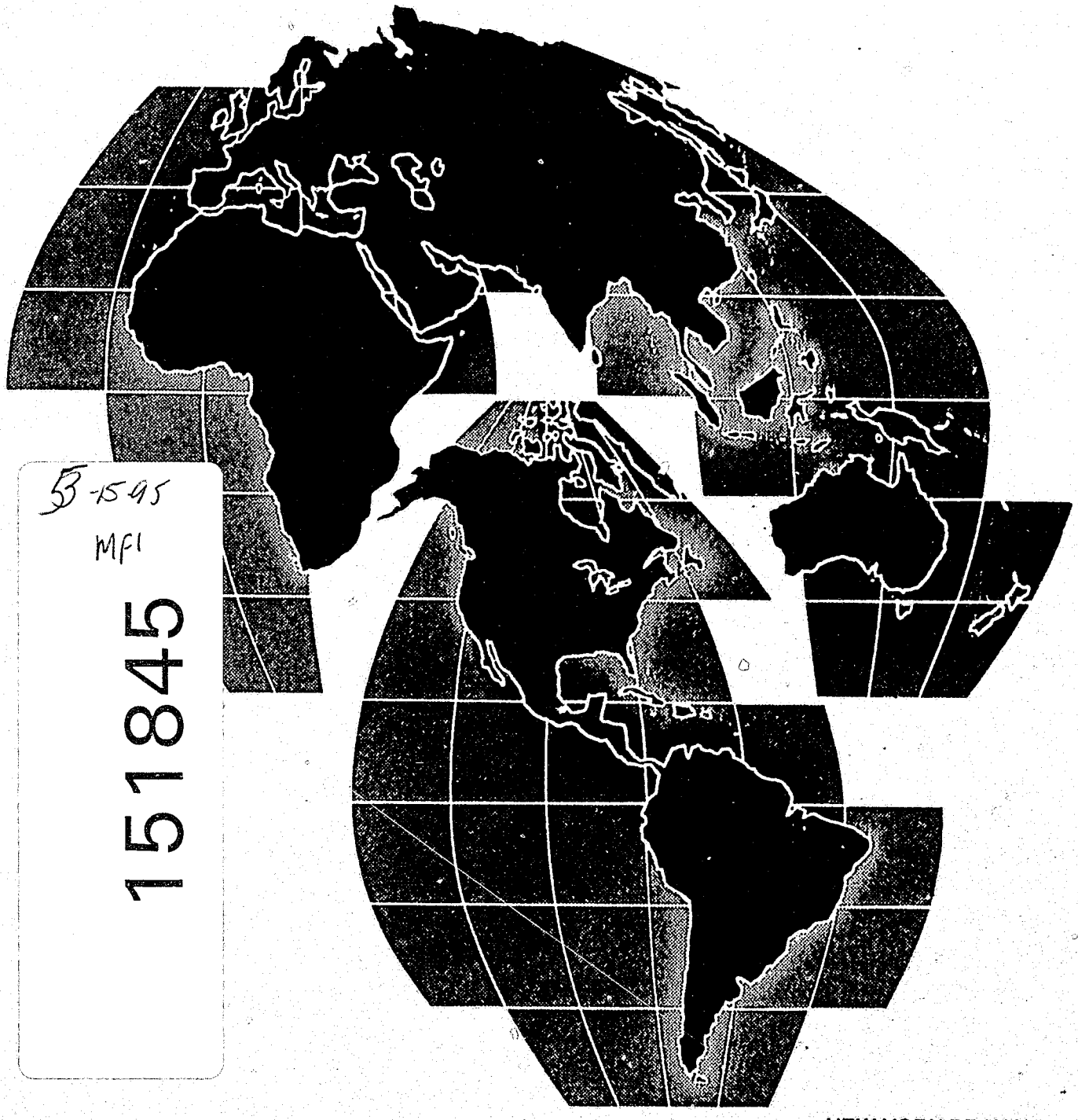
INTERNATIONAL PRISON HEALTH CARE REPORT



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ALLIANCE OF NON-GOVERNMENTAL ORGANIZATIONS (NGOs) ON CRIME PREVENTION AND CRIMINAL JUSTICE
IN CONSULTATIVE STATUS WITH THE UNITED NATIONS

ALLIANCE OF NON-GOVERNMENTAL ORGANIZATIONS (NGOs) ON CRIME PREVENTION AND CRIMINAL JUSTICE

WORKING PARTY ON PRISON HEALTH CARE

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ALLIANCE OF NGOs ON CRIME PREVENTION AND CRIMINAL JUSTICE

DEFINITION AND ORIGINS

A coalition of international NGOs which have consultative status with the UN's Economic and Social Council, the Alliance was formed in 1972 at the request of William Clifford, the Chief of then Social Defence Section (now the Crime Prevention and Criminal Justice Branch). G.O.W. Mueller chaired the Alliance during its early days.

GOALS

- To facilitate planning for international policy in crime prevention and criminal justice by providing for an institutional two-way conduit of information and consultation between the UN Secretariat and the international NGO community

- To assist the UN in identification of issues, provision of research studies, recommendations for action, and technical assistance in specific areas of Alliance interest

- To strengthen the collective services of the Alliance through exchange of information and cooperation among member organizations regarding programs, research projects, publication, and other matters of mutual interest

MEMBERSHIP

There are two classes of Alliance affiliation — member and observer. Membership is open to those non-governmental organizations in consultative status with the UN which have substantial interest in some aspect of crime prevention, criminal justice administration or the treatment of offenders. NGOs in consultative status with some interest in the subject qualify as observers. In addition, observer status is extended to those national and international organizations with a significant interest in this area which are not in consultative status with the UN. Recent Alliance Working Parties have also reached out to "Ad Hoc" members, that is, individuals and/or organizations which limit their participation to the specific area under study.

AFFILIATES

Members:

Academy of Criminal Justice Sciences
Amnesty International
Defense for Children International
Howard League for Penal Reform (UK)
International Association of Chiefs of Police
International Association of Judges
International Association of Juvenile and Family Court Magistrates
International Association of Penal Law
International Association of Residential and Community Alternatives
International Commission of Jurists
International Council on Alcohol and Addictions
International Narcotics Enforcement Officers Association
International Prisoners Aid Association
International Society for Criminology
International Society for Social Defense
Jaycees International
Prison Fellowship International
Societe Internationale de Prophpylaxie Criminelle
The Salvation Army
World Federation for Mental Health
World Psychiatric Association

Observers:

American Correctional Association
Canadian Criminal Justice Association
Commission on Accreditation
Friends World Committee for Consultation
International Council of Prison Medical Services
International Legal Defense Council
International Penal and Penitentiary Foundation
International Police Association (US Section)
International Probation Association
International Social Service
International Society for Traumatic Stress Studies
National Associations Active in Criminal Justice in Canada
The Society for the Psychological Study of Social Issues
World Union of Catholic Women's Organizations

ACTIVITIES

The Alliance functions as a true coalition. The topics are identified by members according to their individual experience and interest. The work is carried out by representatives of member organizations coming together in Working Parties.

The following represent the major activities of the Alliance past and present:

- Its initiative and hard work were responsible for the treaties and conventions which allowed imprisoned foreigners to be returned to their home country to complete their sentences and also introduced "consent of the prisoner" into international law;

- It developed a code of conduct for law enforcement officers and recommended its adoption by the UN General Assembly;

- It conceived and implemented an international research project on children in prison with their mothers, published the results of the project and distributed it to all interested parties;

- It drafted recommendations on the treatment of foreign prisoners which were later approved by the UN General Assembly;

- It actively assisted the UN Crime Prevention Branch by developing draft guidelines for alternatives to prison in preparation for the 8th UN Congress in Havana, Cuba;

- In late 1992 it formed a Working Party on Prevention to assist the UN Crime Prevention Branch in fulfilling the new Commission's mandate in this area.

In addition to working on substantive issues, the Alliance was instrumental in the development of NGO sponsored ancillary meetings as part of the UN Crime Congresses, which are held every five years. The Alliance has been responsible for arrangements, including provision of simultaneous interpretation for these meetings, which are unique in the UN system.

Within recent years the Alliance has established an Information Center which both coordinates the surveys developed by individual working parties and responds to requests for assistance and/or information from individuals and countries around the world. The Center's activities have increased over the past year because of the traumatic changes occurring among Eastern Bloc countries. Many of the latter find themselves ill equipped to deal with criminal justice issues under their new systems of government.

When the UN Crime Prevention Branch was relocated to Vienna, a group of NGOs formed an Alliance in that city. While they have separate membership, both organizations share a common name and purpose. The Vienna group has frequently contributed to the work of the New York

Alliance.

The Alliance and its Working Parties meet five (5) times a year — the second Friday in January, March, May, September and December.

WORKING PARTY ON PRISON HEALTH CARE

In 1993 the Alliance released the results of a survey on the status of prison health care, and developed a list of minimum standards for use by prison systems world-wide. In cooperation with health experts and input from several international sources, a questionnaire was prepared to help determine the current state of prison health care, to compare prison health care on an international scope and to determine the health care needs of the international correctional community.

The following report is a comparative study of international prison health care. The survey was conducted and compiled by the Alliance's Information Center. Surveys, which were also translated into French and Spanish, were sent to Justice Ministers, Prison Administrators, and Ambassadors of Member States maintaining permanent missions to the United Nations. Alliance members were also given questionnaires for distribution.

A search was conducted of existing minimum standards dealing with prison health care. A comparison was done isolating the minimum basic health care standards for the international criminal prisoner. The minimum standards are reported in order to provide the reader with a listing acceptable by the international community. Also included are examples for easy implementation of the minimum standards to help jurisdictions establish needed programs and procedures.

Finally, a listing of organizations that can help nations implement basic health care services is also included. It was recognized that many nations lack the financial and human resources necessary to meet the basic recommended minimum standards within the corrections community. Details on how to contact the Alliance Information Center to get a list of helping organizations or how to acquire needed resources can be found within the report.

An additional information sheet was developed to help identify other areas of potential concern for the Alliance membership to look at and provide help. This information sheet can be found at the end of this report. The Alliance would appreciate any information and comments you feel are relevant to their work.

INTRODUCTION

The Alliance has structured its work on this and similar projects in a way that we hope will result in maximum benefit to those wishing to take action.

First, a survey was conducted to find out what the current "state of the art" is. Though we realize that some answers might contain a little of what the respondents hoped rather than what is, we feel that what we received gives a fairly clear picture of the reality and the hopes.

Next we used several experts to review current international standards and list those felt to be absolutely essential. Though several sets of standards were reviewed, those listed in this booklet were listed in common by every standard setting group.

Again we turned to our experts to help provide written documentation for the implementation of each standard we listed. Thus a nation or individual institution can easily see how to move from what exists to what is desired.

Finally, our staff has compiled a list of non-governmental and governmental agencies which, through foreign aid, might be available to help in the implementation of some of the recommended standards. We fully recognize that some areas of the world are limited in the resources necessary to acquire and maintain the basic health of their general populations. It would be insensitive and foolish to suggest that scarce resources be diverted from others to the prison population. Thus, the suggestions and referrals to sources which correctional authorities can use to accomplish their goals.

INTERNATIONAL PRISON HEALTH CARE SURVEY SUMMARY

During the month of October, 1991, a total of 599 surveys on international health care in prisons were sent to representatives of 223 countries, including: 62, United Nations Advisory Council (Alliance) Members; 109, Correctional Administrators in foreign countries; 141, Embassy Ambassadors; 138, Justice Ministers in foreign countries; 90 to Prison Fellowship International charter national ministries and 59, Permanent Representatives to the United Nations.

The survey instrument included a three page questionnaire, a cover letter explaining the importance of the survey and the work of the Alliance and a request form (sent to United Nation's Ambassadors) for names and locations of Justice Ministers. The survey was translated into Spanish and French and was sent to those requesting translated surveys.

A total of 47 surveys were received from 41 nations representing each region of the world. Those responding by region include: 4 from Africa; 8 from America; 3 from Asia; 7 from Australia and the Pacific Islands; 16 from Europe; and 3 from the Mid East. Czechoslovakia, Italy, Norway, Saudi Arabia and United Republic of Tanzania sent in responses from two separate offices (the table results will specify which office responded). Several surveys were submitted in native language and translations were prepared and added to the results.

Based on the 47 respondents (dual respondents may not have similar responses), survey results show:

Medications are readily available in 39 countries and in 37 prisons systems. In Chile, Ecuador, Lebanon and Lesotho medications are available in the country but not in the prison systems. Luxembourg and Czechoslovakia have medications available in prisons but not in the country.

Basic health and nutrition is a significant problem in 8 countries and 15 prison systems.

Upon reception, a general assessment including medical and psychiatric screening is administered in a majority of the prison systems. Papua New Guinea and Suriname do not have any health care screening measures for their jails and prisons. It was difficult to translate Greece's response.

Testing for communicable diseases is done in all prison systems except: Czechoslovakia (selective); Ecuador (prisoner's request); England (not routinely); Lebanon (in rare cases); Lesotho; Norway (voluntary); Papua New Guinea (only upon prisoner's complaint); Sierra Leone (not routinely); Spain (voluntary); and Tonga (when a condition is suspected). HIV, hepatitis B, sexually transmitted diseases, tuberculosis and cholera are among the communicable diseases that prisoners are tested for at admission in many of the prison systems.

If communicable diseases are detected, prisoners are treated at prison hospitals in 17 prison systems and at outside hospitals in 2 prison systems. Both prison hospitals and community hospitals are available to prisoners with communicable diseases in 25 prison systems.

Physicians are used in prison systems in all countries except Guam, Lebanon and Papua New Guinea and work for either the prison system or the local health department. Likewise, nurses or other health care workers are employed by the same offices and are available in all systems except Guam, Ireland, Italy, Lebanon and Saudi Arabia.

Medications are ordered by doctors or medical officers in a majority of the systems. Fourteen prison systems have prison pharmacies. The remaining systems rely on local hospitals or community pharmacies or on relatives to supply medications needed.

Some form of medical records, including case histories, drug addiction, family history, etc. are kept in all countries except Colombia (in reality, they are not kept), Italy (kept by the doctor, no official prison record) and Papua New Guinea (none).

Health care training is offered only to the professional staff in 16 prison systems; to officers in 20 systems; and to prisoners in 7 systems. No health care training is given in 10 systems and none of the systems responding offer health care training for family members.

Prisoners exhibiting signs of mental illness are treated within the prison in 24 prison systems; in community facilities in 9 systems and 7 systems have both in-house and community facilities available. Greece, Nicaragua and Papua New Guinea do not have any provisions for evaluation or treatment of mentally ill prisoners.

The health care standards vary among prison systems. Most follow the standards set for their communities; however, many respondents reported that the prison health care standards need improving.

Families are not allowed to assist an ill prisoner while incarcerated in any of the responding countries.

Saudi Arabia, Switzerland and the Ukraine were the only respondents that stated that they did not feel that the local prison authorities would be receptive to the provision of basic health care services in their facilities if it was geared toward identifying individuals who might spread disease to security forces and their families. The Netherlands and Norway reported that this question did not apply to their prison system.

Czechoslovakia, Hong Kong, Luxembourg, Malta, New Zealand, Norway, Saudi Arabia, Spain, and USSR (survey was received prior to the dismantling of the Soviet Union and the Eastern Bloc nations) all agreed that members of local health care teams would not be receptive to basic prison health care training if offered by qualified professionals. Northern Ireland stated that this question did not apply to their prison system.

Priority in health care was as diverse as the countries that responded. It is best to read each individual country's response. Most countries did stress education and sanitation in their answers.

PROBLEMS

The survey generated a low response rate. Approximately 20 surveys were returned undeliverable. However; those countries did not generate a response even from the Permanent Representatives to the United Nations. Members of the Alliance were asked to send surveys to their contacts which generated only about 10% of the responses.

MINIMUM PRISON HEALTH CARE STANDARDS

1. RESPONSIBLE PRISON AUTHORITY

There is a Health Administrator, preferably a physician, whose responsibilities include arranging for all levels of health care and ensuring the quality and accessibility of health services provided to inmates.

2. TRAINING FOR HEALTH CARE AND PRISON STAFF

There is a written plan for training health care workers, approved by the Health Authority. Training, appropriate to position, is provided initially at orientation and on an ongoing basis. For prison staff, training, also approved by the Health Authority, deals with awareness of potential emergencies, what they should do when they face life-threatening situations and their responsibility for the early detection of illness and injury.

3. PHARMACEUTICALS

There are written policies and procedures that include procurement, storage, dispensing, distribution, accounting, administration and disposal of pharmaceuticals.

4. SCREENING AND HEALTH ASSESSMENT

There is initial screening by qualified health care personnel for communicable diseases and other conditions needing urgent medical attention. There is an in-depth health assessment, by qualified health personnel, including medical history, physical exam and a mental health evaluation within one to two weeks of arrival.

5. ACCESS TO TREATMENT

All inmates are advised orally upon arrival about access to treatment in institutions. Access includes entitlement to attend daily "sick call" and availability of emergency services when necessary. Suicide prevention and detoxification measures are also in existence.

6. SPECIAL NEEDS TREATMENT

Treatment is available for dental care, pre-natal care, chronic care, as well as ensuring that regular medical and psychiatric evaluation is made available for those inmates in solitary confinement. Also, there are written policies and procedures regarding the care of inmates with communicable diseases, including provision for isolation is medically necessary.

7. MEDICAL RECORDS

A complete medical record, utilizing a standard format, is established for each inmate. Such records are located in a secure place and any information in them is held in complete confidence.

8. MEDICAL/LEGAL ISSUES

Mechanisms are set in place regarding informed consent and the use of forced psychotropic medication. The use of inmates in biomedical, chemical or behavioral research is not permitted, unless such use meets ethical, medical and legal guidelines for human research.

The Eight United Nations Congress on the Prevention of Crime and the Treatment of Offenders

Statement of basic principles for the treatment of prisoners

1. All prisoners shall be treated with the respect due to their inherent dignity and value as human beings.

2. There shall be no discrimination on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

3. It is, however, desirable to respect the religious beliefs and cultural precepts of the group to which prisoners belong, whenever local conditions so require.

4. The responsibility of prisons for the custody of prisoners and for the protection of society against crime shall be discharged in keeping with a State's other social objectives and its fundamental responsibilities for promoting the well-being and development of all members of society.

5. Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and its Optional Protocol, and such other rights as are set out in other United Nations covenants.

6. All prisoners shall have the right to take part in cultural activities and education aimed at the full development of the human personality.

7. Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged.

8. Conditions shall be created enabling prisoners to undertake meaningful remunerated employment which will facilitate their reintegration into the country's labor market and permit them to contribute to their families' financial support and to their own.

9. Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

10. With the participation and help of the community and social institution, and with due regard to the interests of victims, favorable conditions shall be created for the reintegration of the ex-prisoner into society under the best possible conditions.

11. The above principles shall be applied impartially.

MINIMUM PRISON HEALTH CARE PROCEDURES

ORGANIZATIONAL STRUCTURE COMPONENTS

In creating a correctional health service or changing the structure of an existing one, there are several decisions that need to be made. Discussion of the various components of a model structure follows:

Need for a Systemwide Health Services Director

Every prison system — no matter how small — should have at least one individual who is responsible for health services systemwide. The health services director (HSD) should oversee the delivery systems at the unit level as well as develop systemwide policies and procedures. S/he should approve the health services budget and serve as a resource person for the director of corrections at budget hearings. Except perhaps for the very smallest systems with an inmate population of 1000 or less, a full-time HSD is needed.

Reporting Structure for the Systemwide HSD

The HSD should report directly to the head of the prison system. Health care is one of the most crucial and most costly of the services provided to inmates. With the exception of overcrowding, probably more prisons are sued over inadequate health services than any other single condition of confinement. A number of prison systems tend to place health services with other inmate programs such as food service, religious activities and library services, but this is not recommended. The importance of health services in the prison systems' total mission as well as the technical expertise required to make appropriate administrative decisions regarding personnel, service levels, equipment, supplies, etc., argue for a separate division with direct access to the head of the prison system.

