-on leadership from the facility health services director. In both respects, DOCS’ facilities are generally lacking. For example, a State Comptroller’s Office audit of medical expenditures at Arthur Kill Correctional Facility released in June 1999 found that the Department had misspent almost \$300,000 because of poor internal controls and lack of oversight. The report states:

Department and Facility managers are responsible for developing and maintaining a system of internal control to ensure that medical service expenditures are necessary and appropriate. We found that while Department and Facility managers had developed systems to control medical and related payroll expenditures, they did not properly monitor these systems to ensure they operated as intended. Consequently, the Facility incurred and paid unnecessary medical costs totaling nearly \$300,000...

The Comptroller’s office added, “We identified numerous internal control weaknesses that contributed to these operational deficiencies. We recommend that internal controls be strengthened and the overpayments be recovered, where possible.”

Illogical employee reporting structures compound the problem of quality assurance. Health services directors at individual prisons, for example, report to and are evaluated by the superintendent, meaning that security specialists judge the decisions and performance of medical doctors. As a superintendent at a maximum-security prison stated, “I have no medical training. How can I adequately evaluate doctors?”

Quality assurance is also compromised by the fact that too many facility health services directors work part-time and spend substantial amounts of paid work hours off site on an “on-call” basis. They are therefore not present enough to monitor staff performance, review and improve procedures, ensure quality or carry out their leadership functions. The court-appointed medical auditor of a DOCS facility, where a consent decree governs medical services, criticized the Department for inadequate medical leadership at the prison. Describing the many responsibilities of health services directors, the auditor wrote in a 1998 evaluation report: “The medical director has responsibility for recruiting physicians and physician assistants. The medical director is responsible for the quality assurance program, and is responsible for the scheduling of physicians for clinics, segregation rounds and vacation coverage.”

Access to Specialty Care

“If it’s not an emergency, you’re not seeing a specialist.”

—Comment from an inmate on a prison visit

Specialty care in the state prison system is provided by outside specialists. Using a “specialty care coordinated system,” the Department contracts the coordination of specialty health services and acute care to managed care companies in the community. The state’s 71 prisons are grouped into four regions; a separate contractor arranges specialty care in each region. Currently, the Department uses Corrections Physicians Service (CPS), Correctional Medical

Services (CMS) and Wexford in three regions, and its own medical staff to coordinate specialty care in the western region. This region, which includes two large maximum-security prisons (Attica and Wende) as well as an RMU, was previously serviced by CPS. In the fall of 1998, DOCS terminated its contract with CPS.

While the use of specialty care contractors has some benefits, such as improving access to specialists in remote areas and controlling costs, it adds another level of gate keeping that often creates lengthy delays. For example, an inmate in need of specialty care must first be screened by a nurse in order to see a physician, which can take up to three weeks. The physician then examines the patient and determines whether a consultation for specialty care is merited. If it is, the facility health services director must then approve the consultation and designate the level of urgency: “emergent” (24 to 48 hours); “urgent” (5 to 7 days); “soon” (14 days) or “routine” (30 days.) The facility health services director then submits the consultation request to the specialty care contractor, which can reject it. If this happens, the prison physician is in a difficult position, having to tell the inmate that the medical procedure he approved (thereby implying it was necessary) was deemed unnecessary by the specialty care contractor. Unlike patients in the community, inmates have no recourse if a procedure is denied.

The reverse can also occur. A procedure recommended by a specialist can be denied by a prison’s health services director. Ultimately, it is the facility health services director who makes the final determination as to whether a procedure recommended by a specialist will be followed, which in itself is problematic. Inmates frequently reported that prison doctors ignore the instructions or treatments prescribed by outside specialists. Although beyond the scope of this research, it can be said that any form of managed care presents the possibility that efforts to control costs will conflict with the delivery of care.

Another problem with managed care is the lengthy delays that arise when a series of off-site diagnostic procedures (such as CAT scans or MRIs) are needed to identify or rule out a medical condition. In the community, a physician will typically schedule a series of diagnostic procedures over a period of one to two weeks. In prison, given the complicated consultation process described above, the time from the initial consultation to needed surgery, for example, can easily stretch out over four to six months, during which time a sick individual will likely grow sicker and a serious medical condition can become life-threatening.

Moreover, there is rarely collaboration between inmates' prison doctors and specialists who see them in the community. The medical records maintained by specialty care contractors do not include the primary care administered in the prison. There is no effective system for prison physicians to ensure that follow-up appointments on the outside are made or kept, or for community-based specialists to know whether prison medical staff is following their instructions. The following letter from an inmate illustrates the problems that arise when health care is disjointed.

I caught a case of food poisoning and was sent to the emergency room in an outside hospital, where the doctor who examined me prescribed two different medications. I was returned to the facility, and the prison doctor, who had not examined me, changed that prescription to an antibiotic called Cipro. I took it but got worse and worse and was finally sent to the emergency room at Albany Medical Center. (The prison doctor had mistakenly diagnosed me as having a bladder infection.) I was sent back to the prison and continued on the Cipro. I got worse and was eventually taken to the prison hospital in a wheelchair. I was then placed in an observation room, where the medical staff and correction staff informed me that there was nothing wrong with me to cause me so much pain. "What drugs are you withdrawing from?" they asked. Near death, and being in so much pain that I wanted to die, they finally agreed to send my urine and blood out to be tested.

Several hours later they told me I didn't need the Cipro after all and that I didn't have a bladder infection. They gave me pain medication, and I got better quickly after being taken off the Cipro. I asked the nurses and doctors why, as trained medical personnel, they

didn't do the logical thing and ask what medication I was on that could have caused adverse reactions, instead of assuming I was "kicking." They said the symptoms I had weren't typical to adverse reactions to that drug. Well, I got the product information and checked it out, and every symptom that I experienced was listed in the literature.

In general, I'll tell you what any prisoner knows and will tell you: Get sick in prison and you're in trouble.

Sick Call

"I had a very bad pain in my chest and signed up for emergency sick call. I was informed the nurse would come by later. I'm not a doctor but I do know when something is wrong with me. The pain was so great that the other prisoners and I had to start fires in our cells to have the nurse come up. Do we have to act like savages in order to be listened to?"

—Letter from an inmate in solitary confinement

Problems associated with sick call fall into three categories: impeded access to physicians, superficial screening, and hostile attitudes of nurses. At many prisons, inmates reported that they must sign up for sick call three times before they are seen by a doctor. According to a 1998 publication by the American Correctional Association, *Health Care Management Issues in Corrections*:

For inmates of jails, prisons or juvenile detention facilities, access to the health care system and to needed care essentially must be unimpeded. This means that the inmate, without risk of interference by anyone and without fear of reprisal, must be able to alert health care staff of a health need, to receive a timely professional evaluation of that need and to receive treatment in the manner prescribed by a competent provider.

Inmates at nearly every prison reported impeded health care access due to gatekeeping by nurses. Time and again prisoners complained bitterly about both the time it takes to be evaluated by a doctor and generally brusque and occasionally hostile nursing staff. A deputy superintendent explained that nurses receive the most negative feedback because "they are the ones who have to say

‘no.’” There is certainly truth to this comment, but in most instances inmates were quick to distinguish between callous and humane treatment, and often provided the names of nurses or other medical staff who treated them respectfully. Inmates were careful to make sure that researchers were given an accurate picture of the people who treated them well and those who treated them badly.

Some nurses were said to dismiss inmate concerns as a matter of routine, allowing minor illnesses to progress into serious ailments. Even though nurses are required to provide screening and triage, inmates reported that they often do not take vital signs, or physically examine patients. At three facilities, inmates said that nurses did not look at inmates’ medical records during sick-call visits. An Inmate Liaison Committee member at a women’s prison described having a large and painful cyst on her groin. The physician assistant apparently refused to examine the inmate or look at the cyst. “I don’t need to see it,” she allegedly said, and gave the inmate Tylenol. Prisoners at many facilities said medical personnel refused to touch them.