Type of Professional Serving as the Systemwide HSD

The credentials of the individual serving as the HSD are as important as the level to which the position reports. Most of the systems with HSDs were utilizing clinicians of one type or another to fill this position. This is not sufficient by itself. It is imperative that the systemwide HSD have administrative skills, since this is an administrative not a clinical job. Clinical training usually does not include information on budgeting, finance, staffing patterns, material management or working with intra-governmental agencies, which are all skills needed by the HSD. An individual with a master's degree in health administratior is much better equipped to make the correct administrative decisions than are clinicians without such training.

On the other hand, some people believe that the HSD position is so important that only a physician should fill it. This is consistent with the standards which state that there should be a designated physician "...serving as the responsible and principal health authority..."; but others note that as physicians became busier and administrating health care became more complex, a new profession of health care administrators arose. Sometimes, too, authority is a team element — a physician in charge of professional matters plus an administrator for other business. The latter suggestion of a physician-administrator team is perhaps the best solution. A professional health administrator will need a physician clinical director to oversee professional matters and as noted previously, a physician serving as the HSD is likely to require a professional administrato. to assist him or her in decision-making. It does not really matter whether the clinical director reports to the health services administrator or vice versa as long as one of them is the final administrative authority. Where there is a physician who also is trained and experienced as an administrator, s/he could serve in both capacities. The physician's status in the community is an added advantage when approaching state legislatures for funding.

Areas Included Under Health Services

It is recommended that the health services program include medical, dental and mental health care under the same organizational umbrella. While each of these services may require a systemwide clinical director, all three positions, ultimately should report to the HSD. A 1989 survey found that where health services

were split in the prison systems, it was always the case that mental health care was operated separately. Since inmates have minds and bodies that are combined in single entities, it is much more logical for the health services treating these minds and bodies to be combined. It is also more cost-effective, since some staff and some resources can be shared and ordering items such as medications, supplies and medical records can be completed more efficiently. Additionally, combining these services under a single health authority helps to improve the quality of care by ensuring that all providers have access to information regarding patients' allergies, current medications and health status.

For those systems that use another state agency to provide mental health services, coordination of these services with the prison system's health program is imperative. It is recommended that the prison systems' health service director be responsible for coordinating mental health services and work with representatives of the outside agency to ensure that services are not duplicated and that pertinent information regarding patients is shared. Similarly, where one or more services are contracted out systemwide and the prison system operates the remaining services, there still needs to be a single designated HSD who oversees the contract services and supervises the prison systems' services.

Line Authority Over Unit Health Personnel

In order to ensure that systemwide policies and procedures are implemented at the prison units and that professional standards of care are followed, the HSD must have line authority over unit health staff. To place the HSD in the capacity of "consultant" to the prison health personnel is only a slight improvement over those systems that have no health services director. Without the authority to enforce compliance with systemwide policies and practices and to fire health staff when necessary, the HSD (and other central office health staff as well) cannot be totally effective. Line authority also provides the HSD with greater flexibility in staffing. Certain positions can be shared by institutions and health staff can be reassigned on either a temporary or permanent basis as the system's needs dictate.

Some systems use a concept of "dual supervision" where unit health personnel are clinically and professionally responsible to the systemwide HSD, but are responsible administratively to the head of the prison in which they work. Again, this is an improvement over the traditional model, but is less than ideal. The areas of authority are seldom so well-defined that conflicts do not develop between the wardens and the health services director. Additionally, the individual employee is placed in a potential bind, having to choose between two loyalties and at times, between conflicting orders. Under this system, more often than not it is the warden's directions that are followed, since the warden's supervision is immediate and daily and the systemwide health services director's is remote and occasional.

While any model can work depending upon the personalities involved and the degree of leadership exercised at the top, it is recommended that the health services director have line authority over unit health staff. This model is simple and avoids the problems of conflicting loyalties of unit health staff and blurred areas of supervision. The HSD's authority should not be absolute, however, it is important to coordinate personnel decisions with the unit wardens, since their observations can be useful. Decisions regarding hiring, firing and disciplining unit health staff should be made only after input has been solicited from the warden, the chief of health services at the unit, and other relevant supervisory staff.

If the prison system uses a contract firm, the HSD ordinarily will not have line authority over contract health employees. Nonetheless, the HSD can make recommendations to the chief contract administrator regarding the performance and suitability of specific contract personnel.

The Role of Central Office Health Staff

Because of difference in the size, organizational structure and complexity of the prison system's health services, it is difficult to specify the exact number of positions that will be needed in central office. A better approach may be to discuss the types of activities that should be centralized and let each system determine the number of people it will take to perform these tasks in its own system. It has been stated already that every system — no matter how small — should have at least one full-time HSD and further if there is to be only one health person in central office, both clinical and administrative skills are required. The reasons for these recommendations should become clearer after reviewing the activities listed below that should be performed by central

health staff.

a. Fiscal Management

One of the most important roles of the health services central office is to develop the budget for health services and to approve expenditures and contracts. It does not matter whether each prison unit's health services section develops its own budget (which is then consolidated in central office with other units' requests) or whether the central office health staff develops a budget for the system as a whole with input from unit staff. What is important is that the budget be approved by the HSD before being submitted to the director of the prison system and the legislature. Similarly, health services expenditures should be reviewed and approved by the HSD prior to payment.

The HSD also should approve all contracts for health providers, services and products used at the units. In most systems, it will be more cost-effective if the purchase of medical supplies and pharmaceuticals is centralized.

b. Standardization of Documentation

In order to ensure consistency in care and administrative effectiveness, it is necessary that certain types of written materials be standardized. Paramount among these is a systemwide policy and procedure manual. It should specify the levels of care and types of treatment provided and cover administrative matters, personnel issues and medical-legal concerns as well. The basic elements of care and the policies under which staff operate should be the same for all prisons in the prison system, although there may be some procedural differences from unit to unit. For example, the systemwide sick call policy may indicate the level of staff conducting sick call and how the encounters are to be recorded, but the time and frequency of sick call may vary with the individual prisons' needs and size. In addition to the basic health services policy manual, larger systems will want to develop separate procedural manuals for certain services such as nursing, laboratory, radiology, physical therapy etc.

All forms used in the medical record also should be standardized throughout the system. This not only ensures that the same types of information are collected on each patient, but it also facilitates use of the record by staff — both of which are important for continuity of care. In most systems, inmates are transferred so often to other prisons that staff refer to it as "bus therapy." Transfers occur daily for security reasons, medical reasons and to regulate population overflow at particular prisons. If the same forms are used systemwide and all units follow the same chart order, it is much easier for health staff to review the records of transferred inmates and to ensure that their care is not interrupted. Further, it is much more cost-effective to print multiple copies of one set of forms than to print smaller quantities of different sets of forms developed by each unit. It is recommended that systems with mixed organizational models require their contract firms to use the same medical record forms as do the rest of their prisons.

Certain forms used for administrative and statistical purposes should be standardized as well. For unit data to be used appropriately for system planning and decision-making, they must be collected the same way and reported in the same format.

c. Staffing Issues

Certain types of staffing activities are handled best on a centralized basis. The development of staffing ratios and decisions regarding shared positions and the placement of staff are more likely to be realistic if made by someone in central office. Additionally, the HSD can transfer staff and positions as the requirements of the units change.

Staff development is another area that often benefits from centralized planning. Continuing education is required for most health professionals both by licensing bodies and by standard-setting agencies. Centralization of this activity may include curricula development, conducting the actual training or simply coordinating the schedules and keeping the documentation for individual units. Similarly, most national standards mandate that correctional personnel receive health-related training on both a pre-service and an ongoing basis. Central health staff should assist custody staff in this endeavor as well.

d. Quality Assurance/Risk Management

Another important role of the HSD (or other central office health staff) is to oversee ongoing quality assurance activities. A plan should be developed that specifies the type of unit monitoring and evaluation that will occur, the

criteria that will be used, the frequency of such monitoring and who will conduct it. Clinical supervision of unit health professionals and constant review of health care processes are imperative if quality care is to be maintained and liability reduced.

In the larger prison systems, unit personnel should be required to conduct some quality assurance activities, while central staff concentrate on monitoring implementation of systemwide policies, uniform documentation and special reviews. In the smaller systems, the systemwide clinical director may undertake all quality assurance assessments. For those systems using contract firms, the HSD not only should monitor adherence to the terms of the agreement, but should conduct quality improvement studies as well.

Responding to inmate grievances on health matters is another activity that can be centralized. If the inmate is not satisfied with the answer provided at the unit level, it is important to have an individual outside the unit to whom s/he can appeal. The systemwide HSD should be in the best position to determine the merits of inmates' complaints and to decide what remedies, if any, are needed.

e. Health Resources

There are a plethora of other decisions that need to be made on a systemwide basis including those on unit equipment needs, repair-renovation of clinical facilities and planning for new health services units. The HSD also must determine for each prison and the system as a whole which services it will be more cost-effective to provide in-house and which will be better to purchase from community providers. Some of these services (such as inpatient hospitalization, emergency medical transportation and dialysis) are very costly and require careful cost-benefit analysis of all available options.

Clearly, the increasing costs of providing correctional health care coupled with the increasing level of sophistication required to cope with AIDS and an aging prison population mandate the services of a systemwide clinical director at a minimum for each prison system. As noted previously, the smaller states may wish to look for one individual who can serve in both capacities, if two full-time positions are not justified.

STAFF DEVELOPMENT PROGRAMS

Another personnel consideration is to determine the type and extent of training that staff should receive. Both correctional and medical staff have training needs, but since the role of the health services unit differs with respect to that training, they are discussed separately:

Health Staff

Newly hired health staff require orientation to the prison environment and all health employees benefit from ongoing training opportunities. The primary decisions that the systemwide health services director needs to make concern the content of the training, the length and frequency of course offerings, who should receive them and who should conduct them.

a. Orientation

Orienting new employees to the prison environment and to the health services division helps to familiarize them with rules and regulations and to avoid certain pitfalls. While the clinical aspects of medicine in corrections may be similar to the community's, the setting and the patients usually are not. The orientation program for new health employees should focus on these differences as well as on the similarities between correctional and community practice.

Security is the overriding concern in correctional institutions and as such, all new employees must be aware of security issues. It is important, though, to remind health staff that they are not security officers. Their primary role is to serve the health needs of their patients. Another group of professionals is responsible for performing the various custody functions.

Some prison systems still require new health staff to undergo the same initial training as new correctional staff. Health staff do not need training in weaponry, riot control and use of force, which are the province of correctional professionals. While they may need exposure to some of the same issues as correctional staff, they do not need the same intensity of training. Having a single orientation program for all staff not only wastes the clinicians' valuable time in learning material and skills that will not be used, but also fails to address those issues specific to

health services that new health employees need to know. Further, training health professionals first as correctional officers makes it more difficult for them to maintain their role of neutrality in non-medical issues and to avoid co-optation by security officials on health matters. Thus, separate orientation programs for new correctional and health staff is a better approach than joint orientation, even though both groups need some awareness of the other's concerns and regulations.

Another topic that should be addressed in orientation for new health staff is defining the population to be served and describing the inmate social system. Information about who goes to prison, including their ethnic and class makeup, can be useful as can any epidemiological data or description of special needs of the inmates in the system. Also, some mention should be made of the "games inmates play" in attempting to manipulate the health staff for their own purposes. Since new staff are particularly vulnerable, it is a good idea to review some of the ways inmates may try to "con" them into providing unneeded services or violating prison rules. Often, much is made of the manipulative nature of inmates. It is worth remembering, though, that clinicians are "conned" in all settings, public and private. The motives and methods of inmate/patients may differ, but the concept of manipulation is not unique to the correctional environment.

The orientation program also should contain information about the organizational structure of the department of corrections, the health services division and the various prison units. The rules and regulations of the prison system as a whole as well as the health services policies and procedures should be reviewed. The orientation program generally does not cover specific job responsibilities. It is anticipated that additional instruction on particular tasks and duties will be provided on a one-on-one basis at the employee's work station. Other topics that may be addressed in initial orientation for health professionals include an overview of the criminal justice system; an introduction to corrections including its purposes and terminology, and sometimes, inmate slang; and general personnel policies. Throughout the orientation, it is important to remind health professionals that although the setting is different, the basic precepts, principles and standards of their own disciplines remain the same.

The length of the orientation program may vary, but two or three days should be the minimum. When it is offered is a more important consideration. Ideally, new employees should be oriented to the system before reporting to their work stations. Larger prison systems usually can adhere to this timetable, since they may have several new health employees starting at about the same time or they may specifically schedule starting dates to coincide with orientation offerings. Smaller departments may have to balance the employees' need for timely orientation with practical considerations regarding class size. Still orientation should occur within the first month or two of employment for it to be worthwhile.

Some standards require that initial orientation be provided to all full-time health personnel. Consideration should be given to include regular part-time employees and consultants in orientation programs as well. Often, they are excluded because the health services director does not want to pay for their time while in training. This can be short-sighted, though, since these individuals also need an awareness of security issues, health services policies and procedures, and the patients they are serving.

Who should conduct the orientation is another issue. In the larger prison systems, there may be a health education section in central office. Health educators may teach the orientation themselves as well as draw guest lecturers for various components of the curriculum. In smaller prison systems, the orientation may be provided by a co-worker on a one-on-one basis. Who conducts it is less important than having a set curriculum, which is reviewed with all new employees on a timely basis.

b. In-service Training

The term "in-service training" as used here is intended to encompass a variety of training activities ranging from instruction provided on-site to formal continuing education offerings. Its primary purpose is to ensure that health staff are kept up-to-date on clinical issues and administrative procedures. Its primary benefit is that of improving the quality of care and secondarily, reducing staff "burn-out." Any job can become boring over time and it is easy for staff to become jaded about their work or the patients they serve. Providing periodic opportunities for employees to escape their routines helps to improve their skills and morale as well as re-emphasize the goals of the health

care system.

It is not possible to specify the exact content of a "model in-service program" for correctional health professional. Not only do requirements differ among systems, but among the various health disciplines as well. Similarly, there is no standard number of hours required across systems or disciplines. Some standards mandate a minimum of 12 hours of in-service training annually for all full-time health care providers, but individuals practitioners may need more or fewer hours to maintain licensure or certification.

Thus, each prison system should develop its own in-service training plan that reflects the requirements of its own system and the needs of its own personnel. It does not matter where the training is offered, only that various opportunities be provided for employees to attend in-service programs and to obtain formal continuing education credits. Some prison systems conduct almost all of the training themselves using their own instructors and guest lecturers. Others allow their employees to attend in-service programs offered by community hospitals or other system agencies or to participate in annual conferences of system or national health groups.

Regardless of the approach taken, it is important to document all training received by each health service employee. Individual records should list the courses taken, the dates and the number of hours. This information should be maintained in their personnel files and be accessible to supervisory staff.

Custody Staff

Determining the training needs, schedules and curricula for custody staff is not the province of the health services division. Nonetheless, most of the sets of national standards require correctional officers to have some training in health-related issues. Health personnel can be helpful in designing or reviewing proposed curricula and in serving as instructors for certain courses.

Health-related topics for custody staff may include formal training in first aid and cardiopulmonary resuscitation (CPR) as well as training regarding their role in managing special needs inmates such as those who may be mentally ill, HIV-positive, mentally retarded, suicidal, chemically dependent, etc. Health staff also may offer educational programs for their correctional colleagues regarding infection control practices, stress management, occupational safety or environmental health issues. The involvement of health professionals in conducting such courses can help improve the relationships between custody and medical staff as well as to ensure that the clinical information presented is accurate.

MEDICATION DISTRIBUTION

Medication must be distributed every day, up to four times a day, 365 days per year. Given the number of inmates with health problems, some of whom have multiple conditions, the number of medications passed annually in most prisons is staggering. In some prison systems, medications are distributed from a central area. In others, all medications are brought to inmates in their housing areas. Still others use a combination approach (e.g., general population inmates come to a central "pill window" and medications are brought to inmates in segregation). It does not matter which system is used as long as the following precepts are observed:

- Medications are dispensed by individuals licensed to do so;
- Each prescription is labeled appropriately in accordance with applicable regulations, and at a minimum, has the following information: date and pharmacy prescription number; patient name; name of the drug, strength, and amount to be dispensed; directions to the patient for use; prescriber name; and any other pertinent information;
- Medications are passed by health personnel who have been trained (e.g., medication aides) or licensed (e.g., LPN or RN) to do so;
- Administration of medications or their refusal is recorded on individual patient logs or computer files; and
- For security reasons, patients on abusable medications are watched to ensure that the medications are taken and not hoarded.

There are ways to cut down on the number and types of medications distributed. Establishing a pharmacy and therapeutics

committee can be of great assistance in limiting the types of medications that can be ordered by clinicians as well as monitoring their prescribing practices. Periodic studies by such a committee can help to ensure that medications are used for legitimate medical purposes and not for punishment or inmate control. Additionally, the prescribing practices of individual practitioners can be reviewed. Such a committee also can control the use of certain medications by requiring the clinician to obtain special permission to order them or by prohibiting them altogether (such as minor tranquilizers).

Another technique that has worked well in some prison systems is to move to a system of *b.i.d.* (i.e., twice a day) distribution. While some medications (e.g., certain antibiotics) still must be distributed three or four times a day as ordered, many categories of drugs are available in *b.i.d.* preparations. This step alone can represent tremendous savings in staff time.

There are also a number of prescription medications that need not be distributed one at a time. Some prison systems have had good success with a "keep on the person" (KOP) medication program. Prison systems interested in initiating a KOP medication program should develop a written policy and procedure and orient health staff, inmates and correctional staff to its use prior to implementation. At a minimum, the policy should specify:

- which medications may be given in multiple doses and which may not (e.g., psychotropic medications, control drugs and any abusable preparations should always be administered in single doses);
- the types of inmates who may be given multiple doses (e.g., those who have been compliant in taking their medications in the past);
- the reasons an individual may be withdrawn from the keep-on-the-person medication program (e.g., non-compliant, gave or sold medications to someone else);
- the form of medications allowed to be issued in multiple doses (e.g., tablets only or tablets and ointments but no liquid medications);
- the procedures for renewal of the prescription and for disposing of any unused portions; and
- the maximum number of allowable preparations that may be in the possession of a single inmate at one time (e.g., no more than 30 pills of a single type and no more than three prescriptions). This is much more advisable than using a time period (e.g., a week's supply or a month's supply since with some medications, a month's supply would represent an inordinate amount of pills in someone's possession.

BASIC AMBULATORY CARE

Intake Procedures

Every prison needs to have established procedures for medical intake. What those procedures consist of may differ depending on the prison system and the mission of individual prisons. In most systems, there is a single designated systemwide reception center through which all inmates sentenced to the prison system are admitted. In some states, though, the intake functions may be regionalized and in a few states, several institutions perform an admitting function. Regardless of whether inmate admission to the prison systems is centralized, regionalized or decentralized, staff at the first prison in the system at which an inmate appears must conduct the initial health screening and assessment.

1) Receiving screening

While most individuals come to prison directly from jails, very few of them are accompanied by any medical information. Additionally, some inmates come to prison from the street (e.g., those who previously made bail, parole violators). In either case, it is imperative that certain basic health data be gathered on each new arrival immediately upon admission. A qualified health professional should observe and interview every inmate within the first couple of hours of his/her admission. The purpose of this receiving screening is essentially triage; that is, to determine which inmates need to be referred for care immediately, which need to be set up with medications or scheduled for follow-up care, and which inmates safely can wait to be seen according to the usual health admission procedures.

At a minimum, the screening process must include:

- Inquiry into current illnesses, health problems and conditions: mental, dental and communicable diseases; medications taken and special health (including dietary) requirements; for women, current gynecological problems and pregnancy; use of alcohol and other drugs, including types, methods, date or time of last use, and a history of problems that may have occurred after ceasing use (e.g., convulsions); other health problems designated by the responsible physician.

- Observation of the following: behavior, which includes state of consciousness, mental status (including suicidal ideation), appearance, conduct, tremors, and sweating; bodily deformities and ease of movement; and condition of skin, including trauma markings, bruises, lesions, jaundice, rashes, infestations, and needle marks or other indications of drug abuse.