Nurses are not licensed to write prescriptions, but taking vital signs and checking patients’ records are essential functions of sick call duty. The Committee received too many reports of nurses not performing these basic tasks for these complaints to be dismissed as isolated incidents. At one prison, inmates reported that nurses who believe inmates are malingering punish them with “medical keeplock,” meaning they issue the inmate a misbehavior report and lock him in his cell for the day. “The whole system is designed to discourage usage,” one inmate said, echoing the sentiments of many others. “I won’t go to sick call unless I’m dying.”

Rates of Pay and Staffing

There are many drawbacks to working in a prison clinic, from the grim environment to the inconvenience of administering care in a locked institution governed by strict security procedures. In addition, prisons are rarely located anywhere near major cities. Inmate-patients, in general, are sicker, needier and more difficult to work with than non-confined patients. Compounding these problems is that state-employed medical personnel earn considerably less than their community counterparts.

For example, according to the Bureau of Labor Statistics, the average annual income of a physician in the community is \$110,000, while that of a New York State prison physician is \$92,000. Nurse administrators (head nurses) in community hospitals earn, on average, \$53,000 annually, while nurses in New York State prisons earn \$39,000. According to Department officials, the salaries of prison pharmacists are also dramatically lower than those in the community, which has resulted in severe recruitment and retention problems.

An articulate and energetic nurse administrator at a medium-security prison explained that the salary differential has made it increasingly difficult to attract quality nurses. “Even at the maximum levels of state pay, nursing income in corrections still falls way short of community rates.” At her facility, a part-time nurse position had been vacant for two years. “We haven’t been able to fill it so we decided to stop recruiting and just try to make do with what we have,” she said. “But this is definitely a problem, because our population has nearly doubled while our medical staff has stayed the same.” With overtime pay more available for nurses in the community, she said, they can make far more money, and the state provides no incentive to work with inmates. When asked why she stays, she cited her many years in the system and the reward of a pension if she stays. The facility health services director and a deputy superintendent present during the interview agreed wholeheartedly with the nurse administrator’s assessment.

The New York State AIDS Advisory Council's Subcommittee on Criminal Justice provided a cogent analysis of the situation in 1998:

DOCS has suffered from a lack of adequate medical staffing for the past decade. For fiscal year 1990-91, DOCS requested a health care staffing increase of more than 30%. In 1993, DOCS recommended that, 'The existing ratios of professional and support staff should be enhanced,' and noted the need to increase professional salaries, citing especially 'Glaring examples of large competitive differences...for physician assistants, pharmacists...physical therapists...and [nurses].' In fiscal year 1994-95, the requested staff increase for nurses alone was more than 40%. These requests for major increases in health care staff, each following a DOH audit, were not reflected in the Governor's budgets and failed to result in financial or personnel changes. No effort was made to reassess or redeploy health staff at prisons when these proposals were not implemented.

A related problem is the lack of pay differentials among the highest levels of medical staff. The salaries of a regional medical director or a facility health services director are the same as those of regular staff physicians. Given the substantial responsibilities of a facility health services director, including oversight of the entire health care staff (medical, dental and pharmaceutical), responsibility for all inmate health care services (clinic, infirmary, ambulatory, specialty care) and involvement with budgets, operations and scheduling, "Why," as a deputy superintendent asked the Visiting Committee, "would anyone take this job?"

A former DOCS physician noted: "A regular prison physician and the health services director make the same amount of money, so there is no incentive to be a leader." In fact, this physician left DOCS to work for a private correctional health care company. "I didn't leave because I was unhappy," she said. "DOCS simply could not compete with the salary I was being offered, and the facility was closer to my home."

Even more illogical is that the salary of a regional medical director is the same as that of both a facility health services director and a staff physician. Regional medical directors oversee facility medical directors and are responsible for the health care of thousands of inmates in entire hubs (clusters of up to 10 prisons). Again, given the tremendous responsibility of the position and the considerable travel time going from prison to prison, there seems to be far more disincentives than incentives for assuming a high-level medical position in DOCS.

Qualifications and Leadership of Doctors

Inadequacies in the qualifications, leadership skills and onsite work hours of staff physicians emerged as a common problem.

Correctional health care experts consider the most appropriate training for inmate health care to be either in family practice or internal medicine. The Committee rarely met a staff physician with this training. Instead, urology and surgery were common areas of practice. Specialty areas such as these do not properly prepare doctors for work in a busy prison clinic. They involve far less patient interaction than a primary care specialty and offer little training in preventive health care. Not surprisingly, when inmates described problems with medical staff, their criticisms focused typically on physicians who were trained as specialists rather than general practitioners.

Also problematic is that many prison doctors are not board-certified. Neither DOCS nor the Department of Civil Service, the agency that sets standards for state-employed medical personnel, requires or encourages them to become board-certified. In the community at large, board certification demonstrates a level of commitment to practicing medicine. Requirements include an approved residency program, continuing medical education and passing re-examinations on a regular basis. Completing an approved residency program makes a physician board-eligible, which should be the minimum qualification for a doctor to practice

primary care in prison. A non-board-certified or non-board-eligible doctor would be hard pressed to find work as a medical practitioner in the general community.

Leadership and managerial skills appeared to be greatly needed but generally lacking. This deficit was most directly conveyed by the absence of facility health services directors on five separate prison visits, despite advance notice that a site visit was scheduled and the Committee had requested an interview with the director. Explanations were that the health services director was on vacation, worked part-time, was on call, or that the position was vacant. Several facility health services directors told the Committee that they had their own medical practices in the community, and that the position with DOCS attracted them for the generous hours “on call,” which enabled them to continue their community practices. According to an attorney familiar with the Department’s health care system, “For many of them it’s a paycheck. They’re getting \$50,000 a year to work half-time and to supplement the income from their community practice.”

When facility health services directors were present during Committee site visits, they tended to rely on nurse administrators to answer researchers' questions. Frequently, the health services director would turn to the nurse administrator when a question was posed, unless asked directly to answer. It was often unclear as to whether the medical director did not know the information inquired about, or deferred to the nurse administrator for other reasons. A Department health services official admitted, “We don’t have good courses in management, leadership or sensitivity training for physicians who work with this population. Until recently we didn’t even have correctional health care orientation for nurses and physicians.”

Finally, in answer to the question as to why they chose to work in the prison clinic, several physicians said that managed care had put their health care practice in the community out of business. The prison, it seemed, was their employer because they had no other feasible choice.

Clinical Management of HIV/AIDS

“By choosing mass imprisonment as the Federal and State governments’ response to the use of drugs, we have created a de facto policy of incarcerating more individuals with HIV infection...Clearly, we are thus concentrating the HIV disease problem in our prisons and must take immediate action to deal with it more effectively.”

—National Commission on AIDS, 1991

Twenty-five site visits to 22 correctional facilities revealed uneven clinical management, a vagueness among staff physicians about critical HIV/AIDS issues, wide variations in HIV testing, support services and education, and an absence of prevention measures. Despite Department officials’ estimates that by the end of 1999 approximately 25,000 inmates have been tested, in many prisons the Committee visited, inmates told researchers they had not been tested and had no idea how to get an HIV test. Part of the problem can be traced to the absence of Criminal Justice Initiative (CJI) contractors in many state prisons. CJI provides HIV testing, counseling, education and transitional support. However, according to the AIDS Institute, nearly half of state facilities have no CJI education programs, and 14 other facilities are not served by CJI for any service whatsoever, e.g. testing, counseling, education or transitional support.

The Department reports that approximately 1,400 inmates with AIDS have been identified, and that approximately 2,800 inmates (with either HIV or AIDS) are receiving anti-retroviral therapy. However, the number of inmates receiving treatment (2,800) is less than half the number of inmates who the Department believes are HIV+.

At the majority of prisons visited, the facility health services director could not tell researchers how many inmates under his or her care had either sought treatment or were receiving treatment for HIV/AIDS, citing only vague estimates. At a large maximum-security prison, none of the medical staff interviewed knew

how many HIV+ prisoners had an AIDS diagnosis. One staff member told researchers that “the figure is registered in Central Office in Albany. That is where they have an HIV surveillance system,” and said that an HIV specialist visits the facility regularly for onsite clinics. While infectious disease clinics are offered throughout the system and are provided on an as-needed basis, far too few staff physicians have HIV training or are knowledgeable about the treatment plans of inmate-patients under their care. It should be noted that DOCS developed and issued HIV Primary Care Practice Guidelines in July 1995 (revised in December 1996, July 1997 and February 1998), which were often referred to during visits. Guidelines, however, are not quality assessment tools that can be used to monitor actual practices.