- Administration of a test for tuberculosis

- Notation of the disposition of the patient, such as immediate referral to an appropriate health care service, placement in the general inmate population and later referral to an appropriate health care service, or placement in the general inmate population.

The results of this receiving screening should be recorded on a standardized form and a copy placed in each inmate's medical record. For first time offenders, the receiving screening form initiates the medical record. For recidivists, the prior medical record should be reactivated.

It is important that the prison system's policy statement on receiving screening include specific guidelines for disposition. In other words, the health screener should know what procedures to follow and what forms to complete to ensure that any patient needs identified during that screening process are attended to in a timely fashion.

2) Health appraisal

The intent of receiving screening is to gather enough basic information about each new arrival's health needs to ensure continuity of care and to prevent avoidable medical emergencies. It should be followed by a more detailed health history and examination within the first week of each inmate's incarceration. Health appraisal data should be recorded on standardized forms and placed in each inmate's medical record.

The full health appraisal includes a number of steps. Generally, it begins by reviewing the receiving screening forms and gathering additional data to complete the inmate's medical, dental and mental health histories. Information should be solicited regarding past illnesses and hospitalizations as well as current health complaints, medications and treatments. The patient's family history of certain genetic-linked diseases should be included on the form along with the individual's immunization status and known allergies. If height, weight and vital signs were not taken as part of the initial screening, they should be obtained and recorded. At some point during this process, each inmate should receive information about the procedures for accessing health services and for filing medical grievances.

Depending on the time frame between admission and the health appraisal, the patient's reaction to the tuberculin skin test applied at screening should be read and recorded. Additional laboratory tests to detect communicable diseases (e.g., syphilis, gonorrhea) and for other diagnostic purposes (e.g., urinalysis, pregnancy test for females) should be conducted. Vision tests and hearing tests should be done along with mental status exams and dental exams.

A physical exam by a physician or physician extender (e.g., Nurse Practitioner or Physician's Assistant) completes the health appraisal data collection. The exam should consist of a "hands on" assessment of the major organ systems, including a pelvic exam and a Pap smear for females. It is suggested that the form used to record the physical exam results simply list the body parts and systems reviewed and leave space for comments. When the form includes "normal" and "abnormal" columns, examiners often are tempted to draw a line down the "normal" column, which make it difficult to verify that each body part or system has been reviewed.

The final step is for the examiner to review all data collected, specify the medical problems identified and develop an appropriate treatment plan that provides instructions regarding "diet, exercise, medication, the type and frequency of laboratory and diagnostic testing, and the frequency of follow-up for medical evaluation and adjustment of treatment modality." While much of the health appraisal can be completed by health personnel who are not physicians, the hands-on exam, the identification of problems and the development of treatment plans must be done only by a physician or a physician extender. In the latter case, a physician still should review and co-sign the extender's chart entries.

It is not necessary to repeat the receiving screening nor the full health assessment at each institution in the prison system to which an inmate is transferred. However, it is imperative that each patient's health record accompany him/her upon transfer. Staff at the sending institution should review the record to ensure that it is complete. In some systems, a brief transfer summary is filled out that lists current medications, treatments, scheduled appointments etc. Medications may be transferred at the same time as the inmate. Health intake at the receiving prison consists of health staff reviewing the chart of each transferred inmate on the day of transfer and taking the necessary steps to ensure continuation of medications, diet, and other care and treatment regimens.

There are a couple of other issues associated with receiving screening and health assessments that should be addressed — one is their frequency and the other concerns refusals. As to the former, it usually is not necessary to repeat the receiving screening done on the day of admission during an inmate's confinement. If an inmate is discharged from the prison system and returns or goes out on extended furlough, a new screening form should be completed. Otherwise it is not relevant, since more detailed and more current health data should be available in the patient's chart. As to the health appraisal data, at a minimum even for young, healthy inmates, there should be an annual review of each patient's chart and a tuberculin skin test (unless contraindicated). The need to repeat other laboratory or diagnostic tests or to initiate new ones or to conduct another hands-on assessment is dependent on the inmate's age, need and risk factors. It is suggested that each prison system have its clinical director develop protocols that define the frequency and extent of repeat health appraisal data collection for inmates in different age, gender and risk groups. The guidelines published by a number of medical specialty societies can be extremely useful in developing such protocols.

The issue of inmates' refusal of all or part of the health appraisal process is problematic. For the most part, competent inmates have a right to refuse medical care and treatment, which certainly extends to the health appraisal data collection process. They even have a right to refuse communicable disease screening, although when this occurs, medical staff can order that the inmate be quarantined to protect the health of others if there is sufficient clinical justification for doing so. Usually, all that is necessary to get a recalcitrant inmate to agree to the testing is to explain that s/he cannot be placed in the general population until the testing is completed and communicable diseases are ruled out. Suppose, though, that an inmate agrees to the communicable disease testing, but refuses all other tests and exams and will not cooperate by providing health history data? That is the inmate's right and all health staff can do is to explain to the inmate that the sole purpose of the information is to meet his/her health needs.

In good health systems, inmates rarely refuse to participate in the health appraisal process. They understand that it is done for their benefit and cooperate willingly. If an institution is experiencing a high percentage of refusals, it is likely that there are some disincentives built into the process. It may be that health staff are allowing inmates to refuse the health appraisal by notifying a correctional officer instead of insisting that all inmates scheduled be brought to the health unit, so that the purpose of the data collection process can be explained. Sometimes, a high refusal rate can be traced to an over-zealous lawyer who has fashioned a complex consent form that frightens or intimidates the individuals. In most instances, it is not necessary even to provide a separate written consent form for the health appraisal, since there are no invasive procedures except drawing blood and even here, the potential risk of complications or injury is negligible. If a prison is experiencing a high rate of refusal of the health assessment process, it is suggested that health staff interview a sample of inmates to determine why they refused. The results of such a study may suggest procedural changes that will reduce the refusal rate.

LEGAL ISSUES

In the final analysis, it may be simply that correctional administrators no longer had much choice whether or not to provide adequate health care for their charges. Emerging case law at all levels of government began to dictate that at least certain basic elements of adequate health care be provided.

Courts at various levels ruled that certain inmates in certain places were entitled to:

- the essential elements of personal hygiene (e.g., soap, towels, toothbrush, toothpaste and toilet paper);
- adequate and sanitary living conditions (e.g., sufficient space, heat, lighting, and ventilation; clean laundry; essential furnishing);
- adequate drinking water and diet, prepared by persons screened for communicable disease in kitchens meeting reasonable health standards;
- competent medical and dental care backed up by competent supportive facilities;
- drugs and special diets that are medically prescribed;
- drug detoxification and/or treatment for drug dependence;
- professional treatment and evaluation of psychiatric problems in appropriate settings for detainees under civil commitment;
- utilize exercise and recreational areas
- have visitors, touch their visitors and make telephone calls to the outside world.

At first glance, this appears to be an impressive list of inmates' rights. It should be noted, however, that this list was compiled from a number of cases in the United States, not all were federal court decisions and not all applied equally to all categories of inmates (e.g., some applied only to detainees or to civil commitments). It should be noted further that while precedents may be established, court decrees are binding only on the specific litigants involved. There is no assurance that correctional administrators would follow the developing legal trend of safeguarding inmates' rights to medical care. Other solutions to improving correctional health care still were needed.

SPECIALTY CARE

Every prison system, no matter how small, is likely to have some inmates who require the services of medical specialists. The decision as to whether specialty care is offered on-site at every prison, only at specific prisons, only in the community, or some on-site and some off-site, is dependent on a number of factors, the most important of which is which specialty services should be provided within prison system and at which institutions, and which should be provided at community facilities.

Assuming the availability of specialists in the community, their willingness to treat inmates and the existence of appropriate specialty equipment at the prison, it is preferable to conduct specialty clinics on-site. This avoids the added security risk of transporting inmates outside the institution and the added costs of custody time and transportation expenses. Obviously, there are times, though, that certain specialty services are not available locally or that it is not cost-efficient to duplicate specialty services (including expensive diagnostic equipment) on-site.

Regardless of whether specialty care is provided on-site, off-site or both, it is paramount that arrangements for such services be made in advance of need. Each prison system's health services policy manual should define clearly the levels of care available at each prison in the system and specify where additional services are provided. Procedures for making specialty referrals and arranging for transportation when needed should be included.

When specialty services are provided outside the prison system, it is a good idea to use a consultant form that tells the specialist why the referral was made and has space for the consultant to note his/her findings and recommendations. This form must be transferred and returned with the inmate, and then forwarded to the referring physician. Such a form also can be used for specialty consults that occur on-site. Alternatively, the specialist should record his/her findings and recommendations in the regular progress notes section of the patient's chart.

Specialists that work for the prison system — whether as full-time or part-time employees or under personal contracts — need to be oriented to the correctional environment and to the institution's security regulations and health services' policies and procedures. Additionally, each on-site specialist should be required to provide evidence of continued licensure.

Basic Dental Care

All except the very smallest prisons need the capability of providing basic dental services on-site including extractions, surface restorations, prostheses, prophylaxis and other preventive measures. The practice of modern dentistry necessitates not only trained staff (dentists, hygienists, dental assistants), but also dedicated dental space, and specialized equipment, instruments and supplies. Owing to the extent of inmates' dental needs, most prisons will find it is more cost-effective to duplicate basic services in-house at each prison rather than to transport inmates to other prisons or community facilities.

The intake dental examinations identify patients' needs on admission to the prison system, but cannot foretell deterioration of dental conditions over time or address dental emergencies. Inclusion of dental care in whatever system the prison system has adopted for inmates to request non-emergency services (e.g., written sick call system, walk-in) is imperative. If a written sick call system is used, health staff triaging those requests must refer all dental complaints to the dental staff for response. The latter are responsible for reviewing the requests and setting up appointments for inmates to be seen according to the system established for prioritizing dental needs.

Suggestions of basic dental care can be categorized as follows:

- Emergency/Urgent Care. Individuals requiring treatment for the relief of acute oral and maxillofacial conditions characterized by trauma, infection, pain, swelling, or bleeding which are likely to remain acute or worsen without intervention.

- Interceptive Care. Individuals requiring early treatment for the control of extensive, subacute dental or oral pathosis and/or requiring basic education in oral self-care.

- Corrective Care. Individuals requiring treatment for chronic dental and oral pathosis and for restoration of essential function. (This level of care should include restoring carious teeth, extractions, the long term management of periodontal disease, and endodontic and prosthodontic procedures needed to retain or restore essential masticatory function.)

- Elective care. Individuals who have none of the treatment needs specified above.

The above, of course, is only a basis for a system of prioritizing dental needs and for identifying those specific treatment procedures employed by the institution to meet program goals. It should not be overlooked that providing basic education in oral self-care should have a high priority. In fact, documented inmate compliance with self-care instructions should be prerequisite (not a barrier) to receiving any corrective dental care.

The last point deserves additional discussion. Most dentists would agree that regular flossing is the best way to avoid serious periodontal disease, but many prison systems prohibit the use of dental floss for security reasons. Dental floss is quite strong and has been used by inmates to saw through bars or as a weapon. There are ways to accommodate both the dental need and the security concern, however. One solution is to issue the floss daily and supervise inmates to ensure that it is used and disposed of properly. A less labor-intensive solution where inmates are issued plastic picks that have about an inch of floss attached to a small bow is recommended. The amount of floss is too small to cause any security concerns, yet is sufficient to allow inmates to practice good oral hygiene.

Specialty Care

In addition to the dental care provided on-site at each prison, arrangements must be made to obtain specialty services such as periodontics, endodontics and oral surgery when needed. Some prison systems may be large enough to support these specialties in some of their institutions, but most will find it more advantageous to utilize community resources.

Because some dental care can be considered elective, each prison system should have carefully thought-out protocols that specify the types of dental specialty services that will be provided. As with all specialty care, contractual terms and procedural arrangements for appointments, transportation, security, etc., should be made in advance of need.

Emergency Care

True dental emergencies are rare. With the exception of facial fractures, uncontrolled bleeding and infections not responsive to antibiotic therapy, there are few instances when immediate referral for dental care is indicated. Other conditions such as toothaches, abscesses and post-extraction complications may be painful, but they usually do not constitute emergencies. They are better classified as urgent conditions. Even a fractured tooth more often requires urgent rather than emergency care, although one involving the dental pulp or an avulsed tooth may require prompt attention by a dentist to better ensure that it can be retained.

A true dental emergency (e.g., fractured jaw) — especially if it occurs "after hours" — requires that the patient be transported to a hospital emergency department for care. Dental emergencies should be included in all the protocols governing emergency services as discussed under the medical program. On the other hand, urgent dental conditions that occur after regular dental hours can be handled by a nurse or a physician extender with a back-up dentist or a physician on-call to prescribe medication as needed. The prison system's dental director should develop protocols to guide non-dental health staff in managing urgent conditions until the patient can be seen at the next scheduled dental clinic.

Special Medical Needs

1. Chronic and Communicable Diseases/ Conditions

While the terms *chronic disease* and *communicable disease* are not interchangeable, there are certain conditions such as AIDS and tuberculosis that may be classified properly as both. Only a few of these diseases are discussed in this section, either because of their prevalence, their seriousness or both.

a. Cardiovascular Conditions

While mortality data for prison systems is not available, it is likely that chronic and communicable diseases/conditions represent a substantial portion of the deaths in prison attributable to natural causes. Prisoners tend to exhibit a number of the factors that place them at risk for these conditions including a high percentage who smoke, have poor dietary habits and suffer from a lack of exercise. In addition, significant numbers of inmates are hypertensive.

The management of hypertension in prisons is not difficult and does not usually imply the need for any special housing, programs, equipment or staff. Most of these patients can be managed adequately through regular chronic clinics where their medication can be checked, their blood pressure can be monitored and they can be counseled regarding exercise, weight control and avoiding smoking and high sodium foods. Failure to provide regular follow-up for hypertensives, though, can have serious consequences. Hypertension is known as "the silent killer" and can lead to heart attacks, strokes and kidney failure.

In their acute stages, cardiovascular conditions often involve lengthy hospital stays and the services of expensive consultants such as cardiologists or neurologists. For people with chronic conditions, a number of special services are required. Depending upon the seriousness of their conditions, some of these patients may need to be assigned to an extended care facility and others will require protective housing or special consideration in their bunk or tier assignments. Work assignments, if any, are likely to involve restrictions.

Cardiovascular patients should be placed in facilities where there is immediate access to appropriately equipped and staffed emergency services and the availability of 24-hour per day nursing care. They should be seen periodically in specialty clinics by the appropriate specialist (e.g., cardiologist, physiatrist) monitored regularly by the unit physician. Some of these patients also will require additional special services such as physical therapy, speech therapy and other rehabilitative measures.

b. End Stage of Renal Disease

There are a variety of reasons why patients require dialysis. End stage renal disease may result from hypertension, IV drug abuse and AIDS among other conditions, but one of the most common causes is complications from diabetes. Diabetes is a chronic condition that can

have serious consequences if not managed properly. It can cause blindness, heart attacks and strokes in addition to renal disease and can precipitate medical emergencies such as hypoglycemia (insulin shock) or ketoacidosis (diabetic coma). For these reasons, patients whose diabetes is not well controlled should be assigned to units where there is immediate access to appropriately equipped and staffed emergency services and where 24-hour per day nursing care is available.

While good data are not available, the prevalence of diabetes among prisoners must be assumed to be great. For the most of these patients, no special health programming is required beyond regular monitoring at chronic clinics. They can be housed in general population and do not require any dedicated space or special equipment (besides a glucometer) for their care. For patients with end stage renal disease, though, it is an altogether different story.

Regardless of what condition precipitated the need for dialysis, patients with end stage renal disease require extensive services. Estimates of the cost of dialyzing a single patient three times a week in a community facility range from $40,000 to $60,000 annually. Additionally, the prison system needs a dedicated vehicle to transport the patients and security staff to escort them on what is often an all day process. In most prison systems, if there are three or more patients in the system requiring hemodialysis, it will be more cost-effective in the long run to provide this service in-house, even though the initial investment in a dialysis unit, is an expensive proposition. Dedicated space, specially trained staff to operate the dialysis unit, arrangements for waste disposal, the availability of dietary counseling and the services of a consultant nephrologist are needed also.

Patients with end stage renal disease usually do not require any permanent special housing, but should be placed in a prison with an infirmary so access is assured when needed. Some creativity is required in work and program assignments for these patients, since they spend several hours a week in dialysis.

c. Respiratory Conditions

Prisoners are prone to both types of respiratory conditions, infectious (e.g., tuberculosis) and non-infectious (e.g., emphysema and asthma). Tuberculosis, a disease once thought to be well controlled, is again on the rise. This is attributable, in part, to the epidemic spread of HIV infection. Researchers have demonstrated that HIV seropositive subjects with a positive PPD are much more likely to develop active tuberculosis than individuals with a positive PPD who are seronegative for HIV. Since prisons contain a population that is at high risk for contracting the HIV infection, prison systems can anticipate an increase in the incidence of tuberculosis (TB).

Since TB is an airborne disease, its transmission is accelerated in crowded conditions. It is imperative that prison health professionals take aggressive measures to prevent TB and to control its spread. Patients with active TB must be isolated in a room with negative airflow and staff instructed to take respiratory precautions. Once the active stage is past, TB patients do not require any special housing and can be monitored through regular chronic clinics.

The prevalence of non-infectious respiratory conditions (e.g., chronic obstructive pulmonary disease [COPD], asthma) among prisoners is unknown. In the general community, COPD is one of the five leading causes of death. Primary risk factors associated with COPD include smoking, air pollution, allergies, and family history. Its usual onset is after age 50. As the prison population ages, there is likely to be an increase in the number of patients with COPD. Additionally, experienced correctional physicians believe that deaths from asthma may well be the single most preventable natural cause of death among prisoners.

Depending upon the severity of their conditions, some patients with non-infectious respiratory conditions may require protective housing or consideration for ground floor, low bunk assignments. Additionally, they should be placed in non-smoking cells or dorms. Those with more advanced conditions may require placement in an extended care facility with 24 hour per day nursing care and availability of oxygen and a consulting pulmonologist. Wherever COPD and asthma patients are housed, there should be immediate access to properly equipped and staffed emergency services.

Patients with respiratory conditions who are able to work should not be placed in jobs where they are exposed to environmental pollutants. Those with more advanced conditions will not be able to work at all. The clinic should have respiratory therapy services available and patients should be monitored regularly regarding

their pulmonary function. Special equipment including a peak flow meter, a nebulizer, portable oxygen tanks and emergency drugs should be readily available.

d. Seizure Disorders

Very little is known about the prevalence of seizure disorders among prisoners. What little evidence is available suggests that the prevalence of epilepsy is higher among prisoners than in the general population.

The most expensive aspect of caring for patients with seizure disorders is often in the diagnostic phase, which requires a comprehensive history, a thorough physical examination, and special services such as an electroencephalogram (EEG), a computerized tomographic (CT) scan and a neurological work-up. Once the diagnosis is controlled adequately on medication, the patient should be monitored in chronic clinics with periodic consultation by a neurologist as needed. Owing to the possibility of status epilepticus, seizure disorder patients should be placed in prisons that have immediate access to properly equipped and staffed emergency services. Most prisons housing inmates with seizure disorders will find it is more cost-effective to have an EEG machine in-house.

Virtually all seizure disorder patients can be placed in general population, but should be housed on the ground floor and in a low bunk. At least one study suggests that seizure disorder patients not be housed in a single cell. Given their potential for seizures, work limitations for these patients often are required. A number could benefit from vocational education programs designed with their disability in mind (e.g., computer operators). Owing to the stigma associated with epilepsy and the mistaken notions regarding appropriate first aid, an aggressive health education program for both inmates and staff can be important to the care of patients with seizure disorders. Additionally, a number of these patients may require supportive counseling to help them adjust to the social problems that often accompany this condition.

e. AIDS

In contrast to the disease/conditions discussed above, a great deal has been written about AIDS among prisoners. The annual incidence of AIDS in prisons is substantially higher than in the population at large, owing primarily to an over-representation of individuals with histories of high risk behaviors, especially intravenous drug use.

The cost of caring for AIDS patients is substantial. They require expensive medications, the care of AIDS specialists, and are likely to be in and out of hospitals and infirmaries. In their terminal stage, many AIDS patients need continual care in a hospice or nursing home environment. Prisons providing care for several inmates with AIDS should have a respiratory therapist in-house and appropriately ventilated space to offer aerosolized pentamidine treatments. HIV positive inmates also can benefit from the prophylactic application of pentamidine.

Except when clinically indicated, AIDS patients do not need to be housed separately from the general population.

Extensive counseling services are requires for inmates prior to being tested for the HIV virus, after learning that they are HIV positive, and al all stages during the progression of their disease. Work and program restrictions are not required for asymptomatic HIV positive inmates. That status alone should not prevent them from holding jobs (including kitchen assignments), going to school or participating in regular prison activities (e.g., recreation, religious services, library). For AIDS patients, work and program limitations should be determined by the treating clinician.

Special Needs of Women

In any prison system, women usually represent four to seven percent of its total population. Adult female offenders are subject to the same types of chronic and communicable disease and other physical and mental impairments as their male counterparts, although sometimes at different rates. Their unique health needs are associated with the female reproductive system. Thus, they require the same types of basic and specialty health care as males, but also need access to obstetrical and gynecological services.

Any institution housing women must provide for their special health needs. In addition to the basic and specialty services offered to males, the following should be available for females:

- The intake history should include questions regarding the patient's menstrual cycle, pregnancies and gynecological problems.

- The intake examination should include a pelvic exam, a breast exam, a Pap smear, and depending on the patient's age, a baseline mammogram.

- Laboratory tests to detect sexually transmitted diseases (STDs) including gonorrhea, syphilis and chlamydia should be provided for all females, especially since many are asymptomatic for STDs. Additionally, where medically appropriate, females should receive a pregnancy test on admission.

- The frequency of repeating certain tests, exams and procedures (e.g., Pap smears, mammograms) should be based on guidelines established by professional groups and should take into account age and risk factors of the female prison population.

- Women should have ready access to personal sanitary supplies including tampons.

- All females should be provided with health education information on breast self-examination, contraception and pregnancy.

- Consistent with state and federal laws and regulations, pregnant offenders should retain the right to choose abortion or continuation of pregnancy. Pregnancy counseling and abortion services must be available.

- Pregnant inmates must have access to regular pre-natal care, and receive dietary supplements (e.g., milk, extra food, pre-natal vitamins) as prescribed by their physician.

There is another issue concerning women that should be mentioned briefly. Contraceptives should be continued for women who request it. Occasionally, there is a patient who has birth control pills prescribed as treatment for menstrual irregularities and this should be continued at the discretion of the prison physician. Additionally, women who are on birth control pills when they are admitted to the prison system should be allowed to complete their current cycle. Otherwise, it is expensive, impractical and unnecessary to continue women on birth control pills or other contraceptive devices throughout their incarceration.

Some may argue that in the absence of contraceptive, female offenders are at risk for pregnancy, STD's or AIDS. They are, but the possibility of becoming pregnant or contracting STD's or AIDS while incarcerated in a women's prison is remote. Male staff members who engage in sexual activities with female offenders are subject to immediate dismissal and sometimes, criminal prosecution. Further, evidence of female to female transmission of AIDS and STD's is rare. A more practical policy for prison systems is to make available contraceptive devices for women based on medical need or potential risk (e.g., females residing in co-ed institutions, prior to being placed on furlough or in a work release program).

Except as indicated by their specific health conditions, women do not require special medical housing based on gender alone. Most of their unique health needs can be managed adequately in ambulatory settings with follow-up in OB/GYN specialty clinics as required. One potential exception is pregnant inmates. Owing to the large percentage of high risk pregnancies among prisoners, some prison systems house all pregnant inmates in the same area. This facilitates the medical monitoring of their pregnancies, makes it easier to determine who is complying with their pre-natal regimens, and provides a built-in peer support group. Any prison housing pregnant inmates must have immediate access to appropriately equipped and staffed emergency services.

Work and program limitations based on gender alone apply primarily to pregnant inmates. Restrictions for other women are dependent on age and disease/condition factors.

Special staffing includes those already mentioned (e.g., health education, pregnancy counselors, OB/GYN specialists) as well as an increased number of social workers and mental health counselors. Female offenders tend to require more social planning services and more supportive therapy than males, often revolving around issues of pregnancy and children.

Separating mothers and children has profound emotional effects for both groups. The issues of whether babies should be kept in prison with their mothers or what should be done to foster mother/child relationships for incarcerated women are too complex to resolve here. Nonetheless, prisons holding females should be prepared to deal with the emotional

crises that such separation brings.

Equipment requirements for treating females' unique ambulatory health needs are minimal (e.g., exam table with stirrups, goose neck lamp, instruments and supplies to conduct pelvic exams and Pap smears). Few prison systems have a sufficient number of older women (i.e., 35 and above) to justify a mammography machine in-house, and delivery of all babies always should be accomplished in a licensed hospital with delivery facilities for high-risk pregnancies.

Physically Handicapped

The physically handicapped include the mobility impaired (e.g., amputees, the wheelchair bound, those who ambulate with assistive devices such as canes, crutches, walkers) and individuals who are visually impaired, hearing impaired and/or speech impaired. The number of people in prison with these disabilities is not known.

Programming for the physically handicapped in prisons represents a major challenge. The special needs of this group of offenders cut across all aspects of prison life. The responsibility for programming for this population often rests with the health services division of the prison system, although this is neither a necessary nor even a logical placement. The health needs of the physically handicapped are usually the easiest to address. Regardless of which department of the prison system is assigned the primary responsibility for programming for the physically disabled, it is imperative that a cross-disciplinary planning group be established. This group should include representatives from the following areas: custody, classification, construction, medical, dental, mental health, vocational services, educational services, religious services, social services and recreation.

Additionally, once the planning is completed and a program for the physically disabled is operational, it is suggested that a case management approach be adopted for their continuing care. Each physically disabled offender should be assigned to a specific case manager who coordinates all services and follows the patient throughout his/her incarceration. Case management is the best approach to ensure that services are neither fragmented nor duplicated.

The special needs of specific types of physically disabled offenders are discussed below.

a. The Mobility Impaired

Individuals who have difficulty ambulating should be placed in a barrier-free facility, which is easier said than done. Except for perhaps the newest prisons, few existing institutions are truly "barrier-free." Even in prisons where physical alterations have been made, there tend to be areas such as disciplinary housing that are overlooked. The cost of converting existing prisons to barrier-free facilities can be extensive, especially since many older institutions do not lend themselves readily to the necessary architectural modifications. To illustrate, a partial list of barriers might include:

- narrow doorways that do not permit wheelchair access;
- the presence of stairs that may prohibit access to institutional programs;
- insufficient cell space to accommodate wheelchairs, walkers, etc.;
- lips on doorways that prevent access;
- toilets in housing and program areas with high seats and without handrails;
- showers not equipped for use by the mobility impaired;
- drinking fountains out-of-reach for the wheelchair bound; and
- food lines and dining tables inaccessible to the mobility impaired.

Within a barrier-free facility, there are a certain number of the mobility impaired who also require special housing. Some need a protective environment owing to the possibility of victimization. The wheelchair bound require larger cells or dormitory space to accommodate their equipment. A few of the mobility impaired need constant care in an infirmary or nursing home environment. Patients with certain spinal cord injuries must be housed in air conditioned areas.

Work restrictions are likely for this group of offenders owing to their physical disabilities, but a number of amputees and wheelchair users are

work-capable. They should have access to jobs where their disabilities are not a handicap. Others can benefit from vocational training or academic programs. Recreational opportunities should be available as well.

The special medical needs of the mobility impaired often include regular monitoring by a physiatrist and the availability of physical therapy and other rehabilitation services. If the latter are provided in-house, dedicated space and special equipment are required. Each prison system should have at least one van that is specially equipped to transport inmates with mobility impairments. Increased mental health services are needed as well to help such patients adjust to the limitations and social stigma associated with their disabilities.

b. Other disabilities

Some inmates may be visually impaired, hearing impaired or speech impaired and thus, require special services. Most of them can be housed in regular population assignments, but those with severe disabilities (e.g., blind, deaf, mute) may need protective housing owing to the possibility of victimization. By themselves, these conditions do not require any special medical housing.

Work restrictions are necessary for inmates with severe visual, hearing or speech impairments, but most are capable of working in some capacity. Many can benefit from special educational and vocational programs designed to accommodate their particular disabilities.

This group of offenders has few special medical needs created by their conditions. The services of specialists (e.g., ophthalmologists, audiologists, otolaryngologists) are important in initial diagnosis and for those who can benefit from continued monitoring and intervention. Inmates with permanent disabilities, though, require more in the way of social services and supportive counseling than they do medical care for these conditions. Individuals who are blind, deaf or severely speech-impaired may suffer from depression and have difficulty coping with the limitations and social ostracism that accompany their disabilities.

Some inmates with speech and hearing difficulties can benefit from speech therapy. Others require the services of an interpreter in order to participate in any part of regular prison life. Health professionals should be aware of the special problems created in accurate diagnosis and treatment of patients when an interpreter must be relied upon to provide complaints and symptoms of illness.

Each of the specialties (e.g., ophthalmology, otolaryngology) and ancillary services (e.g., audiometry, speech therapy) necessary to test, diagnose and treat patients with visual, hearing and speech impairments has its own equipment needs. Cost benefit analyses should be conducted to determine whether it is better to provide these services in-house or purchase them in the community.

Geriatric Offenders

Advances in medical science have contributed to more people living longer. This fact — coupled with mandatory sentences, longer prison terms, and more restrictive release policies — has meant an increase in the number of elderly incarcerated.

It is clear that older offenders have increased health care needs. For one thing, they are more likely to suffer from chronic illnesses than younger inmates. One study of 41 men aged 50 to 80 who were housed in prison found that 83 percent had at least one chronic health problem and almost half had three or more chronic health problems. For another, there are a host of bodily changes that accompany the normal aging process that can lead to health problems including vision and hearing loss, tremors, sleep disturbances, gastrointestinal disorders, incontinence and mental confusion.

While many older inmates do not require special housing, those who are disabled or infirm should be placed in a protective environment owing to the possibility of victimization. Those with chronic illnesses are likely to have increased utilization of infirmary and hospital services, and a certain number may need extended nursing care and assistance with daily living skills. Work and program restrictions are inevitable for this group of offenders, but few prison systems have developed alternative programs for the elderly.

Prisons housing elderly offenders should have immediate access to properly equipped and staffed emergency services, and the availability of round-the-clock nursing care. The increased need for health services among the elderly means a concomitant increase in regular health staff and the availability of specialists to address their chronic and age-related illnesses and conditions.

If current trends continue, the increased costs of housing and caring for elderly offenders will represent a substantial portion of most dire

prediction (in addition to changes in sentencing guidelines) is to initiate early release programs for the elderly.

The Terminally Ill

A number of the conditions and illnesses discussed above are progressive and eventually lead to a terminal stage, which can be defined as a life expectancy of one year or less. Every prison system must provide for the needs of terminal patients. These individuals have more frequent utilization of infirmary and hospital services, and as they progressively weaken, often require round the clock nursing care. For many who are in the terminal phase of their illnesses, little medical intervention can be provided. The primary health goal is to keep them comfortable and pain-free, and to help them adjust to the concept of death. Supportive counseling from the clergy, mental health professionals or those specially trained to deal with the problems of death and dying (e.g., thanatologists) is essential. Terminally ill patients often experience anger, anxiety and depression, and there is an increased risk of suicide.

Dying with dignity is difficult under any circumstances, but it is particularly hard to achieve in prisons where individuals may be both physically and emotionally isolated from family and friends. There are two approaches that hold promise in meeting the needs of terminally ill prisoners: one is to develop special programs in-house and the other is to increase the utilization of compassionate release. Both options should be pursued. One such program involves housing terminally ill patients in a separate section of the infirmary. A thanatologist works with the terminally ill and their families. Supportive counseling, group discussions, special activities, and assistance in planning for death (e.g., writing wills) are offered.

Compassionate release programs are another approach that can be used with terminally ill patients. Given the extent of crowding in prisons and the unlikelihood of recidivism among the terminally ill, the possibility of early release for those individuals should be explored aggressively. Prison systems are cautioned, though, against the "dumping syndrome" that displaced so many of the mentally ill when the decision was made to deinstitutionalize them. Responsible release policies mandate that provisions be made for continuing care of the terminally ill in community settings.

Special Mental Health Needs

1. Self-Mutilators and The Aggressive Mentally Ill

At first glance, these two categories of inmates with special mental health needs appear to be unrelated, but they share some important commonalities. To begin with, both types of offenders present extreme management problems for correctional officials. Whether inmate's aggression is turned inward or outward, such acting-out behavior is difficult to address and control in a regular prison unit. Secondly, there are times when both types of behavior are associated with underlying mental illness and times that they are not. In evaluating such behavior, traditionally trained psychiatrists and psychologists may well determine that self-mutilators or aggressive mentally ill inmates do not meet the criteria for admission to an inpatient psychiatric program.

There is probably nothing more frustrating to individual wardens than to be told by a clinician that an inmate who has repeatedly slashed his throat is not mentally ill or that an inmate with a psychiatric history is not "mad" at the moment, just "bad." All too often, self-mutilating inmates and the aggressive mentally ill are shuttled back and forth between regular prison units and in-patient psychiatric facilities. Unit staff keep referring them for treatment because they do not know how to manage them, and staff at the psychiatric facility keep refusing them because they do not meet standard criteria for in-patient care. Often, the default options for such inmates is placement in restraints or administrative segregation, neither of which serves either the inmate or the institution well. These are temporary solutions at best that do nothing to address the underlying problem.

Someone must take the lead in developing programs to manage self-mutilators and the aggressive mentally ill in prison. Logically, this responsibility should rest with mental health professionals. The failure of traditional prison mental health programs to address the needs of self-mutilators and the aggressive mentally ill add strength to those arguments. Lowering the barriers to care may mean that inmates do not have to resort to extreme behaviors to gain attention.

2. Suicidal Inmates

Suicide in confinement settings has not been studied widely. There are a few studies that have examined characteristics of suicides in specific jails and lockups and two national surveys that compiled profiles of suicide victims in holding and detention centers.

Two recent studies indicate that the risk of suicide was higher among prisoners than among the population at large. Other similarities of results occurred as well. In both studies:

- All victims were male.
- Their average age was 29 years.
- Whites were disproportionately at risk.
- Offenders charged with crimes against the person (especially death-related offenses) were disproportionately at risk.
- No pattern was established regarding the duration of confinement at the time of suicide.
- Hanging was, by far, the preferred method of suiciding.

Another study also found an increased risk of suicide associated with a history of mental illness and some evidence of an increased risk associated with a history of prior suicide attempts. Both findings are consistent with those reported in the general suicide literature.

While good data on the frequency of suicide in prisons are still needed, suicides (and homicides) in confinement are likely to be among the most preventable deaths. Suicide prevention techniques include screening procedures, architectural considerations, monitoring/observation patterns and interaction techniques.

Obtaining a history of prior suicide attempts as well as current suicidal ideation should be part of the initial mental status exam for all inmates. Equally important are crisis intervention teams who are trained to assess suicide risk at any point during an inmate's incarceration. Available research suggests that among state prisoners, there is no one period of highest risk associated with duration of confinement. Further, mental health staff are cautioned against the use of profiles (especially those based on demographic characteristics) to attempt to predict suicide risk. Current situational stressors are likely to be more salient indicators.

If an inmate has been identified as potentially suicidal, s/he may require special housing on a temporary basis such as placement in a psychiatric observation cell. It is imperative that such cells be constructed following recommended guidelines for suicide-proofing (e.g., no electrical outlets, no protrusions of any kind, security screening on the inside of any bars). The inmate should be monitored at a frequency commensurate with his/her level of risk and referred to a mental health professional for determination of a continuing care plan.

While male inmates in maximum security institutions may have an increased risk of suicide, no prison is exempt from the possibility. Every prison needs a comprehensive suicide prevention plan that addresses these elements.

- identification of potential suicides;
- training of correctional and health staff to recognize potential suicides;
- assessment of suicide risk by mental health professionals;
- procedures for placing the potential suicider in special housing as needed;
- monitoring procedures that designate level of staff, frequency of checks and documentation requirements;
- procedures for referral for continuing care as needed;
- procedures for releasing the individual from suicide watch;
- procedures for notifying appropriate correctional and health staff of inmate's suicide status;
- intervention techniques if a suicide is in progress;
- notification of appropriate authorities in the event of a completed suicide; and
- a full medical and administrative review after any completed suicide (including a psychological autopsy) to determine whether any changes are needed in the suicide plan.

In spite of everyone's best efforts, it is not possible to prevent all suicides in prison. There always will be inmates who offer no clues as to their suicidal intent. Nonetheless, implementing the procedures outlined above will reduce the opportunity for suicide and should reduce the prison's potential liability as well.

3. Sex Offenders

It is difficult to say anything meaningful about the management of sex offenders in prisons and still be brief. In contrast to some of the other categories of special needs offenders discussed above, reams have been written about this group of inmates. Even so, there are no absolute guidelines that have been accepted for the identification, management and treatment of sex offenders within a correctional setting.

One of the problems involved in deciding on treatment programs for sex offenders in prisons is their sheer number. Within the prison's social hierarchy, sex offenders have the lowest status. The stigma associated with sexual deviance also helps explain why "hidden" sex offenders are not likely to seek treatment voluntarily.

Another problem associated with this group of prisoners is their sentence length. Greater societal attention to the problem of sexual victimization in the community led to a series of changes in sentencing guidelines for individuals convicted of sex crimes. Not only are prison systems confronted with large numbers of sex offenders, but they are keeping them for relatively long periods of time. This, too, impacts on the decision as to which sex offenders to treat and for how long.

A third confounding factor in the management of sex offenders is disagreement among professionals as to whether they are "sick" or poorly socialized. Determining the etiology of deviant sexual behavior has obvious implications for its treatment and affects the decision as to whether a medical model, a psycho-social model or a behavioral model will be employed. Several articles on the treatment of the incarcerated male sex offender suggest that different treatment modalities need to be used for different types of sex offenders.

Finally, there are those who question the efficacy of implementing sex offender treatment programs while individuals are incarcerated. Evaluations of community-based treatment programs have shown mixed results. Evidence of successful outcomes in correctional programs is even harder to come by. There is little scientific information to demonstrate that existing treatment programs have a positive impact on either behavior change or recidivism. Additionally, the latter is a negative outcome measure fraught with its own methodological problems, not the least of which is the necessity of successfully tracking offenders once they are released from prison.

With all of these problems, it is no wonder that sex offender treatment systems are rare. While virtually all prison systems offer some treatment to some sex offenders, a systematic approach to managing the needs of this special population is still needed.

4. Substance Abusers

Many of the problems identified in conjunction with treatment of sex offenders in prison are true of substance abusers as well. Professionals do not agree on the etiology of the behavior or the selection of treatment modalities, and the efficacy of such programs within correctional facilities has not been demonstrated. Further, outcome evaluations using recidivism as a measure are subject to the same methodological difficulties noted above.

Compounding these problems is the fact that it is hard to find many prisoners who are <u>not</u> substance abusers. Literally hundreds of thousands of prisoners tested positive for one or more drugs at the time of arrest. Given the magnitude of need, it is not surprising that most substance abusers receive no treatment for this problem while incarcerated. Even though most prison systems provide some services to some substance abuser, only about 11 percent of inmates were enrolled in drug treatment programs in 1987. Some prison systems have residential-type treatment programs for the more severe substance abusers, while others offer educational information or self-help groups (e.g., Alcoholics Anonymous, Narcotics Anonymous) to interested offenders. However, almost no one has a systematic treatment program designed to reach all substance abusers in all prison systems.

One exception to the above is a program initiated by a prison system. The plan for substance abuse services includes:

- initial assessment of substance abuse problems at all reception centers;
- provision of substance abuse education at all facilities by trained substance abuse educators;

- self-help programs at all adult facilities;
- residential treatment units at four male, one female and one juvenile institution;
- intensive out-patient treatment programs at three facilities; and
- special programs for inmates who are both mentally ill and substance abusers at one female treatment center and one male psychiatric center.