Furthermore, there appeared to be few procedures to ensure that sufficient information is given to inmates receiving HAART medication (drug cocktails), or to ensure that adherence to treatment is monitored. Both of these are essential components of HIV/AIDS management, which requires continuous scrutiny, frequent adjustment and ongoing patient education. An HIV service provider who works in New York State prisons reported: “I know of at least one facility where complicated medications are commonly dispensed with no directions other than ‘take twice a day.’ Many of these medications have very specific conditions under which they should be taken or they won’t be effective. Conditions such as with or without water, or how much time before or after a meal they should be taken should always be clearly defined.”

Similarly, after a visit to a medium-security prison, a Committee physician noted:

One HIV+ inmate I spoke with was clearly confused about his complicated though totally appropriate HAART medication and was taking it improperly. I was concerned that the medical staff does not have enough time to explain such regimens to patients. Successful HAART includes far more than a medication prescription. Taking a complex regimen of drugs

that often cause unpleasant side effects without any immediately obvious benefits requires intensive supportive counseling.

HIV Education and Prevention

Despite the high number of HIV-infected inmates, the Department does little beyond providing limited HIV education to reduce the spread of HIV in prison, and therefore into the community when inmates are released. State officials commonly cite education as an adequate form of prevention, but HIV education is not available or easily accessible in all correctional facilities to all inmates. Peer education groups were frequently described by inmates as unsuccessful and/or unattended because of a lack of support from prison officials and because measures to protect inmate confidentiality were not taken seriously. These concerns create anxiety among inmates who fear stigmatization.

As a matter of policy, condoms are not provided and are therefore considered as contraband. Yet anecdotal evidence suggests that sexual activity occurs in prison and that condoms are necessary and desired to prevent the spread of HIV/AIDS. According to an informal survey of 108 former New York State prisoners conducted in 1999 by the Latino Commission on AIDS, 63% of prisoners said they had witnessed inmates having sex while in a New York State correctional facility. Moreover, 17% reported that they had engaged in sex while incarcerated, and 45% reported knowledge of correction officers having sex with prisoners. Because of the frequency of sexual activity in prison, the majority of respondents (80%) felt that condoms should be made available. “Sex in prison is a fact,” noted one respondent, “and protection should be provided.”

Sex upon release from prison is also a fact—as well as a threat to public health. A study of Latino ex-offenders in California found that 51% reported having sex in the first 12 hours after release. Inmates also indicated a preference for sex without condoms once they leave prison.

Given the prevalence of HIV among New York State inmates, the reportedly high level of sexual activity in prisons, the tremendous costs of treating HIV/AIDS and the public health threat infected inmates present once they are released, state policymakers would be wise to permit supervised access to condoms. Currently, three prison systems (Mississippi, Washington, D.C., and Vermont) and three jail systems (San Francisco, Philadelphia and New York City) make condoms available during HIV counseling sessions or when requested privately in sick call. The practice is quietly accepted by the staff, inmates and administration.

Care of the Chronically Ill

DOCS lacks a statewide system for monitoring the care of inmates with chronic illnesses, whether HIV/AIDS, asthma, diabetes, liver disease or chronic heart conditions. No standard tracking system exists for scheduling routine follow-up care, ordering and reporting laboratory results, monitoring appointments and ensuring that critical medications are not only administered, but administered properly. Committee members observed that medical personnel in some prisons address the needs of chronically ill inmates by manually scheduling future visits in appointment books. In other prisons, tracking was done on a computer; in some prisons it wasn't done at all.

The following account, written by a Committee physician following a visit to a maximum-security prison, illustrates the problems that arise when inmates with chronic conditions are insufficiently monitored.

I spoke with an inmate in one of the cellblocks who had been diagnosed with asthma several years prior. He was concerned that he had a chest infection, which had not improved. He showed me all his medication. He was on Theophylline (an asthma management drug considered outdated for several years now), which requires that the drug level in the patient's blood is

monitored regularly to ensure it remains in the narrow therapeutic range. The inmate said he had not had a Theophylline level test done for at least two years. In addition, he showed me his inhalers, one of which (the steroid inhaler) had the wrong instructions on the label: '2 puffs every 4 to 6 hours as needed.' A steroid is a baseline treatment that should be taken on a regular and daily basis, not as needed. Furthermore, the use of a steroid inhaler does not help in an acute situation of asthma-induced shortness of breath as the label falsely suggested.

When I asked the inmate if he understood when and how to take his medication, he had no clue; he would therefore be unable to help himself in the event of an emergency...I also checked to see whether the inmate used his inhalers correctly. The proper technique is critical for the delivery of the drug into the lung, where it is meant to act. It takes a bit of patience to teach the technique and perseverance from the patient to learn it. The inmate was using his inhaler as a sort of breath spray, with no awareness of the proper technique and function of the inhaler. (I showed him the right technique and clarified the schedule of medication, which the pharmacist or prescribing doctor obviously had confused.) I brought his case to the attention of the nursing administrator. He promised to look into it and thanked me for having 'picked that up.'

Patient Confidentiality

"Inmates have a constitutional right to privacy in their medical diagnoses and other medical information. The 'casual, unjustified dissemination of confidential medical information to non-medical staff and other prisoners is unconstitutional,' as are actions or policies by prison administrators that indirectly disclose medical information without justification."

—American Correctional Association, citing *Casey v. Lewis* (1993)

In the confined world of prison, confidentiality is difficult to maintain. In the outside community, doctor-patient confidentiality is held in the highest esteem and considered a cornerstone of professional health care. Despite the difficulty of maintaining confidentiality in prison, it can be argued that inmates have a greater

need for privacy than those outside because they live in a closed community, in an environment where violence, coercion and extortion can and do occur.

At many prisons the Committee visited, correction officers' knowledge of inmates' medical concerns was a source of tension. Counter to standards of both the American Correctional Association and the National Commission on Correctional Health Care, several New York State prisons require that inmates receive correction officer approval in order to sign up for sick call. They must either obtain a correction officer's signature on the sick call slip or register in a sick call appointment book held by a correction officer. At one facility, correction officers post the names of inmates on a medical "call-out" list that can be seen by any prisoner in the dormitory; at several facilities, inmates must first submit sick-call requests to correction officers, who then compile a list for the medical staff. Inmates in many of the Special Housing Units reported incidents in which nurses gave inmate medication to correction officers to deliver. At a large maximum-security prison, inmates reported that a correction officer frequently was present in the doctor's examining room. This practice breaches confidentiality, as well as DOCS' own policy, which states: "Absent indications of possible physical confrontation or upon request by health services staff, a discreet, out of earshot position is appropriate." At prisons where correction officers serve as gatekeepers to sick call, or insist on being present in examining rooms, inmates reported incidents where correction officers used prisoners' medical information to ridicule them, or denied them access to medical attention.

Language and Cultural Barriers

“The typical health care professional originates from and lives in a world very different from that of the inmates, 95% of whom are from a lower socioeconomic class. The prevailing cultural view is that people are poor not because they have no money, but rather because they have not made the necessary effort to become successful...This further generalizes into ‘they really don't care about themselves.’ When a prisoner is seen with a longstanding medical problem it is all too easy to assume that patient neglect or carelessness is to blame. These class prejudices combine with ignorance about patients’ culture, background and environment to create barriers to high-quality interactions and communication.”

—Gordon Schiff, M.D. and Ronald Shansky,
in Challenges of Improving Quality in the Correctional Setting

Approximately 85% of state prisoners are either black or Latino, yet Committee researchers met few African-American or Latino health care providers. Obviously, inmate-patients can be served well by qualified health care providers from any country, but when language and cultural differences inhibit communication, as was sometimes the case, the quality of health care interactions suffers. It was reported to the Committee that the racial and cultural differences that exist between urban, minority patients and foreign-born physicians are common sources of tension that prevent open communication of sensitive information. On several prison visits, language barriers made it difficult for Committee researchers themselves to understand the meaning of staff physicians' comments.