Clearly, there is a need to address the problem of substance use and abuse among prisoners. Most correctional administrators acknowledge the link between substance abuse and crime, but not all are convinced that it is their responsibility to help find a solution. A prisoner in need of medical attention for a problem associated with substance abuse (e.g., overdose, withdrawal) must be provided with appropriate treatment; however, these occurrences are rare at the prison system's reception center, since they no longer need medical attention for substance abuse. Detoxification has occurred at the local jail or another community facility.

While rehabilitation of substance abusers in prisons may not be mandatory, correctional administrators would do well to consider expanding their efforts. A comprehensive program for substance abuse services in prisons could have important long-term benefits for the criminal justice system as a whole and holds some promise for reducing the rate of substance abusers returning to prison.

5. The Mentally Retarded Offender

Among the general population, estimates of the number of retarded citizens range from one to three percent. Among prisoners, the estimates range from zero to 38 percent. For adult offenders, the prevalence of mental retardation is between four and nine percent. Part of the variation may be attributable to differences in defining mental retardation. The focus here is solely on the retarded, since as a group, they are most closely associated with special health needs.

Like the physically handicapped, the needs of the retarded offender cut across several program lines. Planning for this group should include representatives from custody staff, social services, special education, vocational programs, prison industries and recreational services in addition to mental health staff. Traditional responsibilities of the latter include administration of intelligence and psychological tests to diagnose retardation, and the development of individual habilitation plans for offenders who meet the definition of retardation. Case management is a useful approach for this group of offenders.

Mental health counselors also can assist retarded offenders to accept the limitations of their conditions and to develop constructive ways of dealing with their anger and frustration. Many of the retarded have difficulty adapting to the prison environment and may become management problems. They are more likely than non-retarded offenders to be charged with disciplinary offenses — sometimes because they do not understand the rules and behavior. Retarded offenders can benefit from both individual supportive counseling and group problem-solving activities.

At a minimum, every prison system must take steps to assure the physical safety of the retarded and their "freedom from undue restraint." Retarded offenders are highly susceptible to victimization by other inmates that can range from co-opting their commissary items to sexual misconduct. As a consequence, some type of protective housing is needed. Professionals differ as to whether segregated institutions, segregated housing or mainstreaming the retarded as much as possible is the best approach to managing them within prisons. Regardless of the approach taken, housing decisions for retarded offenders must take into account their special need for personal safety.

Communicable Disease and Infection Control

Communicable diseases also can result in short or long term problems that greatly stress an institution. Most communicable disease outbreaks can be prevented and/or contained to a great degree. In order to deal more effectively with communicable diseases in the correctional setting, it is important to understand the types of communicable diseases that are most likely to present themselves and the measures that can be taken in response, either in a preventive or a reactive fashion. In this section, information necessary for institutions to develop effective infection control and communicable disease programs is presented.

1. Most Prevalent Infectious Diseases in Inmate Populations

Sexually-transmitted diseases frequently are discovered during intake physical examinations. Syphilis, gonorrhea and chlamydia are found in both adult and juvenile inmate populations. Sexually-transmitted diseases are linked increasingly to illegal drug use. Prostitution for drugs is a common occurrence. The best sex education lessons may be lost when a person is in a drug-induced mental state. Multiple sexual partners without the protection of condoms can result in repeated infections with the potential for long-term problems including those associated with late latent syphilis, neurosyphilis, syphilis in pregnancy, congenital syphilis and pelvic inflammatory diseases that can lead to sterility and ectopic tubal pregnancies.

While sexually-transmitted diseases alone impact on a person's health, they also may predispose a person to bloodborne viremia. Open sores created by sexually transmitted diseases can be portals of entry for the almost always lethal human immunodeficiency virus (HIV). HIV infection and hepatitis B (HBV) are classified as sexually-transmitted and bloodborne diseases. Both are found in ever-increasing numbers in the inmate population.

Approximately 25 percent of HIV carriers develop chronic active hepatitis, which often progresses to cirrhosis. Furthermore, HBV carriers have a risk of developing primary liver cancer that is 12 to 300 times higher than that of other persons.

Studies have indicated a higher prevalence of HBV in prison populations than is found in community populations.

HIV infection continues to be an extremely serious public health problem around the world. Since the virus was first identified and methods of transmission recognized, massive education programs have brought about behavior changes in the male homosexual community resulting in fewer infections. Unfortunately, the same cannot be said for intravenous drug users. Their numbers are ever-increasing for both men and women. Heterosexual HIV infection is increasing also. Frequently, this is a result of the female being infected by her male intravenous drug-using partner. She then can infect her babies during pregnancy or the birth process. Heterosexuals also must be educated to practice "safe sex" to slow the spread of the disease.

Prison and jail AIDS cases continue to be overwhelmingly attributed to IV drug use and homosexuality, as do all AIDS cases. AIDS education is the most critical component in the management of HIV infection in correctional settings. All staff must be schooled in the management of persons with HIV infection. A thorough understanding of the modes of transmission of this infection will allay fears in the unknowing and foster a therapeutic climate for both staff and inmates.

Health care staff must be trained to identify those inmates who have experienced high-risk behavior and to recognize those persons who possibly are infected. Health care staff must be knowledgeable about the etiology, diagnosis and treatment of all phases of HIV infection.

Inmates must be provided with information about HIV infection that is easily understood. Inmates need an understanding of the modes of transmission of this disease and how they may prevent themselves from becoming infected. The risks of tattooing, sharing needles and razors, and anal intercourse must be emphasized. Recognition of early symptoms of the disease such as white patches in the mouth, weight loss, fatigue, swollen glands and diarrhea is important. This knowledge allows the inmates to present themselves to health care providers for supportive treatment.

Tuberculosis (TB) is another contagious disease that is of concern in correctional facilities. Tuberculosis had been on the decline since the early 1950s. In 1985, this trend reversed, and showed a correlation with the increasing number of persons with HIV infection and AIDS.

TB remains a problem in correctional institutions where the environment is often conducive to airborne transmission among inmates, staff and visitors. A recent study reported the incidence of TB among inmates of correctional institutions was more than three times higher than that for nonincarcerated adults. HIV infection in persons with latent tuberculosis infection appears to create a high risk for development of TB.

An effective screening program for tuberculosis must be implemented as part of the reception process. Since this disease is spread primarily as a result of inhaling airborne droplets from an infected person who has coughed, this screening should be completed before inmates are transported to their permanent institutions. The intradermal Mantoux tuberculin skin test should be administered upon intake for inmates and at the time of employment for staff, and

annually thereafter for both groups. TB skin tests should be interpreted in light of HIV or other complicating diseases by current guidelines as developed.

All inmates and staff with positive tuberculin reactions who have not previously completed an adequate course of therapy should be considered for preventive therapy unless there are medical contraindications.

2. Need for Immunizations for Inmate Populations

The best way to reduce vaccine preventable disease is to have a highly immune population. Universal immunization is a critical part of good health care and should be carried out in all physician offices and public health clinics.

Upon intake to a correctional setting, each inmate should be questioned regarding his/her disease and immunization history. If information is not known or if the inmate is a poor historian, appropriate vaccine should be provided. Persons living in a closed environment are more susceptible to disease. Also, a person who is HIV-positive is especially vulnerable to all infections.

3. Basic Immunizations Required

All adults should receive a primary series of tetanus and diphtheria, then receive a booster ever 10 years. Persons more than 65 years old and all adults with medical conditions that place them at risk for pneumococcal disease or serious complications of influenza should receive one dose of pneumococcal polysaccharide vaccine and annual injections of influenza vaccine. In addition, immunization programs for adults should provide MMR (measles, mumps and rubella) vaccine whenever possible to anyone believed susceptible to these diseases. Use of MMR vaccine ensures that the recipient has been immunized against three different diseases and causes no harm if s/he already is immune to one or more of its components.

4. Aspects of Infection Control

Basic hygiene is important for all staff and inmates. Soap, water and towels must be readily available. Hand washing is the single most important means of preventing the spread of infection. Clean clothing and linens should be provided on a regular basis. Every inmate should have his/her own toothbrush, toothpaste, comb and razor. These items should not be shared with anyone. There should be a routine of housekeeping chores that allows the inmate proper management of personal items and disposal of waste.

a. Universal Precautions

The increasing prevalence of hepatitis B and HIV infections increases the risk that health care workers will be exposed to blood from patients infected with these diseases. Health care workers need to consider all patients as potentially infected with HIV or other bloodborne pathogens and to adhere rigorously to infection control precautions for minimizing the risk of exposure to blood and body fluids of ill patients. The premise that all bodily fluids are considered potentially hazardous is the cornerstone of universal precaution infection control procedures.

Universal precautions are intended to prevent parenteral, mucous membrane and non-intact skin exposures of health care workers to bloodborne pathogens. In addition, immunization with HBV vaccine is recommended as an important adjunct to universal precautions for health care workers who have exposure to blood. Universal precautions apply to blood and to other body fluids containing visible blood. Occupational transmission of HIV and HBV to health care workers by blood has been documented, although not in a correctional setting. Blood is the single most important source of HIV, HBV and other bloodborne pathogens in the occupational setting. Infection control efforts for HIV, HBV and other bloodborne pathogens must focus on preventing exposure to immunization. The use of gowns, goggles and other equipment is indicated only when there is a likelihood of blood contamination.

b. Modes and Risks of Virus Transmission in the Work Place

Although the potential for HBV transmission in the work place is greater than for HIV, the modes of transmission for these two viruses are similar. Both have been transmitted in occupational settings only by percutaneous inoculation, or by contact of blood or blood-contaminated body fluids with an open wound, non-intact skin (e.g., chapped, abraded, weeping or inflamed), or mucous membrane. Blood is the single most likely source of contracting HIV or

HBV in the work place. Protective measures against HIV or HBV for workers should focus primarily on preventing these types of exposures to blood as well as on delivering HBV vaccinations. Even though nationally there are hundreds of daily occurrences of inmates spitting, biting and throwing bodily waste on officers, there is no documented instance of HIV transmitted to an officer as a result of such behavior.

Correctional officers often are required to search prisoners and their cells for hypodermic needles and weapons. In accomplishing this task, they must be ever vigilant to prevent puncture wounds from possibly contaminated needles or weapons. Great caution should be used in searching clothing. The inmate should be asked to empty and turn pockets inside out for better visualization. Flashlights should be used when searching dark or hidden areas. The officer should never reach into a darkened area without first ascertaining by a visual inspection that the area is safe. Caution should be foremost in the officer's mind during the process of any search.

The use of latex gloves is necessary only when there is possible exposure to blood. Latex gloves will not prevent needle or puncture sticks. Only careful vigilance prevents contamination from puncture sticks.

Correctional officers may be exposed to blood during assaults, fights, stabbing, nosebleeds, sports injuries or any number of other ways. If a situation occurs where there is anticipated exposure to a person's blood, protective clothing such as latex gloves, disposable gowns, masks and goggles should be worn and after use, disposed of as infectious waste. If there is accidental exposure of blood to exposed skin, the skin should be washed immediately with soap and water. Soiled clothing should be removed and properly laundered. Blood spills should be removed by someone wearing latex gloves. The contaminated area should be cleaned with soap and water followed by a 1:10 solution of household bleach and water.

c. Isolation Procedures

Upon suspicion or diagnosis of a communicable disease, the inmate must be examined promptly by a physician. The inmate should be kept in a room separate from other inmates until a determination is made as to the necessity for and type of isolation required. It is always safer to over-isolate than to under-isolate when the diagnosis is uncertain. This is especially true in a closed environment. Also when a need for isolation has been identified, all personnel must carefully comply with any posted precautions.

A private infirmary room with handwashing facilities and bathing and toilet facilities is required most often. An infirmary room with special ventilation (vented to the exterior) is necessary for a respiratory disease such as tuberculosis. Use of masks, gowns, gloves, bagging of used articles, disposal of infectious waste and other environmental issues are covered completely in other literature.

THE HEALTH RECORD

The prison system's policy manual establishes a framework for the health delivery system that is generalized across all institutions. The health record is particularized. It summarizes all health encounters for a specific inmate. While the format and basic contents of the health record (i.e., the forms used) should be standardized across the prison system, the specific content reflects the assessment, care and treatment provided to individual patients. Basic issues associated with the development and management of health records are discussed briefly below.

1. Format

The primary purpose of the health record is not only to document the care provided to a specific patient, but also to facilitate communication among the various providers who treat a single patient. A unified health record system — that is, a single record for each patient in which all providers make their notations — is the best way to enhance continuity of care. Health staff sometimes resist moving to a unified record system. Undoubtedly, it is easier for each service (e.g., medical, dental, mental health) to have its own records and store them in their own treatment areas. The problem with this approach is that it is both less efficient and less effective than a unified record system. Inefficiencies include the necessity of each service duplicating basic health data on each patient (e.g., treatment history, allergies, medications) as well as duplicating health record resources (e.g., folders, files, storage space, staff). Separate record keeping systems are also less effective than a unified system, since the former require constant communication among

the services to alert each to any current treatment being provided to a patient by another service and thus, allow greater opportunity for error. With a unified record, any provider can see at a glance what medications and treatment have been prescribed by others for the same patient.

The organization of the forms within the unified record should be standardized. There are three types of format: source-oriented, problem-oriented and integrated. In a source oriented format, forms are organized into sections by the department that provided the care (e.g., dental, laboratory, radiology, mental health). In a integrated format, forms are filed in chronological order regardless of which department provided the care. The problem-oriented medical record (POMR) is separated into four sections: the database (i.e., assessment information about the patient's history, the physical exam, mental health evaluation, dental screening and diagnostic studies); the problem list (i.e., a summary of the patient's primary problems with notation as to whether they are on-going or resolved); the treatment plans (i.e., specification as to how the identified problems will be resolved or managed); and the progress notes (i.e., notations at each health encounter that indicate what follow-up has occurred in implementing the treatment plans).

2. Basic Contents

The forms to be used in the health record should be standardized throughout the prison system. This is the only way to ensure that the same information is collected for each patient. Additionally, it is more efficient to reproduce copies of standardized forms than it is to allow each institution to create its own. Also, standardized forms are less confusing to health providers, which is an important consideration given that most prison systems transfer inmates to other institutions rather frequently.

To further enhance continuity of care, a standardized chart order for the health record should be adopted. It is a list of all approved forms to be filed in the health record that specifies in which section and in what order they are to appear. This simple step guarantees consistency in filing forms and make it much easier for health providers to use the record. It also saves time since each provider, regardless of institutional assignment, knows exactly where to look in the standardized chart for a specific piece of information. Finally, a standardized chart order that lists the approved forms prevents the health record from becoming cluttered with extraneous memos and other materials.

While it is difficult to specify the exact forms that are needed in a health record, at a minimum, the medical record file contains these documents:

problem list;
receiving screening and health assessment forms;
all findings, diagnoses, treatments, and dispositions;
prescribed medications and their administration;
reports of laboratory, x-ray, and diagnostic studies;
progress notes;
consent and refusal forms;
release of information forms;
discharge summary of hospitalizations;
reports of dental, psychiatric, and other consultations;
special treatment plan , if any;
place, date, and time of each medical encounter;
signature and title of each documenter.

3. Charting Guidelines

It also is useful to develop a standardized method of charting for narrative forms such as progress notes. The most widely used format is known as "SOAPing" or SOAP notes." Soap is an acronym that stands for the basic components that should be included in a progress note; namely:

Subjective complaint,
Objective finding,
Assessment of the findings, and
Plan for treatment.

Additionally, a list of approved abbreviations and symbols that can be used in charting is needed. This helps to avoid idiosyncratic notations that other providers do not understand and to reduce the possibility of errors in carrying out medication orders or treatment plans. For the same reason, it is imperative that clinicians be instructed to write legibly. It is both arrogant and foolish for them to scribble orders that others cannot read.

Providers who write in patient charts also should be instructed to include clinical notations

only. The health record is not the place to make personal comments about one's patients or other providers. Further, professionalism must be maintained in chart notations. For example, it is not necessary to record for posterity the exact swear words an inmate called a provider. In fact, unless such exchanges have some bearing on the patient's treatment, they should not be recorded in the medical record at all.

4. Confidentiality

Clearly, the principle of confidentiality that is inherent in the provider/patient relationship extends to the health record and the information it contains. Distribution of health information must be restricted and access to the record must be strictly controlled. This is accomplished by ensuring that privileged health information is not disseminated to non-providers, by storing health records separately from custody records in locale cabinets in secure areas, and by developing a list of the types of individuals who may view the health record. On the latter point, laws and regulations may differ as to who legally may have access and what information may be discussed, so it is advisable to check the regulation. Generally, though, access to health information and records should be restricted to health providers.

There are times when non-health staff members such as the person legally responsible for the facility are permitted access by law to certain health information about their charges. When a request to review a record from an authorized non-health staff member is received, it is best for the health services staff member to take the record to that individual and respond to questions as appropriate. This is preferable to sending the record by itself, since the health staff member can ensure that only information pertinent to the matter at hand is released. Additionally, the health staff member can locate the information more readily and interpret it as necessary for the lay person.

While inmates should be expressly prohibited from gaining access to other inmates' health records under any circumstances, the question sometimes arises as to whether inmates should be permitted access to their own health records. It is advisable for each prison system to delineate a clear policy statement that addresses patients' access to their own health records.

5. Transfer of Health Records/Information

To enhance continuity of care, it is imperative that inmates' health records accompany them when they are transferred to another institution in the prison system. Health staff at the sending institution should:

- pull the health records of all inmates on the transfer list;
- review them to ensure that none of the people on the transfer list are on medical "hold";
- prepare a transfer summary that briefly lists current problems, medications, on-going treatment and any pending health care appointments; and
- secure the records in a locked box or some other mechanism so that they can be transferred with the inmates.

Health staff at the receiving institution should review all records of incoming inmates within a couple of hours of their arrival, do what is necessary to reestablish the inmates on medications and treatment programs, and reschedule health care appointments as appropriate.

For inter-system transfers of health records, it is not necessary to obtain a signed release of information from the inmates. If a request is received for copies of health records or information from an individual of agency outside the correctional system, written authorization from the inmate to release such information generally is required.

If an inmate is transferred temporarily too a community health facility for consultation or care, it is not advisable to send along the patient's health record owing to the possibility of loss or damage. Instead, a referral form should be used that summarizes pertinent information about the patient and provides space for the community provider to note his/her treatment findings and recommendations for follow-up. The completed referral form should be returned to the institution with the patient and filed in the patient's chart.

6. Retention of Records

Jurisdictions, differ with respect to legal requirements for the length of time that inactive

health records must be retained. A written policy statement on record retention should be developed for each prison system that conforms to the legal requirements of that jurisdiction. It should specify where inactive records will be stored and for how long before they are destroyed. The policy also should indicate the procedure for re-activating the health record if an inmate returns to the prison system.

INFORMED CONSENT AND THE RIGHT TO REFUSE CARE: INFORMED CHOICE

Informed consent is the process of ensuring that the patient's values and preferences govern the care provided. The informed consent process requires that the doctor share with the patient sufficient information to permit the patient to choose among medical options. The physician must provide information on the diagnosis, the prognosis, the alternative available treatments, the risks and the benefits of those treatments and the possible outcomes if medial suggestions are refused. The patient must then apply personal history, private values, ability to withstand pain and suffering, and religious beliefs to reach a personally appropriate (even if idiosyncratic), voluntary, uncoerced, informed and comfortable decision.

Once so stated, the problem is immediately apparent. Some scholars argue that prisons are places of such systematic deprivation and repression that voluntary behavior is precluded, although others have disagreed. Prisons are the paradigm of the "total institution" and work to destroy individual self-evaluation and independent behavior. Others argue that despite the nature of incarceration, inmates still can provide "good enough" consent and that alternative (i.e., consent by other) is even less appropriate. Structural supports may be required, however, to permit, buttress and facilitate the voluntariness of inmate choice.

Informed consent, as a process, has been defined as the ability to understand the information, measure the information against personal values and preferences, and communicate the ultimate decision. Outside of prison, this process, although based in the moral agency and legal right of the patient, often involves discussion with and consideration of the interests of others. "What will it cost?' "What will be the impact on my family?" "How will others react?" These are questions patients frequently ask as part of a personal calculus of decision-making. In prison, they are both harder to ask, as they are more abstract, and harder to answer.

Informed consent is a process and not a piece of paper. The requirement for obtaining informed consent or refusal is not satisfied by producing a document signed by the inmate. Informed consent describes the dialogue by which provider and patient share information, answer questions, hone the issues and decide on the steps to be followed in providing care. Especially in complicated medical situations, this may take time, many visits, and additional tests or data to reach a satisfactory conclusion. Time, respect, communication and trust are all central to the adequacy of this dialogue.

The rule outside of prisons is clear: with few exceptions, adult persons who are capable of making health care decisions have the right to consent to or to refuse care, even if the result of that refusal is death. This rule is based on three common law conceptions: that any touching without consent and without legal justification is a battery; that every individual has a right to the possession and control of his/her own person free from interference except by legal authority; and that individuals possess a right of bodily integrity.

The law and the ethical analysis of informed consent and refusal inside of prisons are, not surprisingly, far more complicated. The legal rule appears to be that inmates have the right to consent to care, but do not have equally extensive rights to refuse care. One such case held that an inmate, who was attempting to refuse dialysis for his renal failure, could have his right to refuse care overridden, if his refusal and subsequent death could affect the administration of the prison. In this case, the court found that his refusal was not a genuine refusal of care, but rather an attempt to manipulate the system in order to obtain a transfer, and therefore, the court overruled his refusal of dialysis.

There is another reason to be leery of refusals of care in prisons: it is often difficult to distinguish between a refusal or care and a possible denial of care. In one such case, there was an allegation that the behavior of a brutal and sadistic physician led inmates to refuse care. These inmates stated that they did not truly want to suffer from their underlying medical conditions, but preferred that suffering to the deliberately painful and ineffective alternatives provided by the physician. When an inmate fails to appear for treatment, someone must

determine whether s/he decided not to come because the symptoms abated, or because of a conflicting program or perhaps, a family visit, or whether s/he was prevented from coming.

There may be practical ways of grappling with some of these ethical concerns. One way is to structure a system for inmate access to and refusal of ambulatory care that helps to ensure that any refusal is genuine and informed. Such refusals should be in writing and should occur in the health unit after the inmates has been counseled regarding the possible consequences of his/her refusal of care. When the result of the refusal could be significantly health-imperiling or life-threatening, the prison system staff may wish to consider establishing an interdisciplinary committee composed of health professionals, correctional officials and clergy. This *ad hoc* group could meet with the inmate and discuss the refusal to ensure that it is informed and voluntary.

This discussion should not be construed to imply that every "no show" at sick call requires such extensive measures. As noted previously, the course of many illnesses is self-limiting. Written refusals should be required whenever there are potentially serious consequences of that refusal. Similarly, health staff should be required to follow-up "no shows" only when inmates' failure to appear may have an adverse effect on their health status.

4. Confidentiality

Confidentiality is central to the doctor/patient relationship. It is based upon a number of ethical principles (most prominently, respect for persons and their secrets) and a utilitarian principle of encouraging full disclosure. It also is based on the legal concept of "privileged relationships," which protect discussions between a husband and wife, priest and penitent, lawyer and client, and doctor and patient. This privilege is limited and means only that otherwise relevant information sometimes can be excluded in court. The privilege, however, reflects a societal policy that fostering open and honest communication in these relationships is so important that it justifies some sacrifices in the judicial process. Confidentiality generally is required of health personnel in their professional oaths, the observance of which is made mandatory by state licensing statutes.

Arrayed against these protections is a vast number of processes and procedures which, together, render the principle fragile and frayed: a hospital chart is a means of communicating and is open to all caregivers — it supports the sharing of information, which permits continuity of care across shifts and among different professions; third party reimbursement opens charts generally to the scrutiny of the professionals; the computerization of medical information makes personal data easily accessible; gossip, which given human nature is widespread, opens secrets to public comment.

Despite this picture, the general ethic in medicine is that a patient's secrets uttered in confidence must be guarded by the physician or other health care provider. There are some exceptions to this rule and confidentiality is never an absolute; for example, a breach may be permitted for the good of the public (such as in mandatory reporting laws) or for the protection of a specifically endangered individual. In general, however, the aura of confidentiality permeates health care interactions.

The principle of confidentiality should equally guide the provider/patient relationship within prisons; however in prisons, the public health imperatives and the need to protect others from illicit drugs or weapons may conflict more often with the health care practitioner's duty of confidentiality. Outside of prisons, providers do not practice in an alien surrounding; they generally do not have conflicting loyalties. Inside they do, and that ongoing tension affects how the principle of confidentiality is employed in practice.

Maintaining confidential communication within prisons is a monumentally difficult task. Some breaches may be unavoidable; for example, medical information may be surmised from an inmate's pattern of movement or schedule of visits to the health unit. the rumor mill in prisons is busy and surprisingly accurate. In spite of this, every effort should be made to adhere to the principle of confidentiality. Sick call screening and triage should not be performed in dormitory units or within earshot of other inmates or correctional personnel. Health staff should not discuss one patient in front of another. Medical records themselves should be protected and should not be available to correctional staff. They should be stored in space that is protected from officer or inmate access. When health records are transported by officers (e.g., during inter-unit transfers of inmates), the records should be placed in sealed envelopes or containers and delivered unopened to health staff.

Confidentiality is important not only to the

privacy of an inmate, but also as an underpinning for the truth-telling necessary for an adequate history and physical assessment. Histories of drug and alcohol abuse as well as incidents related to trauma, or to sexual attack or behavior, are far more likely to be explained accurately to a provider if the inmate is sure of the privacy of the communication. If the provider acquires information that indicates an immediate danger to the inmate (e.g., suicidal intent) or an immediate danger to others (e.g., the possession of weapons), that information must be communicated to correctional authorities. Absent such identifiable dangers, inmates' secrets should be protected and guarded.

5. Biomedical Research in Correctional Settings

Research with human subjects in prisons and jails has a long history of abuse in this and other countries. In the past, prisoners often were used to test cosmetics or new vaccines or new chemotherapeutic agents without adequate prior informed consent. Even when there was ostensible consent, some argued that the systematic and profound deprivations of prison life vitiated the consent, because there was not a sufficient degree of voluntariness.

In 1976, the National Commission for the protection of Human Subjects of Biomedical and Behavioral Research addressed the problem of research involving prisoners. Various perspectives were examined. One argued that prisoners gain a wide variety of benefits from participating in experiments including much greater financial reward than otherwise obtainable in prison; improved physical surroundings, which provide greater comfort and safety; and the relief from boredom. the proponents of research also argued that society as a whole gains from the increased scientific knowledge.

Historically, prisoners involved in biomedical research were treated more humanely, given better living conditions and shielded from some of the boredom, danger and fear of prison life. Many inmates valued these benefits and sought to continue as subjects in research and drug protocols. Nonetheless, members of a national commission were concerned about the risks of research and the compromised ability of an inmate to weigh the risks and benefits, given the continuous emotional and material pressures of their surroundings.

These concerns led to recommendations of general restrictions on the conduct of research in prisons. Following these recommendations, regulations were passed governing research on human subjects in general and on prisoners in specific. The special section on prisoners stated that the purpose of the regulations was "to provide additional safeguards...inasmuch as prisoners may be under constraints because of their incarceration which could affect their ability to make a truly voluntary and uncoerced decision whether or not to participate in research."

The regulations identify four categories of permitted research:

a. Study of the possible causes, effects, and process of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;

b. Study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;

c. Research on conditions particularly affecting prisoners as a class (for example, vaccine trials and other research on hepatitis which is much more prevalent in prisons than elsewhere, and research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults) provided that the study may proceed only after consultation with appropriate experts, including experts in penology, medicine and ethics, and published notice of his/her intent to approve such research;

d. Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject. In cases in which those studies require the assignment of prisoners in a manner consistent with protocols approved by an Institutional Review Board (IRB) to control groups which may not benefit from the research, the study may proceed only after consultation with appropriate experts, including experts in penology, medicine and ethics, and published notice of his/her intent to

approve this research.

Note, though, that research in these categories can proceed only when approved by a specially organized IRB with a prison advocate present, charged under the regulations with reviewing all research involving human subjects.

More recently, as the HIV epidemic has advanced and as more prisoners have become infected with the virus, the debates regarding the applicability of research have shifted to discussions about the availability of experimental treatments. Even in the past, there were prisoner advocates who argued that the regulations were preventing inmates from access to measurable benefits by restricting their participation in research. Now, however, those assertions have particular relevance and poignancy.

Most treatments for the opportunistic infections that beset HIV-infected persons are carried out under the terms of research protocols. This is so because the virus and its treatments are so new that a moral posture toward the infection requires the maximum collection of data to support or disprove treatment hypotheses. Therefore, "protecting" inmates from research may mean effectively excluding them from "treatment." This irony of public policy has led some to argue that prisoners can and should be included in the later stages of research protocols when there is no other access to care. This same logic would apply also to prisoners with certain kinds of cancers where treatment generally is administered under

Some prison systems with a large percentage of HIV-infected prisoners may need to amend law or regulations to permit research interventions in prisons. All institutions that choose to permit prisoners to participate in clinical trials (the last stages of drug testing) should establish guidelines and procedures to protect the process of consent.

6. Terminal Care and Advance Directives

The expansion of HIV infection in the drug-using community as well as the war on drugs have brought an increase in the number of prisoners who are HIV-infected or terminally ill with AIDS. In 1989, the New York state prison system reported approximately one inmate every other day was dying of an AIDS-related illness. This was far in excess of any other state prison systems, but may foretell even more widespread infection in the years ahead.

Caring for the terminally ill requires compassion, skill in providing comfort and support, knowledge of pain management and the ability to help, and permitting the dying patient to experience the stages of death from denial to acceptance. It is difficult to provide for an acceptable quality of death in a prison where comforts are limited, providers skilled in dealing with the terminally ill may be scarce, and family and loved ones generally are excluded from intimate, continuous participation. Terminal care can be provided best by a hospice or hospice-like facility in the community. The needs of dying patients and the requirements of security are mutually exclusive. Compassionate release or medical furlough programs are best calculated to address the needs of dying inmates and their families.

Even when this is not possible, every reasonable effort should be made to humanize the process of dying. There are a few prisons that have a thanatologist on staff to work with terminally ill inmates. As the rate of HIV infection rises and the prison population ages, the services of a thanatologist and/or some program designed to meet the needs of terminal patients will become increasingly important.

Outside the prison, very ill or terminally ill patients, or health persons with strong and clear preferences increasingly execute advance directives regarding their health care choices for the future. These directives include living wills, which state specific preferences for care if the patient is no longer able to participate in health care decisions; and durable powers of attorney, which appoint a specific person to decide on health care plans if the patient is incapacitated and which, in addition, may or may not provide specific guidance regarding care choices. These documents become effective only when the patient is incapacitated and permit antecedent personal choice rather than the decisions of strangers (e.g., caregivers) to control care. The goal of advance directives generally is to limit care including ventilators, dialysis and resuscitation. They were developed by persons who say the growth in medical technology and the potential for abuse if the existence of technology dictated its use.

The use of these instruments in prisons is problematic. If advance directives are approved for use, they must not be permitted to mask denials of care and they must be chosen voluntarily after adequate discussion. On the other hand, it would be unfair and unjust to deny

prisoners this control over their health care at the end of life. Again, a multi-disciplinary committee of health providers from the prison and community as well as clergy and public officials may provide the perspective and oversight necessary to ensure fairness.

4. Special Issues: Seclusion, Restraint and Forced Psychotropic Medication

In every prison, there are times when mental health emergencies, as a result of disorganized or dangerous behavior on the part of the mentally ill or mentally retarded individual, justify the use of seclusion, restraint or forced psychotropic medication. It is imperative that every prison system have written policies and procedures in place that delineate the circumstances under which seclusion, restraint or forced psychotropic medication may be used to control an inmate's behavior. State laws and regulations have been developed to govern these situations and they must be strictly adhered to in the use of these extreme treatment modalities.

In every prison system, the director of mental health services should be aware of all state laws and regulations governing seclusion, restraint and forced psychotropic medications. Additionally, s/he should research the clinical issues surrounding their use and be cognizant of the recommendations of national professional associations.

Based on the results of researching both the legal and clinical issues, written policies and procedures are needed for all three treatment modalities that cover the following elements at a minimum:

- prohibiting the use of the modalities for punishment;
- requiring their authorization only by a physician or another clinician where specified by law;
- defining the clinical criteria for use (e.g., patient is dangerous to self or others);
- limiting the time and frequency of use of these extreme measures;
- specifying staff responsibilities for monitoring patients, reevaluating their progress and fully documenting such encounters in the patients' medical records; and
- training relevant staff to ensure that they are familiar with all aspects of such policies and procedures.

Additionally, the prison system's mental health director should require that staff at each prison maintain statistics on the frequency of use of each of these procedures. This will facilitate conducting quality assurance audits on the systemwide utilization of seclusion, restraints and forced psychotropic medications. Such studies can help to determine whether the prison system's procedures are adequate to protect patients' rights and whether staff are using them appropriately.

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American College of International Physicians
Catholic Relief Services
Development Studies Association
Federation Nationale de Ligues Contre la Drougue
Human Rights Advocates International
International Association for Maternal and Neonatal Health
International Association for Suicide Prevention
International College of Surgeons
International Committee of Catholic Nurses and Medico and Socio Association
International Committee of the Red Cross
International Committee of Health Professionals
International Council of Nurses
International Council on Alcohol and Addictions
International Dental Federation
International Federation of Medical Students' Associations
International Federation of Physical Medicine and Rehabilitation
International Federation of National Red Cross and Red Crescent Societies
International Human Rights Law Group
International League for Human Rights
International Social Science Council
International Union of Nutritional Scientists
International Women' Health Coalition
Islamic Relief Agency
Medical Women's International Association
National Council for International Health
National Council for the Social Studies
National Council on the Aging
Panhellenic Anti-Drug Cooperation Committee
Society for Public Health Education
Third World Foundation for Social and Economic Studies
U.S. Department of Health and Human Services, International Program Activities
Woman's Christian Temperance Union

ALLIANCE OF NGO's ON CRIME PREVENTION & CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	MEDICATIONS AVAILABLE		BASIC HEALTH & NUTRITION		HEALTH CARE SCREENING MEASURES USED IN PRISON & JAILS	COMMUNICABLE DISEASES			PROVISIONS FOR ISOLATION OR TREATMENT
	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
AUSTRALIA	Yes	Yes	No	No	General assessment on reception by nursing staff. Referral to medical officials as necessary	HIV compulsory screen	At reception and discharge	HIV, only routinely.	Prison hospital, infectious disease unit at nearby teaching hospital.
	Same range as in communities								
AUSTRALIA, NORTHERN TERRITORY	Yes	Yes	Yes	No	Medical & psychiatric assessment on reception, transfer and discharge in all reasonable instances; communicable diseases including AIDS/HIV, STD, T.B. and Hepatitis B.	Pathology and Mantoux	On reception; at 3/12 and 12/12 or discharge for AIDS/HIV	On reception for T.B; STD's, etc.	Adequate provision for isolation and/or separation of prisoner accommodation, etc.; treatment is under taken by Prison Officers and Health Professionals during normal working hrs.
	At a cost to the Northern Territory Government (no cost to prisoners)		Prisoner population, 80% aboriginal-health status generally poor.						
AUSTRALIA, TASMANIA	Yes	Yes	No	No	Initial medical including compulsory testing for HIV/HepB	Venous blood for HIV/HepB. Other tests as required	On admission and at 3 mos.	HIV/HepB, other tests as required	Remain in prison hospital for duration of internment
			Special diets for health problems (diabetes)						
AUSTRALIA, VICTORIA	Yes	Yes	No	No	1) all prisoners seen and examined by a medical practitioner on reception to prison; 2) dental screening with OPG x-ray; 3) all prisoners offered serology screening (Hep. B, Hep. C, Syphilis, HIV)	(see health care screening question)	Generally at reception	Hep. B, Hep. C, Syphilis, HIV (99.1% acceptance)	Acute hepatitis (ill & abnormal LFT's)-hospitalized; Hep B & Hep C carriers, syphilis are not isolated; HIV positive prisoners share special unit with up to 20 non HIV's
	Strict control of sedative and hypnotic medication								
BELIZE	Yes	Yes	No	No	Health care measures commence on admission of the offender, careful inspection of the body and health history of the individual after which the medical officer is informed.	Under the direction of the lab technician	Quarterly or if the medical officer directs	Any diseases that the medical officer suspects is becoming a problem to include AIDS.	Isolation at the national hospital where possible or treatment at the clinic under the direction of the medical officer.
	If not in stock at the hospital, the prison institutions with purchase medications under the directions of the medical officer.		The situation has improved over a 14 mo. period.						
BOTSWANA	Yes	Yes	No	No	Subjective and objective assessment of clients by nurses who usually refer to medical officers as may be necessary. Also, laboratory tests as may be necessary as well-blood, stools, urine, HVS (in the case of females) x-rays, etc.	Laboratory tests	When necessary, on admission to prisons and when health workers are suspicious	TB, STD including AIDS, skin conditions, EG scabies, Hepatitis B, etc.	Isolation is done in prison clinics or referred to civil health facilities for isolation and treatment. Please note: prison clinics have isolation cubicles.
	Civil health facilities do assist prison in the rendering of medical care		Botswana government has set as priority basic health and nutrition.						
CHILE	Yes	No	Yes	Yes	Health exam upon intake to the prisons; an investigative campaign for contagious deceases (TB); preventative treatment for scabies and lice	With clinical & laboratory stains	Medical exam upon intake and when there are symptoms	Screening for TB; investigation with cultures and typhoid through blood cultures	Acute infections are hospitalized and treated in a hospital located inside the prison; carriers of the HIV virus are located in a special confined area separated from the general population.
	The medicine not available in the prisons, bought in the amounts that resources allow.								