In addition, 10% of New York State prisoners are classified by the Department as “Spanish-dominant,” yet it was rare to find a member of the medical staff in any prison who was fluent in Spanish. In addition, medical instructions regarding dosages, important side effects and expiration dates are provided only in English, making them useless at best, or dangerously confusing at worst, for Spanish-speaking patients. Medical staff told Committee members that other inmates, correction officers or non-uniformed staff with Spanish language

knowledge served as translators. This practice raises a host of problems. First, translation errors are likely to occur when individuals who are not trained in the very specific discipline of medical translation serve as interpreters. Translation errors, in this case, can involve matters of life and death. Further, confidentiality is breached and safety is jeopardized when inmates must rely on other inmates or correction officers to communicate sensitive health care concerns. Members of nearly every Inmate Liaison Committee interviewed cited a lack of Spanish-speaking staff as a great concern to the Hispanic population. As one inmate in a maximum-security prison explained: “Imagine you only speak Spanish, and you have to tell a doctor who barely speaks English, through a C.O. who barely speaks Spanish, that you have hemorrhoids.”

Moreover, the exponential growth in foreign-born inmates over the past ten years poses considerable challenges for correctional health care providers. Between 1985 and 1995, the number of foreign-born inmates in New York more than tripled. Department officials report that less than a third of foreign-born inmates come from countries where English is the dominant language. In its 1998 report, *The Impact of Foreign-Born Inmates on the New York State Department of Correctional Services*, DOCS notes: “If the proportion of foreign-born inmates continues to grow, it will likely produce an increasingly serious strain on DOCS resources in the future.” A senior DOCS health official said that the growing number of inmates, from the Caribbean and South America in particular, poses serious health and fiscal concerns for the prison system that confines them and for the taxpayers who subsidize it. Inmates from these countries have lower rates of immunization, higher rates of HIV/AIDS and suffer more from other chronic illness compared to native-born prisoners. Thus, they will require a greater number of medical services, from treatment to translation assistance.

MODEL PRACTICES

The Visiting Committee observed model practices at several prisons, most of which were the products of thoughtful and proactive senior prison administrators working closely with dedicated medical staff. At these facilities, Committee members observed a commitment to quality health care on the part of both correctional and medical staff. Some of these practices are described here for possible replication in other prisons.

Grievance Reduction Strategy at Sullivan Correctional Facility

Sullivan Correctional Facility is a maximum-security prison with approximately 800 inmates. At the time of the Committee's visit in early 1999, prison officials expressed concern about the high number of medical grievances. Several months later, the facility made a number of changes, resulting in a 50% reduction in medical complaints.

The administration established an "ILC/Administrative Sub-Committee," comprised of members of the Inmate Liaison Committee, senior prison administrators and medical staff. The group meets monthly to discuss concerns and identify ways to reduce medical grievances. "These meetings have proven to be successful by opening paths of communication, whereby information can be shared to alleviate misconceptions and make for a better informed committee," the superintendent said. The minutes of the meetings are posted throughout the dorms. ILC members learn from medical staff why certain policies or procedures exist and share this information with their constituents. Medical staff gains insight into the needs and concerns of inmate-patients and determines ways to address them.

To assess inmates' access to sick call, Sullivan designed a triplicate sick call form. Copies are retained by the inmate, the clinic and the administration. "This way, we can see whether and when the inmate submitted the request for sick call," the deputy superintendent reported. "It is another way to determine that access is unimpeded."

Finally, Sullivan administrators took a proactive approach to expediting specialty care consultations with outside service providers. They held two meetings with facility physicians, specialist contractors and the regional medical director to better understand why referrals are either postponed or denied. "Currently, MD's are being trained so that pended [medical jargon for postponed] referrals can be answered more quickly," reported the superintendent. "Additionally, a review was done regarding the six points of a well-written consultation request. The group is working on a 'fast track' method, whereby certain conditions can be monitored by case managers assigned to both the facility as well to [the specialty care contractor]. Regional meetings will be held at quarterly intervals in order to eliminate unnecessary 'pendeds' and denied consultations."

Medical Services at Coxsackie Regional Medical Unit

The Coxsackie Regional Medical Unit (RMU) represents the Department's first experiment in privatized health care. Based on three separate site visits (in 1996, 1997 and 1998), feedback from inmate-patients and in-depth interviews and phone conversations with medical staff there, the Committee concluded that the Coxsackie RMU offers superior health care services. The facility is staffed and run by Correctional Medical Services (CMS), a division of the publicly traded Spectrum Health Care, the largest health care provider in U.S. prisons. In the spring of 1998, the unit housed 60 inmate patients, a significant number of whom were terminally ill and would die in the unit's hospice (22% of the inmates had cancer; another 20% had AIDS). The staff was knowledgeable and answered

Committee questions with ease, revealing the strength of the unit's data collection and tracking systems. The medical director, a prison doctor for nearly two decades, was formerly employed by DOCS and now works for CMS. Staff and inmate-patients valued his leadership and communication skills. Committee members were favorably impressed with the hospice and moved by the staff's humane and caring treatment of the inmates. "We work hard to reunite terminally ill patients with their family so that no inmate dies alone," a nurse said. "We do what we can to facilitate medical parole." She added that some prisoners choose to die in the RMU hospice, where they have formed relationships with staff and inmates, rather than in an outside hospital. The following inmate letter was received in June 1998 after the Committee's visit.

I am writing this letter of appreciation about the doctors and nurses at the Coxsackie RMU and the care I receive here. I know the only time you hear from inmates is when there are problems. Well, I don't have any problems with this unit. I have been in the infirmary at Mt. McGregor and Green Haven. I have been locked down since 1995 and in and out of hospitals since 1980. Of all the places I've been, this is the best by far.

I have a very bad heart disease, and it is good to know that the doctors and nurses and yes, even the C.O.'s, are very professional. They don't mind going that extra mile to provide me with the best of care. I just wanted you to know that there is bad and good everywhere, but here the good outweighs the bad. I know good care when I receive it, and I'm receiving it right now. I just wanted the doctors and nurses and yes, even the C.O.'s, to get a 'two-thumbs-up,' and I think they should all get a raise.

Does high-quality health care come at an exorbitant price? In the case of Coxsackie, it may come at a cost saving. In March 1999, the Department supplied the Correctional Association with a comparison of the costs estimated to operate the unit by DOCS versus an outside provider. The Department's projected costs were \$4,706,801; those of CMS were \$3,800,000. The "savings," according to DOCS, if these projections were accurate, would be nearly one million dollars (\$906,801).

“Another benefit of privatized health care is that it is more visible,” said a CMS employee who requested anonymity. “Public companies have more accountability, so there is naturally a higher level of scrutiny.” While there are certainly pros and cons to privatized correctional health care, in the case of Coxsackie, at this time there are clearly more pros.

Management of HIV/AIDS at Wende Correctional Facility

Wende Correctional Facility is a maximum-security prison in the western region of the state. It houses approximately 925 inmates. It is highlighted here for its model HIV services and its knowledgeable and energetic medical staff.

When committee members asked about HIV/AIDS treatment, the physician assistant displayed impressive knowledge of the latest treatments and the levels of infection among Wende inmates. Of the 32 HIV+ inmates, he reported, without having to look at a chart or notes, 24 were taking HIV medication. He explained how inmates are tested, the counseling and education they receive and how he tracks medication compliance.

At Wende, inmates request testing through sick call. A nurse does post-test counseling and, if a person is positive, he is immediately referred to a physician. “We try to reiterate the importance of testing, treatment and compliance with medication,” the physician assistant said. “I review their charts regularly to determine viral load counts and check the pharmacy records to see if they are taking their meds.” If an inmate is not compliant, the physician assistant offers counseling, education and encouragement. “Currently, 20 of the 24 are doing pretty well with their medication,” he noted.