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INTERNATIONAL PRISON HEALTH CARE

COUNTRY	MEDICATIONS AVAILABLE		BASIC HEALTH & NUTRITION		HEALTH CARE SCREENING MEASURES USED IN PRISON & JAILS	COMMUNICABLE DISEASES			PROVISIONS FOR ISOLATION OR TREATMENT
	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
COLOMBIA	No	No	Yes	Yes	The most important prisons have a medicine doctor and are able to attend the urgent situations. However, their work is done in very bad conditions, with poor resources. Control and follow up of patient's situations is non-existent.	Blood test, but general programs are non-existent	General programs do not exist. A judge can order medical examination.	The scope of the test will depend upon the judge's order	Treatment is beyond question. Isolation is provided in special rooms where these inmates can be separated from the others.
	Colombia is poor country. A substantial part of the population has a very poor access to basic medications. The prisons' situation is even more dramatic.		The prisons' environment is very bad in health and food conditions						
CZECHOSLOVAKIA (Director of Prison Health Care)	No	Yes	Yes	No	Roentgen X-ray (lungs, heart); BWR urina examination (glucosis, protein, UBG); does not examine HIV	Selective epidemiology test (salmoneua)	At admission, in one-year periods.	TBC-Mantoux II (III)	Separate TBC Hospital within prison system; the other communicable diseases are taken to a special ... in prison hospital or civil hospital
	The situation varies in time, prison population gets equal or better health care		The prison population gets equal or better health care than the regular population						
CZECHOSLOVAKIA MUDr.	Yes	Yes	No	No	Medical care in our jails and prisons is screened by the Ministry of Health of Slovak Republic bodies, representatives of Slovak National Council, bodies of prosecution and courts as well as by the officials of the Medical Service Administration of the Corps of Reformatory Education of Slovak Republic	Prisoners are tested for communicable diseases in health-care centers of the Corps of Reformatory Education in cooperation with specialists from the National Health Care Administration. Detection is implemented through x-ray examinations and laboratory tests. We diagnose TBC, gonorrhoea, trichomonas vaginitis, infectious hepatitis, etc.			Communicable diseases are treated at infectious department of prison hospital or, if need be, at infectious departments of National Health-Care Administration.
ECUADOR	Yes	No	Yes; this is shown in the malnutrition and infant mortality rates		Purely curative	Don't test except at the personal request of the prisoner	When they get their turn for attention at one of the state labs		The only treatment offered is somatic; there are no isolation chambers in the jails. Sometimes they stay in an individual cell and in very rare instances are accepted in a health center.
	The administrative process does not permit efficient attention to this area								
ENGLAND	Yes	Yes	No	No		Not routinely	Only according to clienal needs		As required
ESTONIAN REPUBLIC	Yes	Yes	We have problems in good nutrition and technical provision		Surgical and all kinds of therapy	Laboratorium & x-ray methods	When prisoner enters prison or visits a doctor		Isolation to special wards, disinfection of dwellings and things; prophylactic measures to other prisoners
	Besides set of false teeth								
FRANCE	No	No	Yes	Yes	Research of TB, venereal deceases, HIV, mental disorders	Involvement retirement	When the doctor asks it	HIV, Hepatitis B, toxoplasma microbes	It depends on what prison, ask the psychiatrist or generalists or dentist
			We have dietetic systems in prison						
GREECE		There is no problem of medical care and boarding in the prisons			The doctor examines the patient. If an illness has been confirmed, the doctor tries to cure it or he asks an expert to examine the patient. In serious cases the patient is sent to the hospital. The prisoner has the right to ask to be examined by his family doctor in front of the doctor of the unit.				If the illness is contagious the patient is either admitted to the hospital or he is isolated in the prison according to the doctor's orders

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INTERNATIONAL PRISON HEALTH CARE

COUNTRY	MEDICATIONS AVAILABLE		BASIC HEALTH & NUTRITION		HEALTH CARE SCREENING MEASURES USED IN PRISON & JAILS	COMMUNICABLE DISEASES			PROVISIONS FOR ISOLATION OR TREATMENT
	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
GUAM	Yes	Yes	No	No	A brief health screening question list is administered on admission and prior to housing done by a Correctional Officer who had been instructed by a physician. This consists of the visual opinion of the officer. Is the inmate bleeding, conscious, suicidal, etc. History of physical examination done by a physician, lab test.	By history, physical exam, laboratory test.	Within 10 days of admission	T.B., Hepatitis B., Syphilis done routinely. HIV testing is not done routinely. However, it is offered if an inmate is agreeable, consent to be signed by inmate. Public Health, Guam has done HIV testing last year to about 80% of the inmates.	Patient together with all his personal belongings are transferred to an isolation/precaution room in the Infirmary ward where he has his own commode and sink. He is instructed to wear a mask, gloves and gown going to and from the bathroom. An isolation/precaution is put up on his door. Staff attending said inmate is instructed to follow the Universal precaution policy. Patient is treated accordingly and a specialist on Infectious Diseases vacated. Epidemiologist is notified
			Some inmates would complain of the same kind of menu being served often but not its nutritional quality. And, special diet not being followed adequately.						
HONG KONG	Yes	Yes	No	No	Every prisoner on admission is interviewed by the Medical Officer within 24 hrs. Thorough physical examination and mental assessment is conducted including checking of any external injury marks on the body caused prior to admission. Detailed past health history including operation, serious illness, fractured of bones, dislocation, congenital disease, etc. are carefully obtained, and if in doubt, the relatives will be consulted. History of drug abuse is also taken nd detection of intravenous injection marks as well as drug withdrawal symptoms are also included in the screening procedures. Pathological and radiological examinations are taken to exclude communicable diseases (x-ray chest, blood tests for venereal diseases, urine & stool tests, spectum test etc., I.V. drug users and person giving history of homosexual behavior and activity will be tested for AIDS). Prisoner with mental or personality problems will be referred to the Clinical Psychologist or Psychiatrist for assessment and treatment.	History taking, physical examination, blood test	On admission to any penal institution	Every prisoner, on admission to any penal institution, must be examined by a Medical Officer within 24 hrs. to screen for communicable diseases such as pulmonary TB, venereal diseases, hepatitis.	Prisoners/remands once detected to have communicable diseases will be treated initially in the isolation ward /cell (some institutions are provided with isolation wards or cells). In case facilities are not adequate, then the case will be referred to Infectious Diseases Unit of public hospitals for treatment
	There is a hospital or sick bay with a dispensary in every penal institution and medications are obtained from Department of Health		In general, basic health and nutrition is not a problem in Hong Kong or in prison. The prison diet is approved by Governor in Council and is closely monitored by a Catering Officer who is a qualified dietitian						

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INTERNATIONAL PRISON HEALTH CARE

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	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
IRELAND (NORTHERN)	Yes	Yes	No	No	All prisoners are examined as soon as possible after committal, usually within 24 hrs.	Clinical examination and history taking.	At committal	Due to low level of communicable disease within the community at large, routine testing is considered unnecessary. T.B. is now eradicated.	Each prison establishment has its own hospital with its own isolation facilities. Where particular diseases require it provision has been made for specialist consultant advice.
IRELAND, REPUBLIC OF	Yes	Yes	No	No	All prisoners are medically examined as soon as possible following reception. Thereafter, they are seen on demand and if there are other medical indications	No continually	If clinically indicated or at the request of the prisoner	STD, Hepatitis B, T.B., HIV (only after consent and counseling)	In relation to most communicable diseases isolation/treatment depends on medical indications. In relation to HIV, it is current policy to segregate though the prison department has been advised that there is no medical indication. This policy is under review
ITALY (University of Padova Psychology Department)	Yes	Yes	Yes	Yes	Screening is not done automatically; illness if undiagnosed on entering prison is only picked up with the manifestation of the symptoms.	Only on diagnosis			Prisoners can be treated with the jails medical unit or in specially set aside sections of civil hospitals or with prison clinics. In practice, outside treatment is harder to obtain because of bureaucratic problems. Isolation cannot be guaranteed.
	All prisoners have the right to necessary medication by law, in practice, however, access may be more difficult		Prisons tend to be old and overcrowded						
ITALY (PRISON ADMINISTRATION)	Yes	Yes	No	No	Screening measures aimed at identifying syphilis, venereal diseases and hepatitis A & B	Screening for R.W., hepatitis B & HIV antibodies (Elisa tests and Western Blot test) only for the last of them the prisoner's consent is required	On reception into a Prison Service establishment	See previous answer	Removal to the prison sick-room; removal to a prison diagnostic therapeutical centre; removal to an outside health care facility
	In each prison emergency operations are dealt with by the "duty doctor" or supplementary medical service doctor. At territorial precincts there are first-aid services and supplementary medical services as provided for by the Public Health Law								
JAPAN	Yes	Yes	Yes	Yes	We conduct regular check-ups including interviewing, physical examinations and other testings, in addition to check-ups conducted at the time of admission and transfer		At the time of admission and when considered necessary	Pulmonary tuberculosis, dysentery and other diseases	Relocation to a segregated ward and transfer to outside hospital

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	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
KUWAIT	Yes	Yes	No	No	Every prisoner is medically checked before entering the jail and later a medical file is opened if the prisoner needs a special medical care.	By medical test	Before entering the jail	Cholera & AIDS	If such diseases are detected, he will be transferred to the hospital
	Additional medication can be obtained from local hospitals or clinics of Ministry of Public Health								
LEBANON	Yes	No	No	Yes	None	They are not tested, except in very rare cases			The infected person is isolated in a private cell. Treatment will be provided, but usually with great delay.
	Medications are readily available in pharmacies. They are comparatively expensive. They are almost non-existent in prisons.		There is no health and nutrition problem of alarming dimensions in Lebanon, except in prisons.						
LESOTHO	Yes	No	No	No	There is supervision on hygiene of the prison and the prisoners including cleanliness, sanitation and ventilation.	No			Prisoner is treated in isolation and counseled.
	There is sometimes shortage of doctors								
LUXEMBOURG (GRAND-DUCHY OF)	No	Yes	No	No		Blood test, clinical examination	On entry	HIV (voluntary), syphilis	No isolation in general, except contamination by usual and social contact
MALTA	Yes	Yes	No	No	Clinical examination on admission; chest x-ray; HIV and HbSag or agreement	Blood or urine samples	On admission or as necessary	An anemia, TB, AIDS, Hepatitis, STDS	Person is referred to Hospital for Infective Diseases
NETHERLANDS	Yes	Yes	No	No	In general, medical examination at intake in prison includes anamnesis, physical examination and urine glucose and protein control. Moreover, any detainee is tested for tuberculosis.	Compulsory testing only for T.B.	At intake of the detainee	T.B., mantoux reaction test for those from after 1945, or x-ray of the chest for those born before 1945, on clinical symptoms or at positive Mantoux.	Any "open" (i.e. contagious) tuberculosis is to be admitted in the penitentiary hospital. Other communicable diseases are treated as usual in general (community) practice.
	All medications are delivered by local pharmacists								

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INTERNATIONAL PRISON HEALTH CARE

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	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
NEW ZEALAND	Yes	Yes	No	No	Any screening deemed necessary on clinical grounds will be done. All inmates have health assessment done on reception and then on an "as needs" basis during remand or sentence	By appropriate assessment and test for suspected diseases	As soon as required	There is routine Hepatitis B screen done in some institutions-in others, on clinical evidence. HIV testing is done on clinical/ lifestyle evidence as is TB, meningitis, hepatitis C etc. All testing is with consent of the inmate.	Each case is assessed-placement and treatment being provided according to Department of Health and/or community guidelines which may include transfer to a public hospital
	The cost to the department is equivalent to the cost in the community		Prison inmate reaction scale is based on nutritionally adequate daily allowance advised by Department of Health dietitians.						
NICARAGUA	No	No	Yes	Yes	Owing to the cutting of medical supplies, we have had to undertake activities of a more preventative character: Medical exam upon intake of offender; Tests to detect contagious diseases; Health education through talks and offender participation on cleaning day-trips/tests although there are many limitations because of shortages of materials and laboratory chemicals (re-agents)		During medical exam at intake and through the programmed medical consultation	Urine and feces, blood (BHCm VDRL), Baciloscopia Barr.	When a contagious disease is diagnosed, the patient is isolated in separate cells, but without the necessary conditions, and there they apply the treatment with periodic doctor's control
			In our country, because of the precarious economic situation, health and malnutrition problems are causing high death rates in the general population as much as in the prisons						
NORWAY (PROJECT SUPERVISOR OF PRISON HEALTH)	Yes	Yes	Yes	Yes	On admission all prisoners are offered medical examination. This examination includes a medical history and dental status by a dentist. In general, will a prisoner who has given his consent be offered blood and urine sample and test on: Haemoglobin,sedimentation rate, hepatitis A/B/C, HIV, TUB	On voluntary basis	When the prisoner asks for the test	The prisoner decides on the doctors recommendation	They are given the same treatment as patients outside the prison. If necessary a prisoner will be transferred to a hospital outside the prison. We don't practice any form of segregation within the prison.
	Prison authorities have cooperated on making a medication list for prisoners. None of the medications recommended is suppose to give drug dependency. The list is only a guideline, but followed by most doctors.								
NORWAY (RONNAUG AABERG ANDRESEN)	Yes	Yes	NO	No	Consultation when asked for by prisoners	No routine testing			The same as for persons outside prisons
	When prescribed by a physician								
PAPUA NEW GUINEA	Yes	Yes	Yes	Yes	None	No test until prisoner complains	Does not arise	Does not arise	As advised by the health authorities.
	To a certain extent								

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	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
PHILIPPINES	Yes	Yes	Yes	Yes	At Bureau of Prisons, Section of IREC (Inmate Reception & Education Center) is in charge for such health care screening measures, IREC is manned by psychologist/psychiatrist and medical officer (assigned) at Medium Security Camp Infirmary to meet the needs of the arrival of inmates from different jails. Newly arrived inmates a re temporarily housed at IREC for medical and psychological examinations. Medical examination include thorough physical examinations done by physician assigned at MSC to determine eye defects and to help respiratory tract infections, cardiac abnormalities, as well, as presence of abdominal mass and hemorrhoids and other physical abnormalities. those with findings are further evaluated by chest x-rays, laboratory examinations and with surgical problems are recommended for surgical interventions after evaluation by a specialist. Psychologist and Psychiatric problems are recommended for confinement for further evaluation and treatment.	Use of chest x-ray; complete blood count; urinalysis and fecalysis; blood culture; special test such as widal test, malarial smear, etc.	Upon onset of signs and symptoms of such disease; failure of initial medications, still disease persists; reoccurrence of disease	Blood, urine, s tool, discharge to t est the causative organism	1) give the patients the right (drug) medicines, like anti-microbial, supportive medicines lie anti-pyretic, vitamins or the right dosage and duration; 2)isolate patients by creating sections and avoid spread of disease; 3) have a series of laboratory examination to determine if treatment for such disease has been successful; 4) provide food and nutrition food to aid in early recovery of patients; 5) provide proper hygiene which are one of the cause for outbreaks of communicable diseases; 6) give immunizations to sterile cases contacts, children, etc.; 7) educate patients on ways for presenting communicable diseases on water/sewage disposal, insect bites, food intake and other related agents.
	Medication in prison are being purchased quarterly (regular). Requisition of medicines are being made by member of Therapeutic Committee (Medical Staff) which is composed of 3 physicians, a dentist, a nurse and a pharmacist, and upon approval, these medicines are being purchased by the Supply Division of the Bureau. However, there are medicines which are requested on emergency due to the need of admitted inmate-patients. The pharmacists is (the one) responsible of the purchase of emergency medicines.		Prisoners are being provided their food 3 times a day prepared by a nutritionist of the Bureau and prior to distribution of food sample of food is being checked by the Medical Officer of the day. Ways of providing of non-patient, either in the form of A) raw ration (canned goods, uncooked eggs, etc. or B) cooked food. Admitted inmates: others are given low salt diet, soft diet, full diet, high carbohydrates depending on physicians' order.						
SAUDI ARABIA (Assistant Director General, Medical Services Directorate, Ministry of Interior)	Yes	Yes	No	No	On the first day and before the prisoner is allowed in, a general check-up will be made including physical examination, chest x-ray, CBC, blood testing for HIV, TPHA, LFT and hepatitis	Complete physical examination, CXR, lab investigation	In the health center attached to the prison	TB, HIV, TPHA, hepatitis, infectious diseases like chicken-pox, measles, etc.	The patient will be isolated in a private room, according to the instructions from the treating physician. The patient may continue to be treated in the isolation section of the prison or referral to a specialized hospital (TB hospital or infectious diseases hospitals).
SAUDI ARABIA Arab Security Studies & Training Center in Riyadh)	Yes	Yes	Yes	Yes	General check at the beginning, then medication during the period of the sentence	No special tests	At the beginning	Normal diseases	Isolation in special wing or sending the prisoner under guard to a hospital
SIERRA LEONE	No	No	Yes	Yes	Prisoners on admission into prison are examined by a doctor and any diseases present are noted and if necessary action is taken	Test for communicabl e disease are not routinely done.	In clinics	Mainly for tuberculosis, sometimes for leprosy	There is an isolation unit for tuberculous patients in a block of cells. Tuberculous patients are treated in clinics or if serious sent to a hospital for communicable diseases
	All medications have to be imported and foreign exchange is in short supply		High cost of living, osculating inflation and poor eating capacity						

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INTERNATIONAL PRISON HEALTH CARE

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	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
SLOVENIA, REPUBLIC OF	Yes	Yes	No	No	General medical examination on a person's coming to prison; complete medical treatment, if necessary; isolation of prisoners with communicable diseases.	All prisoners are subject to general medical examination.	On their coming to prison or jail.	If suspicious for any communicable disease, they are tested for any possible disease without restrictions.	Prisoners with communicable diseases go to special prison health care department or they are taken to hospital.
SPAIN	Yes	Yes	No	No	Screening for communicable diseases; AIDS, hepatitis B, syphilis, TBC. Apart from that, all inmates undergo a general physical examination at entry in prison	Voluntary testing	At entry in prison	AIDS, hepatitis B, hepatitis Delta, hepatitis C, syphilis, TBC	Isolation: provisions are taken to isolate inmates according to the guidelines provided by the C.D.C. Treatment: the prison's physician treats the patient. If hospitalization is necessary, inmates are taken to a hospital and treated there.
	Every prison in Spain has a pharmacy where the most commonly used drugs are available								
SURINAME	Yes	Yes	Yes		We don't have health care screening measures	In a hospital laboratory and at the Bureau of Public Health	As soon as it is detected	V.D.R.L. & H.I.V.	Isolation is possible; treatment by general physician/dermatologist
SWITZERLAND	Yes	Yes	No	No	Any measure necessary to the maintenance or health recovery of the prisoners, if needed outside the prison in a hospital.	Through appropriate tests	When it is necessary or on the prisoner's request	Nowadays, it is mainly to test for seropositiy and AIDS that are considered (tests made with the agreement of the prisoner), but it is the same for hepatitis and TB.	Solution within the prison or outside it (except for the seropositives) and appropriate care. In case of AIDS, interruption of the sentence or medical care as for a free person.
TONGA	Yes	Yes	No	No	Every citizen of Tonga, prisoners included, is entitled to free medical care. Therefore, whatever health care screening measures exist in the country, both prisoners and general population have access to them.	Same as everyone else	When the need arises	For whatever condition is suspected	If hospitalization is warranted, prisoners are admitted to a hospital's isolation ward just like the rest of the population. Care and management in prison is possible if indicated
	Law dictates that all prisoners must be visited by the prison medical officer every 24 hours								
TRINIDAD & TOBAGO	Yes	Yes	No	No	Visual assessment; case history; physical examination	Inmates are tested based on medical history and by random assessment	On reception and when inmates are paraded by para medics on medicine parade	Social diseases, hepatitis, T.B. and HIV. The latter on the request of the inmate.	The inmate is informed of his/her condition. They are isolated and are referred to Special Clinics for treatment and counseling
			Overcrowding brings problems in terms of chicken pox and flu viruses						

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	IN COUNTRY	IN PRISONS	IN COUNTRY	IN PRISONS		HOW TESTED	WHEN TESTED	WHAT IS TESTED FOR	
UKRAINE	Yes	Yes	Yes	Yes	The sanitary-hygienic measures in your correctional institutions and prisons. Preventive examinations, labor protection of prisoners.	Medical examinations, laboratory methods of examination	When entering to the prisons, periodically and before release	Of the organism in general, and also the examination of organs and systems. Biological mediums and secretions	Persons with who infections diseases are isolated. The food-stuffs which may be the infections diseases carriers to be processed or destructed
	The convicted persons have the rights for medical service in the health care institutions of the penitentiary system.		There is no required reserve of food-stuffs to ensure the full-valued balanced nutrition						
USSR	No	No	Yes	Yes	Immunization, hospitalization, prophylactic medical examination, medical supervision, dental, sanitation, orthodontic and orthopedic treatment, etc.	roent-genoscopy, photoro-entgenraphy, examination, etc.	After arriving, during prophylactic examinations	Diphtheria, TB, syphilis, etc.	Isolation in special cells, prison or common hospitals, special prisons.
	No there are real difficulties with medication (lack of natural resources, destroying or mutual ties between former republics		The situation becomes even worse and worse						
UNITED REPUBLIC OF TANZANIA (DOCTOR IN CHARGE OF PRISON MEDICAL SERVICES)	No	No	Yes	Yes	1. general medical examination (physically) on admission; 2. PTB sputum and x-ray chest only on medical indications; 3. no HIV screening unless medically indicated and therefore referred to a government hospital.	Physically only erg. PVS discharge.	After a complaint		Isolation is rarely done, only when absolutely necessary, i.e. in case of cholera, otherwise they are treated as outpatients or admitted in prison sick bay.
	Prisons have joined the essential drug program which ensures the monthly supply of essential drugs only.		Poor resources financially leads to poor health and nutrition in prisons.						
UNITED REPUBLIC OF TANZANIA (SECRETARY GENERAL)	Yes	Yes	No	No	We protect the possible places which might be easily affected should any break outs of epidemiology occur.	By smear for B/S: examinations	Every 6 mos.	Dermato-logical, eye site, B/Culture, for any possible diseases and loss of weight and lack of vitamins	We separate the patient at a confined place and treatment is conducted accordingly
	All efforts are made to compete with the need		There is no problem at all in all areas						