Responsive Leadership at Beacon Correctional Facility

The value of compassionate, responsive leadership in a prison setting cannot be overemphasized. In 1998, when Susan Schultz became superintendent of Beacon Correctional Facility, a 228-bed prison for women, one of her first priorities was to identify the reasons behind the high number of medical grievances. She asked the Department's Health Services Division to conduct an internal audit. "I wanted to determine if inmates' complaints were justified," she said, "and that malingering wasn't the problem." According to the superintendent, early results of the audit indicated that malingering was not, in fact, the problem. Committee members were impressed with the superintendent's candor and her commitment to improving inmate health care.

Because Beacon is a minimum-security prison known as a "camp," where the length of stay (approximately two years) is lower than average, the Department does not provide full-time, onsite medical coverage. Beacon inmates in need of medical attention are transported to the clinic at Fishkill, a men's prison half a mile up the road. This arrangement presents problems when staff is not immediately available for transportation and seemed to concern both inmates and staff.

Several months after the Committee's visit, the Department agreed to assign a physician to Beacon one day a week (for four hours) to review patient charts and examine up to six inmate-patients. Superintendent Schultz said she was hoping to double the physician's time. Patients in need of specialty care are seen by specialists, who now come to Beacon on a regular basis to conduct clinics.

Superintendent Schultz also responds well to new issues. When the Correctional Association reported that inmates expressed concern about Lyme disease (Beacon inmates live and work in a heavily wooded area), the superintendent took action. The Department's Health Services Division developed

two Lyme disease protocols: an educational guide for inmates who work outdoors, and a guide for staff on the symptoms and treatments of Lyme disease.

Seizure Training for Correction Staff at Albion Correctional Facility

Correction officers are typically the first to arrive on the scene of medical emergencies. Certification and training in certain life-saving procedures are vital. At the state's largest women's prison, Albion Correctional Facility in western New York, inmates reported that housing area correction officers either did not know how to, or were reluctant to, respond when an inmate had a seizure, leaving her to be tended by other inmates. Prisoners expressed a high level of anxiety about the frequency of inmate seizures and the lack of response from medical or security personnel. After the visit, the Correctional Association recommended that a protocol be developed to educate correction staff on seizure response. Medical staff at Albion has since developed a training module for correction officers on responding to inmates with seizure disorder.

Medical Services at Bedford Hills Correctional Facility

Bedford Hills Correctional Facility, New York's maximum-security prison for women, is recognized in correctional health care circles as providing first-rate medical services. It is rare for the Correctional Association to receive a complaint about medical care from a Bedford Hills inmate.

Improvements in health care were prompted by litigation (*Todaro v. Coughlin*, filed by the Legal Aid Society in 1974) resulting in a court order governing all aspects of care, and by a superintendent who has championed reform from the start. Among the most significant changes at Bedford Hills are enhanced staffing levels and access to physicians. The facility health services director has expertise in the clinical management of HIV/AIDS; staff physicians have training in primary care. Furthermore, the ruling mandates that a prisoner has the right to

see a physician if requested. Regardless of the recommendation of the sick call nurse, if a patient requests a physician appointment, one must be scheduled no more than 14 calendar days from the request. Also, the court order requires that nurses conducting medical screening at Bedford Hills receive training in triage assessment and the diagnosis and treatment of infectious diseases.

Finally, Bedford Hills deserves praise for its peer education program for HIV+ inmates. Known as “ACE” (AIDS Counseling and Education), the program has received national recognition for its effectiveness in educating inmates about HIV/AIDS. *Breaking the Walls of Silence* (Overlook Press, 1998) traces the development and successes of the program.

MEDICAL SERVICES IN WOMEN'S PRISONS

Special Needs of Female Patients

Participating in a nationwide trend, New York State has experienced a tremendous rise in its female prison population. Fifteen years ago, 900 women were confined in New York State prisons. By 1999, that number had nearly quadrupled to over 3,500 women.

Between 1997 and 1999, the Correctional Association conducted site visits to four women's prisons: Albion Correctional Facility, a medium-security prison near Rochester; Bayview Correctional Facility, a medium-security prison and work release center in New York City; Bedford Hills, the system's only maximum-security prison for women, and Beacon Correctional Facility, a minimum-security work camp in Dutchess County. In addition to touring the medical clinics, Committee researchers discussed health care issues with prison administrators, all levels of the medical staff, members of the Inmate Liaison Committees and individual prisoners during conversations in dorms, Special Housing Units and the mess hall.

Studies show incarcerated women require more health care services than male prisoners and tend to use health services more often. In fact, in response to the growing number of women behind bars, the National Commission on Correctional Health Care recommended separate standards in 1994 for addressing the special needs of incarcerated women. The Commission cited evidence that the traditional, male-centered model of prison health care neglected the needs of incarcerated women.

To provide adequate health care to female prisoners, it is important not only to move beyond the traditional male-centered model of correctional health care but beyond the community model as well, which has narrowly defined women's health needs in terms of reproductive health. In 1994 former New York Governor Mario Cuomo directed the New York State Division for Women and the Department of Health to study women's health issues. According to the report issued by this group, the Governor's Interagency Work Group on Women's Health, it is essential that health care providers who treat female prisoners understand the social illnesses that affect their physical and mental health. Problems such as domestic violence, drug addiction and sexual assault must be addressed in the broader treatment plans of female offenders.

Because of poverty, chronic drug use and impeded access to medical care in the community, incarcerated women are more likely to experience serious health problems—epilepsy, diabetes, high blood pressure, asthma, HIV/AIDS and mental illness—than their counterparts in mainstream society. In New York, mortality among female prisoners is double that of women in equivalent age groups in the community.

Similarly, female prisoners are disproportionately affected by HIV/AIDS compared to incarcerated men and to society as whole. Overall, HIV prevalence is 50% higher in incarcerated women than it is in male inmates throughout the United States and almost 100% higher in northeastern correctional facilities. According to DOCS' most recent blind HIV seropositivity study, 18% of women in New York State prisons are infected with HIV, compared to approximately 9% of men. In addition, women prisoners are at higher risk for contracting other sexually transmitted diseases and gynecological infections, for many of the same reasons they are at higher risk for HIV infection: drug use, unprotected sex with multiple high-risk partners and sexual abuse. At Albion Correctional Facility, for example, a nurse reported that approximately 80% of inmates had been treated for sexually transmitted diseases.

The frequency among women prisons of physical and sexual abuse, considered antecedent to HIV infection, contributes to health problems among women prisoners. In a 1998 study of Bedford Hills inmates, approximately 80% reported histories of severe physical violence and/or and childhood sexual abuse. For many incarcerated women, such abuse is an underlying cause of drug and alcohol addiction. The vast majority (nearly 80%) of the women in New York State prisons are self-reported substance abusers.

It has also been determined that female inmates have a higher prevalence of clinical depression than male inmates, particularly because of the severe emotional stress women experience when they are separated from their children. Fully three-quarters of women in prison are mothers, and most of these women were the primary caretakers of their children prior to incarceration. (About 10% of women inmates are pregnant when they enter prison.) For many women, being separated from their children produces profound depression and anxiety, which can lead to mental and physical illness, including self-injury and/or mutilation. Not surprisingly, recent studies reveal high rates of post-traumatic stress disorder among female inmates. In *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, author Terry Kupers, M.D. writes:

Studies show there is a high incidence of depression in women prisoners—higher than in men. Perhaps it is merely a matter of men acting out their emotional turmoil in aggressive acts that draw a lot of attention, whereas women suffer their depressions silently. But we also know that the experiences that make women prisoners a unique group—their long history of abuse, their deep commitment to mothering, their difficulty in maintaining self-esteem for an entire prison term filled with harsh treatment and sexual harassment—are also serious risk factors for depression and other forms of emotional distress.

Finally, depression can dampen a patient's motivation to adhere to anti-retroviral therapy. "This emphasizes the need to address core issues such as

depression so that patients will be motivated to adhere to ART,” according to participants at a February 1999 conference on the care of HIV+ prisoners.

Areas of Improvement

Over recent years, DOCS has made system-wide improvements in addressing the medical needs of its growing female prisoner population. In 1998, it revised its policy on gynecological examinations and Pap smears to include annual instead of three-year check-ups. In addition, in 1999 the Department established a comprehensive Primary Health Care Guideline for Female Prisoners. According to Department officials, the Guidelines were reviewed and approved by the New York State Chapter of the American College of Obstetrics and Gynecology. They require all new prisoners to receive a breast and pelvic exam, Pap smear, chest x-ray, blood work and urinalysis (including a pregnancy test), and an EKG. Mammograms are given to women aged 40 and above.

The Department also now requires that a female “observer” be present when a male physician performs a gynecological examination, a standard of care in the community. This practice not only minimizes the potential for sexual harassment and protects male employees against allegations, but helps relieve women’s apprehension of undergoing a gynecological exam. Female prisoners with histories of sexual trauma are particularly fearful of gynecological examinations conducted by a male practitioner.

Persistent Problems

The three leading concerns of female inmates were poor HIV/AIDS management, lack of confidentiality and insufficient mental health services. Researchers concluded that, except at Bedford Hills, HIV/AIDS services in women’s prisons are in need of improvement. The most noticeable shortcomings were the lack of adherence tracking for inmates taking HIV medications; delays in

receiving medication; too few medical staff with HIV/AIDS training; and a lack of administrative support for peer counseling and support services for infected inmates.

At two different women's prisons, inmates reported that medical staff administered the wrong medication. One inmate interviewed by a Committee physician said she received HIV medication even though she was not HIV+. The inmate became quite sick, and said the physician assistant admitted she had made a mistake and told the inmate not to report it. This story seemed unbelievable until Committee members heard of a similar incident at another women's prison. An HIV+ inmate in the infirmary told a Committee member that a nurse had given her the wrong HIV medication. Despite her protests, the inmate said, she could not get past the nurse to bring the matter to a doctor's attention. When meeting with the medical staff, Committee members raised the inmate's complaint. A physician assistant checked the inmate's records and confirmed that she had, indeed, been given the wrong medication. Apparently, the quality of HIV/AIDS care at this prison had deteriorated sharply after a staff nurse specializing in infectious diseases left the facility.

The following observations of a Committee physician following a 1997 site visit to a women's facility illustrate the range of issues associated with inadequacies in the Department's delivery of HIV/AIDS services.

Instances of delays in receiving prescribed medications were cited by the inmates. In one case, AZT (Zidovudine) was not available for two weeks. This delay has the potential to seriously compromise anti-HIV therapy by leading to viral resistance. On the other hand, most of the inmates interviewed were receiving combination anti-retroviral therapy for HIV disease.

A number of the women expressed a need and desire for an HIV support group. While acknowledging that a counselor had organized a six-week educational program on HIV, there was no ongoing support for inmates who had been diagnosed with HIV/AIDS. Indeed, the superintendent had refused to permit the periodical *AIDS*

Newsline to be distributed to the inmates, insisting it had to be mailed to individual inmates for them to receive it. She maintained her position even when the Visiting Committee pointed out that inmates might be concerned with confidentiality if AIDS-related material was being mailed to them.

In addition, inmates consistently raised concerns about the lack of medical privacy and confidentiality, particularly related to disclosure of HIV status. At one prison, women reported that sick call was sometimes conducted behind a curtain rather than in a soundproof area. At this facility and another women's prison, medical staff said they used inmate interpreters to translate the concerns of Spanish-speaking inmates.

In its standard on confidentiality, the National Commission on Correctional Health Care states: "Recognizing that being labeled as HIV+ may put an inmate at undue risk for compromised personal safety, it is particularly important that the rules of physician/patient confidentiality regarding HIV test results and diagnoses of AIDS be followed." Fear of stigmatization discourages women from being tested, from participating in support groups and from seeking life-prolonging medication.

Insufficient counseling is among the top three complaints the Correctional Association receives from female inmates. On every prison visit, inmates expressed an intense need for better and more mental health services. Separated from their children and confined in correctional facilities far from home, many female prisoners experience profound depression. Given the prevalence of HIV/AIDS, mental illness, addiction and victimization among female prisoners, Committee members were not surprised by their appeals for professional support.

For example, an inmate whom the Committee interviewed said she had been struggling with a painful and pressing situation, but was informed she would have to wait three weeks to see a mental health worker. According to the inmate, the counselor listened to her for a few minutes and summed up the session with a

brusque: “There is nothing I can do for you.” This account was similar to many others reported to the Committee.

FUTURE CONCERNS

Hepatitis C

“Hepatitis C is a long-term disease. We have ineffective therapy, and there is no vaccine. The problem is of overwhelming size.”

—Dr. Emil Miskovsky, a correctional health care expert
at the University of Texas, Medical Branch

Described by health care professionals as “the next epidemic,” hepatitis C poses a serious threat to inmates, correctional health care workers and the public at large. Recent prevalence studies of hepatitis C in U.S. prisons indicate that 40% of inmates are infected with the virus. Chronic hepatitis C develops in approximately 70% of infected people; 20% of these individuals will develop cirrhosis, which seriously damages the liver. Figures from the American Liver Foundation show that:

- African-Americans are twice as likely to be infected with hepatitis C as non-Latino whites;
- About 3.2% of African-Americans are infected with hepatitis C, compared to 2.1% of Latinos and 1.5% of the general population;
- 75% of injection drug users acquire hepatitis C; and
- Approximately 40% of individuals who are HIV+ are co-infected with hepatitis C.

Hepatitis C is easy to transmit and difficult to treat. The main drug therapy available for hepatitis C, interferon, is not only expensive (costing more than \$10,000 annually for medication alone), but has numerous side effects. According to the *Hepatitis C Practice Guidelines* issued by the Department in March of 1999, these side effects include: “chronic irritability, fatigue, myalgia, headaches, rage, confusion and neuropsychiatric disorders.” The guidelines also state that “severe and incapacitating depression can develop in persons without a history of

depression.” Equally troubling is that, according to the guidelines, “HIV infection is a relative contraindication to interferon treatment for hepatitis C. Since response to therapy is poor and current treatment regimens for this population are investigational, treatment should only be considered for inmates with normal T-cell counts and low viral loads and who have been compliant in their total HIV management process.” As noted previously, Committee researchers found that treatment compliance among HIV-infected inmates is generally uneven and insufficiently monitored.

According to DOCS, “The Department has recognized the growing importance of hepatitis C within the community and in its inmates.” Recently, DOCS asked the Department of Health to include testing for hepatitis C in its upcoming HIV seroprevalence survey and hosted a teleconference about hepatitis C in 1999.

In mid-1998, the Correctional Association began receiving letters from inmates and their relatives regarding hepatitis C. Complaints concern insufficient information about the disease, a lack of support from health care workers for infected inmates, perceived impediments to treatment and denial of vitamins and dietary supplements. The following letter from the mother of an inmate illustrates these concerns:

My son needs immediate care by a clinic specialist. He has hepatitis C that is in an advanced stage. The facility took him to a clinic once. Nothing else was done for him. Most of the time he is nauseated. He doesn't eat for three days at a time. He asked about Ensure (a dietary supplement DOCS provides for some inmates) because he wanted to get some vitamins and nourishment from that at least. The doctor told him he had to order it. He has requested blood work for three weeks now to see if his condition is worsening. He is in pain and depressed, which is part of the disease. He has asked to see a psychologist, all to no avail.

An Aging Population

“Death is not the worst possible outcome of medical care. Death is not even the worst possible outcome of incarceration. Dying alone, in pain, without social, familial and spiritual supports is the terrifying end that many prisoners fear. Unfortunately, it is too often the reality they experience.”

—Nancy Neveloff Dubler and Budd Heyman,
in *Clinical Practice in Correctional Medicine*

Although the research did not include geriatric care in New York State prisons, this report would not be complete without a discussion of the strain on health care resources that elderly inmates present. In New York State prisons, men 55 and older comprise one of the fastest growing cohorts. With the reenactment of the death penalty in 1995, which included a sentence of life without parole, many inmates will spend their final years behind bars. Department figures show that 560 state inmates are currently facing a minimum of 50 years in prison:

- 335 are serving minimums of 50 to 74 years;
- 88 are serving minimums of 75 to 99 years;
- 91 are serving minimums of 100 years or more; and
- 46 are serving life without parole.

As the elderly become a larger percentage of inmates, correctional administrators will confront many challenges in addressing their needs. As discussed in the 1998 publication, *The Changing Career of the Correctional Officer*:

If aging inmates are simply placed with the overall population, they will be vulnerable to being preyed upon by younger, healthier inmates. They are also less likely to be able to participate physically in recreational and vocational programs that are traditionally offered in correctional facilities. Nor, in many cases, can they eat the same foods as other inmates, because aging is often accompanied by more restrictive diets.

Meeting the housing, recreational, rehabilitative and even dietary needs of geriatric inmates presents issues that correctional agencies will be confronting in the years ahead.

Studies show that nearly every geriatric inmate has some long-term chronic debilitation that requires frequent medical attention. In fact, the annual cost of confining a prisoner age 55 and older averages \$69,000 per year, about triple the cost of confining younger inmates because of the higher rates of chronic illness among older prisoners.

In addition, there are policy and moral implications to keeping elderly and infirm inmates behind bars. Countless studies show that as people age, both the tendency and the ability to commit crime decline. Housing elderly people who pose little threat to society in nursing homes with bars defies sound prison management when overcrowding already threatens security. In 1999, the New York State prison system operated at 130% capacity.

Morally, too, society must examine its values when it subjects hundreds of people to spending their final years in prison when alternative sanctions, such as electronic monitoring, for example, exist.

RECOMMENDATIONS

1. Increase External Oversight

Far too many taxpayer dollars are spent (\$175 million in fiscal year 1998-1999) on health care within prison walls for there not to be external review and higher standards of accountability. Given the longstanding problems associated with health care in New York State prisons and the larger public health issues at stake when inmate health care is inadequate, more stringent external oversight is recommended.

To this end, the Correctional Association urges the Governor and State Legislature to appoint and fund an oversight committee charged with assuring quality health care in state prisons. Such a committee might include correctional health care experts and practitioners, individuals with public policy, public health and fiscal management credentials, the commissioner and chief medical officer of the Department of Correctional Services (DOCS), and senior officials from the Department of Health. The committee would monitor the quality of medical services in state prisons and have the authority to direct facility-level and system-wide change. It would disclose its findings and recommendations regularly, in the form of a published report or conference, to the Governor, the legislative leadership and the Senate and Assembly's Committee on Correction and Committee on Health. Findings should also be made available to the public.

Clearly, the challenge of providing health care to 71,000 state prisoners is made more difficult by systemic constraints that will require budgetary changes, union negotiation and legislative oversight to overcome. The Correctional Association recommends that the state give serious consideration to developing and implementing the following recommendations, and that the proposed oversight committee guide their implementation.

2. Strengthen Quality Assurance Mechanisms

Inmate health care varies greatly among state prisons and no meaningful, coordinated quality control program exists to regulate care. To raise the quality and uniformity of prison health care, a commitment to quality assurance must be articulated by the chief medical officer, practiced by facility health services directors and evaluated regularly by regional medical directors. Specifically, the Department should:

- Design and implement a system-wide quality control protocol to guide practitioners in improving and evaluating the quality of inmate health care.
- Conduct yearly medical audits at each prison. The Department should publish and compare audit findings, including the number of medical grievances among prisons as a way to stimulate improvements. Baseline numbers should be established, and the Department should require action plans for lowering grievances in those facilities with above average grievances.
- Include the performance of health care staff and the number of medical grievances in the annual performance evaluations of state correctional facilities.
- Encourage accreditation by either the National Commission on Correctional Health Care (NCCHC) or the Joint Commission on Accreditation of Health Care Organizations (JCAHO). These agencies are known for rigorous audits and higher standards of evaluating correctional health care than the American Correctional Association.

3. Increase Salaries of Medical Staff

Prison medical personnel earn considerably less than their community-based counterparts. The quality of inmate health care will likely not improve unless the Governor and State Legislature increase the salaries of medical staff to make them competitive. In addition, there is little difference in the annual wages of regional medical directors, facility health services directors and prison physicians, and therefore little incentive for advancement. The Correctional Association recognizes that the salaries of state health care providers are determined by the Department of Civil Service (not DOCS) and that it will take collective bargaining to increase them. It is recommended that state legislators work with the appropriate union representatives, DOCS and Department of Civil Service officials to:

- Make the salaries of prison health care providers competitive.
- Stratify the levels of compensation among regional medical directors, facility health services directors and prison physicians.
- Enhance the salaries of physician assistants, nurse practitioners and pharmacists significantly. Increased pay for these positions, in particular, is essential.

4. Raise Qualifications of Physicians

For many of the physicians the Committee interviewed, the prison clinic appeared to be the employer of last resort. Lack of board certification, training in primary care and the leadership skills necessary to manage a busy prison clinic emerged as common problems. The Committee recommends that the Department of Civil Service and DOCS:

- Require higher qualifications for facility health services directors. A minimum standard of Board eligibility (which requires completion of an approved residency program) and a preference for Board certification in internal medicine or family medicine should be considered. Leadership ability and communication skills should also be more carefully evaluated in hiring decisions.
- Explore ways to terminate unqualified medical staff more expeditiously. Having to recall a physician's medical license in order to terminate employment (as an official reported is sometimes the Department's only recourse) is a profound indication of misguided policy.

5. Stop Subsidizing Health Care with Family Benefit Fund Monies

Since fiscal year 1995-1996, the Department has used over \$50 million from the Family Benefit Fund to subsidize inmate health care. The Family Benefit Fund was created to help the families of inmates maintain important ties with loved ones behind bars, not to pay for health care, which is clearly a state responsibility. The Department currently supplements the Fund with commissions ("kickbacks") it receives from phone companies, to which it awards lucrative phone contracts. Recipients of prisoner phone calls (inmates can only make "collect" calls) are charged \$1.10 per minute for long distance calls. Therefore, it is prisoners' friends and family members—the majority of whom live in New York City's poorest neighborhoods—who are subsidizing inmate health care. In addition to not using Family Benefit Fund monies to subsidize health care, the Department should:

- Solicit bids for new telephone contracts that offer no kickbacks to the state and that provide the lowest rates possible.

- Consider issuing inmates pin numbers as is done in New York City jails. This way, funds for calls can be deducted from commissary accounts and inmates are not restricted to making collect calls only.

6. Broaden and Expedite Recruitment

Staff shortages and long-term vacancies compromise the quality of care in many prisons. Despite increases in the prison population in the past decade, staffing levels have remained virtually the same in many clinics. Such critical positions as facility health services director go unfilled for months, in some cases years. In addition, more aggressive efforts should be made to increase minority representation among medical personnel. Health care providers who understand the cultural and psychosocial issues of inner-city patients are needed throughout the system. The Department should:

- Recognize the serious burdens that clinic vacancies place on existing staff and develop creative, more effective ways to expand and expedite recruitment. Better efforts should be made to re-deploy existing health care staff to cover unfilled positions.
- Offer a loan payback system for graduates of New York City or New York State medical schools. Physicians accustomed to working with inner-city patients are more likely to be familiar with the language, culture and ailments of New York State prisoners.
- Develop relationships with primary care residency programs in city hospitals to attract graduates who will look favorably upon loan repayment options.
- Consider sponsoring or piloting a residency training program in a prison clinic to improve recruitment.

7. Augment Training of Medical Staff

Appropriate officials at DOH, the State University of New York (SUNY) and teaching hospitals throughout the state should work with DOCS to:

- Train facility health services directors and staff physicians in Continuous Quality Improvement, the clinical management of HIV/AIDS and hepatitis C, and methods for addressing the psychosocial needs of inmate-patients.
- Provide training modules in the identification of infectious diseases and opportunistic infections for all medical personnel who conduct sick call. Restrict sick-call assignments to those individuals who have received this training.
- Offer special training for and evaluation of nurses who conduct sick call. Nurses should be required to take vital signs and document information on medical charts and be better skilled at distinguishing between (and coping with) malingering inmates and those with genuine health care concerns.
- Require facility health services directors to offer nurses support and guidance on how to handle inmate complaints, identify depression, de-escalate conflict and reduce grievances.

8. Expand HIV/AIDS Testing, Tracking, Education and Prevention

The Department lacks a statewide quality assurance program for the clinical management of HIV/AIDS. Twenty-five site visits revealed uneven care of HIV+ patients, too many health care personnel untrained in the clinical management of HIV/AIDS, and wide variations in the availability of HIV testing, support services and education. To avoid the public and personal health care costs associated with poor HIV/AIDS management, the Department should:

- Encourage every inmate who enters the system to take an HIV test. Prisoners should be offered testing opportunities every three to six months thereafter since inmates are often deluged with information upon entry and likely to postpone testing. More inmates should be receiving primary treatment of HIV sooner rather than later.
- Increase funding for the Criminal Justice Initiative so that the established goal of providing the full range of HIV services in each prison can be realized.
- Distribute (in writing or on video) educational materials on HIV/AIDS, in English and Spanish, to all inmates, not just those considered high-risk or known to be infected.
- Strongly encourage inmates who are diagnosed with HIV to begin life-prolonging treatment. More opportunities for pre- and post-test counseling and peer education and support groups should be offered.
- Recognize the existence of high-risk behavior among inmates that leads to the spread of HIV/AIDS (sexual activity, intravenous drug use and tattooing). As other correction departments throughout the country have safely done, the Department should help prevent transmission by making condoms available to inmates requesting them from the clinic.

9. Expedite Computerization of Medical Records System

While some states are experimenting with such innovations as inmate “smart cards” that store a patient’s entire medical history and future appointments on a memory chip, many New York prison clinics still operate with manual appointment logs and medical records. Lack of a uniform, computerized medical

system results in serious and costly problems: Inmate charts and medical records are lost during transfers to other facilities; chronically ill patients miss appointments and critical follow-up procedures. While DOCS has begun the complicated process of computerization, it is critical that state officials:

- Immediately allocate the funds and resources needed to expedite the steps DOCS has taken toward computerizing its medical system.
- Explore ways to link the medical records systems of the New York City and New York State corrections departments so that costly tests administered in city jails are not repeated unnecessarily, days later, in state facilities.

10. Improve Care of the Chronically Ill

Inmates with chronic conditions, such as asthma, diabetes, HIV/AIDS and heart disease, are insufficiently monitored by prison health care staff. Important follow-up appointments to determine medication adjustment and adherence and changes in a patient's condition are frequently missed because no single doctor examines and treats the same patient regularly. The Department's pilot practice of assigning inmate-patients to a single primary care provider in prisons is a step in the right direction. The following steps also should be taken:

- Designate a chronic health care services coordinator at each prison to ensure that regular services and treatments, as well as outside specialty care appointments, are scheduled and completed in a timely manner.
- Assign every inmate who has a chronic condition to a regular primary care provider who coordinates medical services, educates and counsels the patient and monitors medication adherence and response to therapy.

- Use incarceration as an opportunity for patient education and devise innovative programs for that purpose. At Green Haven, for example, a nurse is developing an inmate health education program that will be broadcast on the prison television station.
- Create and distribute in English and Spanish disease prevention brochures and guidelines for living with chronic illnesses. Such measures encourage inmates to take responsibility for their health, mitigate the costs of serious and preventable illness, reinforce doctor recommendations, and save precious medical staff time.

11. Respect Physician-Patient Confidentiality

In the closed and idle world of prison, rumors and gossip spread quickly. Personal information can be used by inmates and staff to embarrass and humiliate inmates. Many prisoners complained about instances in which medical personnel and/or correction officers disclosed confidential medical information, which was later used against them. To address this problem, DOCS should:

- Emphasize in staff training the community standard of physician-patient confidentiality. Inmates' medical information should be restricted exclusively to health care providers, unless the security of the institution or the well being of staff or inmates is seriously threatened.
- Eliminate security staff involvement in sign-up procedures for sick call. Consider installing locked boxes throughout facilities, accessible only by medical staff, in which inmates place requests for sick call.
- Announce call-outs for health services as general medical appointments, not HIV-specific, mental health-specific or other dead giveaways such as "Time for psych meds," as inmates at one facility reported to researchers.

12. Increase Language Translation Services

There are over 7,000 Spanish-dominant inmates throughout the New York State prison system. Researchers received reports of Spanish-speaking inmates who were given medical information they did not understand, drug prescriptions they could not read and generally substandard health care due to miscommunication. The following recommendations should be implemented so that the needs of a significant and growing population of prisoners can be met:

- Give written—as well as oral—instructions with all new prescriptions. This information should be readily available in Spanish if needed.
- Require that at least one member of the medical staff, and more members in facilities with significant percentages of Spanish-dominant inmates, be fluent in Spanish.
- Expand use of AT&T's telephone interpretation service, which provides instant translation in 17 languages. This service is currently used by intake screening staff at Downstate Correctional Facility.

13. Supplement Social Services for Female Inmates

Female inmates suffer more from clinical depression than male inmates, mainly because of the profound despair they feel at being separated from their children. In conjunction with the New York State Office of Mental Health, the Department should:

- Increase funding for social workers for individual and group counseling.
- Open a family reunion program at Albion Correctional Facility (the largest women's prison in the state) to help female prisoners cope with separation

from their children, strengthen family ties and prepare family members for the inmate's return.

- Contact women's organizations in the community for volunteer speakers, mentors and post-release services.

14. Address Long-term Health Needs in Discharge Planning

The Department releases approximately 30,000 inmates annually. With the exception of HIV+ inmates, who receive a month's supply of medication at discharge, inmates with chronic medical conditions are released without even a prescription. Obviously, most prisoners do not have jobs with medical benefits awaiting them in the community and must rely on Medicaid to cover their medical expenses. However, the New York City agency that oversees public assistance and Medicaid (The Office of Human Resources Administration) takes a minimum of 45 days to process applications, which presents serious problems for inmates who need medication daily and/or medical treatment regularly. It is recommended that:

- The appropriate federal, state and city agencies work together to ensure that the medical needs of ex-offenders, particularly the elderly and those with chronic illness, are met at least temporarily in the community.
- Prison medical staff and correction counselors begin transitional planning for inmates with HIV/AIDS and other chronic or life-threatening conditions at least six months prior to release.
- Discharge planning be conducted by trained counselors (not inmates) in each prison, who are able to identify community resources, process paperwork and guide inmates in how to access treatment upon release.

15. Take More Proactive Steps to Manage Hepatitis C

The steps the Department has taken in addressing hepatitis C—issuing treatment guidelines, initiating testing and hosting an educational conference—are steps in the right direction. However, given the prevalence of the virus in prisons throughout the country, the high cost of treatment and the complexity of treatment regimens, New York health officials might be wise to:

- Work with DOH and SUNY to enhance diagnosis and treatment procedures. (The Virginia Department of Corrections, for example, is collaborating with the University of Virginia to develop a telemedicine program to treat infected inmates.)
- Offer hepatitis C awareness and prevention information to all inmates, correction staff and health care providers.
- Since the virus is easily transmitted through sexual contact, make condoms available to inmates through sick call.

16. Provide Alternatives to Incarceration for Elderly Prisoners

The growing number of elderly inmates presents significant fiscal, policy and moral dilemmas. Given that the health care costs for geriatric inmates is triple that of younger inmates and the likelihood of re-offending by elderly prisoners is low, many states have adopted compassionate release programs and alternatives to incarceration such as electronic monitoring. New York lawmakers should re-examine the value of mandating that hundreds of people spend their final years in nursing homes with bars, and do taxpayers, correction staff and elderly inmates a service by following their enlightened colleagues from other states, such as Virginia, Maryland and Louisiana, in identifying more humane alternatives for elderly prisoners. The Governor and state legislature should:

- Endorse and enact Senate Bill 2582A and Assembly Bill 00257A, which would provide for the geriatric parole and electronic detention of elderly inmates who no longer pose a threat to society.

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