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INTERNATIONAL PRISON HEALTH CARE

COUNTRY	MEDICAL PERSONNEL		HOW MEDICATION IS ORDERED, OBTAINED & ADMINISTERED	WHAT HEALTH CARE RECORDS ARE KEPT	WHAT HEALTH CARE TRAINING IS OFFERED
	PHYSICIANS	NURSES, ETC.			
AUSTRALIA	Yes; Department of Health (prison medical service)	Yes; Department of Health (prison medical service)	Ordered by doctor, purchased and obtained by pharmacists, given by nurses	Full medical and dental records	Only professional staff
AUSTRALIA, NORTHERN TERRITORY	Yes; a general practitioner (N.T. Department of Health and Community Services)	Yes; N.T. Department of Health and Community Services	Script written by medical officer and medications individually packaged (in single dose) by private pharmacy and charged to Correctional Services Department	Health care records are maintained on all prisoners; in one prison "at risk" files accompany the prisoner to the cell block.	Qualified health personnel employed; education program available to prison officers with limited programs available to prison AIDS, HIV, STD's, etc.
AUSTRALIA, TASMANIA	Yes; health department	Yes; corrective services	Ordered by a medical officer (general practitioner, obtained from central pharmacy with major city hospital, administered by registered nurses.	"Universal" record system	Occasional St. John Ambulance First Aid Course for prisoners; CPR, first aid training for new prison officers.
AUSTRALIA, VICTORIA	Yes; Victorian Health Department	Yes; Health Department	Prisoner attends doctor at prison (5 full time med. practitioners); prescription dispensed by prison pharmacy (city) or a local pharmacy (country); dispensed in bottle marked with prisoner's name, medication name, dose, frequency, expiry date mainly administered by medically trained prison officers, and in some areas by nursing staff.	Medical records	Family-nil Prisoners-health issues: anti-drug and alcohol programs, advice regarding communicable diseases
BELIZE	Yes; the government	Yes; the government	Medical prescription is submitted to the hospital if unable to obtain, it is purchased as directed by the medical officer and administered under the supervision of the senior officer responsible for issuing same.	Health care begins on admission each person has a medical record according to the prison rules.	First aid training only, family members not applicable presently.
BOTSWANA	Yes; Botswana Government	Yes; Botswana prisons & rehabilitation service	Consultation is done by nurses, prescriptions made or referred to medical officers. Medicines are readily available in prisons' dispensaries. Health workers and nurses give prescribed doses at prescribed times.	Out patient medical records, TB records, in patient medical records, monthly weights, mother and child health care (ANC, PNC, Pre-school cards-weight monitoring and immunizations), family planning records.	Basics in health education and nutrition, enrolled nursing, state registered nursing, midwifery, community health nursing, family nurses practitioners' courses, nursing/health administration (health education of inmates and family members)
CHILE	Yes; ministry of justice	Yes; ministry of justice	The medicines are ordered, administered and controlled by the health personnel of each jail unit	A record/dossier for each subject who consults the health team is made on which is recorded each instance of medical attention, exams and treatment	In addition to health professionals (doctors, nurses, etc.) prisoners are prepared in specific topics such as the AIDS prevention program.
COLOMBIA	Yes; they work for the prison center	Yes; for each prison	Prisons are supposed to have minimum medication. If the required drug is among those kept by each prisons pharmacy, it will be provided to the inmate, if not he will try to get it through his family or private resources.	By law, records should be kept, in reality they are not kept.	None
CZECHOSLOVAKIA (Director of Prison Health Care)	Yes; paid by prison system, serve for prisoners and personnel	Yes; paid by prison system, serve for prisoners and personnel	Handed out directly in prison	Analogical to civil health care	Personnel is trained in first aid; doesn't work with family members

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	MEDICAL PERSONNEL		HOW MEDICATION IS ORDERED, OBTAINED & ADMINISTERED	WHAT HEALTH CARE RECORDS ARE KEPT	WHAT HEALTH CARE TRAINING IS OFFERED
	PHYSICIANS	NURSES, ETC.			
CZECHOSLOVAKIA (MUDr.)	Yes; Physicians are employees of the Corps of Reformatory Education (prison officers) and they take care of the members of the Corps, retired (former) members of the Corps, civil employees as well as of indicted and sentenced persons.	Yes (see physicians,	Medications for prisoners are supplied from dispensaries or from the central stores of medications when orders or prescriptions are submitted. Medications are dispensed according to the physician's prescription.	Every prisoner has his personal health record containing anamnestic data and chronologically recorded objective medical findings. This record is kept throughout the stay of a prisoner in our institutions	All employees undertake regular training in providing the first aid in a case of accident or sudden change of the health condition for the worse. Professional abilities of the staff of the Medical Service of the Corps are continuously completed in regular courses lead by the specialists from up-dating institutions for doctors and health-care personnel at medium level. The Medical Service staff gives lectures on topical health-care problems to prisoners (AIDS, TBC, hygiene, stomatology, etc.)
ECUADOR	Yes; the state	Yes; the state	Only with a prescription from the jail doctor	Yes, but not technically	None
ENGLAND	Yes; 50% employed	Yes;	Medication held in a prison pharmacy; prescribed by a doctor; dispensed by a pharmacist; delivered by medical case officer or nurse; safe medication is held in possession by the prisoner	Full confidential medical records are held in the medical case centers	Six months nurse training for officers and regular on going training for the medical case staff
ESTONIAN REPUBLIC	Yes	Yes	Treatment begins after examination by doctor and fulfilled and controlled by nurses	Documents including history of illness and dispensary card	Personnel of prison have one time in year examination for health
FRANCE	Yes; minister of justice	Yes; minister of justice and health	By the doctor of the prison. Full-time or by vacation.	Drug addicts, suicides, hunger strikers.	General university and also in each prison by doctors having the habit of jails and practicing there
GREECE	State employees, some temporary and others are permanent employees	State employees	The medicine is immediately available. According to article #110 of the valid penitentiary code, the pharmacist with the cooperation of the doctors gets the medicine and he or she is responsible to store, conserve and distribute according to the doctors' authorization.	The head nurses keep the books, take care of the files , documents, and health records. They keep the records of the lab work and arrange the nurses' daily reports.	It does not exist.

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COUNTRY	MEDICAL PERSONNEL		HOW MEDICATION IS ORDERED, OBTAINED & ADMINISTERED	WHAT HEALTH CARE RECORDS ARE KEPT	WHAT HEALTH CARE TRAINING IS OFFERED
	PHYSICIANS	NURSES, ETC.			
GUAM	No	No	Prescriptions a re written by a licensed M.D. in the Infirmary Unit which are then brought by Correctional Officers assigned in the Unit to pharmacists authorized by Department of Corrections to fill prescriptions. The same officers who obtain the prescribed medications will bring the medication back to the Infirmary unit-endorsing the medications to the Correctional/Infirmary Unit Officers within 08 hrs. of writing the Rx. Administration or oral medications are done by Infirmary Unit Officers following instructions labeled on the medication container. Medications are given only to patients for whom it was prescribed. Emergency or injectable are given by the Physician.	Commitment orders; initial intake sheet; reviewing/screening form; demographic data; consent for treatment form; visit/ problems/diagnostic listing; intake health screening; medical intake evaluations, complete medical history, complete physical exam, lab screening requests (PPD skin test, serology, Hbsag, HIV testing-offered or voluntary and signed), urinalysis, CBC, RPR, medical impressions or diagnosis, treatment plan, follow-up care; diagnostic reports; lab reports; pathology report of tissue specimen; copy of immunization status; medical administration record; on hand medications; medical referral and consultants special report; restriction of activity; refusal for treatment form; special diets; casework service; emergency medical service report from Guam Memorial Hospital; consent for disclosure if needed; medical exit clearance.	Currently, all Correctional Officers assigned in the Infirmary Unit are taking EMT courses which includes CPR training at Guam Community College. There are about 8-10 of them.
HONG KONG	Yes: majority of the penal institutions in Hong Kong are provided with residential Medical Officers seconded from the Department of Health of Hong Kong. Others with no residential Medical Officer arrangement is made on daily visiting basis by Medical Officer from other penal institutions. Medical Officer is required to perform on-call duties after office hours on rotation basis covering all penal institutions for emergency cases such as seriously ill, accidents and suicides.	Yes; staff working in the penal institutional hospitals/sick bays in Hong Kong are either registered nurses, enrolled nurses or in-service hospital trained. In fact, they are double trained for custodial duties and nursing duties.	In the Correctional Services of Hong Kong, when a prisoner falls sick, he will be seen, examined and treated inside the penal institution as an in-patient in the sick ward or as on out-patient in the institution. Medication, nursing care and treatment will be issued/carried out by qualified hospital staff such as registered nurse, enrolled nurse etc. according to the Medical Officers' prescriptions. Medication is issued from individual dispensary of the penal institution.	Every newly admitted prisoner/remand will be provided with a separate personal medical record until discharge. This medical record will, together with his/her penal records filed in a specific institution on discharge or release. The old records will be retrieved upon one's reconviction for reference.	All custodial staff are trained with basic first aid. Staff working in the penal institutional hospital are either qualified registered nurse, enrolled nurse or hospital in-service trained with passes in basic first aid and home nursing care in addition to normal custodial training. They work as a team headed by a Medical Officer and are monitored by a Superintendent (nursing) in Headquarters.
IRELAND, NORTHERN	Yes: Prison Medical Service is independent of the prison authorities.	Yes; independent nurses work within the system, however, the bulk of the care is provided by Hospital Officers employed by prison authorities.	Medical Officers carry out daily surgeries to which prisoners have unfettered access. Prescribed medication is readily available from the prison hospital pharmacy, administered by Hospital Officers (usually in liquid form) at intervals determined by the Medical Officer.	Confidential health care records are held for each prisoner. Forthcoming legislation requires that prisoners or their legal representatives will have access to them.	Many Hospital Officers have professional nursing qualifications. The remainder undergo a 6 mos. course as currently determined by the Home Office Prison Department for England and Wales. Additionally under Health & Safety legislation correctional staff are encouraged to undergo first aid training.
IRELAND, REPUBLIC OF	Yes;general medical services and psychiatric services are provided by health staff.	No	Medications are ordered on a doctors order. They are administered by Medical Orderlies (prison officers with a basic first-aid training).	Each prisoner now has a personal medical file in prison.	Prison staff do not routinely receive health care training. Those staff working as Medical Orderly receive a basic 6 wk. training.

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	MEDICAL PERSONNEL		HOW MEDICATION IS ORDERED, OBTAINED & ADMINISTERED	WHAT HEALTH CARE RECORDS ARE KEPT	WHAT HEALTH CARE TRAINING IS OFFERED
	PHYSICIANS	NURSES, ETC.			
ITALY (UNIVERSITY OF PADOVA PSYCHOLOGY DEPARTMENT	Yes; the penal authorities (a medically trained guard is assisted by a doctor on call)	No; the penal authorities (only in few larger jails)	If ordered/prescribed by a doctor, it is administered by the medically trained guard. If the prison does not have the drug in stock, it is ordered by the national sanitary service USSL.	Health records, kept by the doctor do not exist, therefore, in prison no official records are kept.	None, except for that of the medically trained guard
ITALY (PRISONS ADMINISTRATION)	Yes; the prison health service is ensured by the appointed physicians' work belonging to the Prisons Administration, by medical practitioners' and by duty doctors' operating within the national health service	Yes; there are both permanent nursing staff belonging to the Prisons Administration and professional staff hired under contract for the purpose, operating within the National Health Service	Prescriptions from the physician and administering of medicine, medical examinations to be effected by specialists, if they are necessary, are subject to Governor's approval. Removals to outside health care facilities are allowed by the appropriate judicial authority	Case history	It is spread the Ministry of Health's instructions and each instructive contact with the Local Health Units is favored
JAPAN	Yes; the government	Yes; the government	We order it to an outside pharmacy and administer it for a day's or a few days' use.	Patients' charts are kept	General health education and special health education focusing on transmittable diseases
LEBANON	No	No	By him personally, or through the insistence of the news media and human rights activists.	Very few	None
LESOTHO	Yes; they work for the public.	Yes; they work for the prison.	The doctor visits a prison weekly, if special treatment is required a prisoner is admitted at government hospital for treatment.	Everyone who attends medical service uses his health book which normally will reflect his/her medical history.	Our officers are attached to the governmental hospital for further training for duration of about 3 yrs.
LUXEMBOURG (GRAND DUCHY OF)	Yes; Ministry of Justice	Yes; Ministry of Justice	Medical prescription, given by nurses	Computerized confidential files	
MALTA	Yes; Prison Establishment/ Health Department	Yes; Prison Establishment	Prescribed by doctor in charge; obtained from Main Hospital; administered by nurses	Case Histories kept in prison clinic	None
NETHERLANDS	Yes; part-time employed by the Ministry of Justice	Yes; full-time or part-time employed by the Ministry of Justice.	All medication is to be prescribed by the physician (prison doctor) and is to be ordered at and delivered by local pharmacists. Usually medication is administered by medical service personnel (nurses) but administered by othe. personnel (wing-officers) may take place.	All records as usual in community general practice.	In addition to the training of medical service personnel, all wing-officers have passed a first-aid training course and health education courses. Education on health topics (communicable diseases, drug addiction, HIV and AIDS) is offered to officers and to prisoners as well.
NEW ZEALAND	Yes; they are general practitioners contracted part time to the Department of Justice	Yes; Department of Justice	On prescription by the general practitioner; from a community pharmacy; by the nurse in most instances, but may be by a prison officer. In life threatening situations such as asthma, angina, some medications will be held by the inmate. Medication which could be hoarded and used to overdose or "sell" is, where possible given in liquid form.	Full records are kept (assessment by nurse and general practitioner test results, psychiatric reports, ongoing clinical comment, medication records, dental records, x-ray reports, blood test results, etc.	Lifestyle Changes Programme (a programme developed by the department to teach inmates and staff about HIV/AIDS), CPR and first aid to prison officers. All nurses are registered by the Nursing Council having passed a programme of nursing education. Some short course/placement is provided for those who have not had experience in emergency and accident, sexually transmitted diseases, phlebotomizing, etc.
NICARAGUA	Yes; in the prisons there is a permanent medical personnel for the offenders.	Yes; there is medical nursing personnel, but it is difficult because there is no medicine.	When a prisoner needs medication, the pharmacy is asked. If they don't have any, a relative is asked, but in general, the prison administers it and it is given under the control of the medical personnel	There is a "Statistics & Records Unit" where 100% of the clinical records are controlled as well as therapeutic control documents and death records	There are not presently any training programs nor training for personnel already employed. They enter with a level of preparation in health.

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	MEDICAL PERSONNEL		HOW MEDICATION IS ORDERED, OBTAINED & ADMINISTERED	WHAT HEALTH CARE RECORDS ARE KEPT	WHAT HEALTH CARE TRAINING IS OFFERED
	PHYSICIANS	NURSES, ETC.			
NORWAY (PROJECT SUPERVISOR OF PRISON HEALTH)	Yes	Yes	Prisoners who need medical assistance during their term of imprisonment can make an appointment to see a prison doctor either through a warden or through a prison nurse. The doctor prescribes the medication and a nurse prepares the dosage. In larger prisons a nurse will usually delivers the medication, while in smaller prisons a warden will have that task.	The health records are the same for patients in prisons and detention as for patients in the society in general. We have very strict rules of confidentiality, regulated by professional health act and Public act.	Persons working in prisons are offered information/training in Communicable diseases, medication-rules, drugs, etc.
NORWAY (RONNAUG AABERG ANDRESEN)	Yes; for the local health authorities	Yes; the local health authorities	Ordered by physician, obtained from local pharmacy and administered by nurse or prison staff	Personal health card, to which only the medical has access	First aid and training of staff
PAPUA NEW GUINEA	No (does not arise)	Yes; department of correctional service	Through the aid post orderly, health extension office or local hospitals.	None	Only to aid post orderlies and H.E. officers.
PHILIPPINES	Yes; physicians attend to prisoners and civilians to include dependents of prisoners, employees and their dependents and other civilians who consult the hospital's Medical Staff in case of emergency	Yes; same	Prisoners who are sick come for daily consultation and after consultation, physicians order and prescribed medicines necessary for inmates medical problem. For OPD cases, prisoner consult physicians (4-5). Prisoners obtained the medicines prescribed/order by the physicians at the hospital pharmacy for a day dose only except for the living-out prisoners may get medicines for a 3 day dose, admitted prisoners, however, obtained their medicines (hand on orders by attending physician) from a Nurse/Civilian attendant.	Prisoners who have consultations have their OPD card where doctors get down their findings as well as the management. Admitted prisoners have their own admission chart.	Health care training is being offered to medical staff (physician, nurses, attendant) such as first aid measures, ECG, x-rays, also nurses & attendants are trained at or to assist surgeon, nurses are trained how to handle cases of psychiatric patients, ICU patients.
SAUDI ARABIA (Assistant Director General, Medical Services Directorate, Ministry of Interior)	Yes; some for Ministry of Health, some for Ministry of Interior	Yes; some for Ministry of Health, some for Ministry of Interior	The treating physician will order the medication, it will be dispensed from the pharmacy in the jail's health centre. The male nurse in the jail will receive the medication and will be held responsible to give it to the prisoner on single dose basis under his supervisor.	A follow up card for the short-stay prisoners and a comprehensive medical file for the others.	The medical care in prisons is provided by trained health care professionals (doctors and nurses) only.
SAUDI ARABIA (Arab Security Studies & Training Center in Riyadh)	Yes; Ministry of Justice or Intern	No	Announce his case to the administrative which provide according to the actual situation	Medical files	No training
SIERRA LEONE	Yes; for the government	Yes; for the government	Medications are prescribed by doctors or health care workers, then are given if available. When not available, prisoners' relatives or friends purchase them.	Medical notes are kept and diagnoses entered in an admission book	Training of different cadres of nurses are available both in the prison and other medical institutions. No training is given to prisoners or their relatives.
SLOVENIA, REPUBLIC OF	Yes; employed by prisons as members of health care professional staff.	Yes; employed by prisons as members of health care professional staff	Medications are ordered by physicians, obtained from the prison drug store, and administered by nurses.	General health care records are kept by prison physicians for all persons held in detention.	None; professional health care staff is part of our prison personnel.

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INTERNATIONAL PRISON HEALTH CARE

COUNTRY	MEDICAL PERSONNEL		HOW MEDICATION IS ORDERED, OBTAINED & ADMINISTERED	WHAT HEALTH CARE RECORDS ARE KEPT	WHAT HEALTH CARE TRAINING IS OFFERED
	PHYSICIANS	NURSES, ETC.			
SPAIN	Yes; Ministry of Justice	Yes; Ministry of Justice	the physician prescribes the medication that is obtained form the prison's pharmacy and administered by the nurse	There is a standardized health care record form for use in prisons	Health care is provided by health care professionals (physicians, nurses) that are available 24 hours. Health education is offered to inmates and prison workers.
SURINAME	Yes; the Foundation for Regional Health Services (R.G.D.)	Yes; Dienst der Delinquentenzorg	We have a small amount of medication in our pharmacy and if not we collect it at other particular pharmacies.	We use personal diagnostic cards	No training
SWITZERLAND	Yes; for the prisoners	Yes; for the prisoners	In general it is ordered and administered (liquid) by the medical staff.	Each prisoner has a record by the medical services	It is part of the training. Besides, prevention is stressed; staff and prisoners are given documentation on AIDS and other communicable diseases.
TONGA	Yes; Ministry of Health, Government of Tonga	Yes; Ministry of Health, Government of Tonga	Ordered by X physician, supplied free and administered depends on type of illness, medication and whether hospitalization is necessary or not.	Same as for any other patient	First Aid and management of minor injuries and illnesses
TRINIDAD & TOBAGO	Yes; government, under the Ministry of Health	Yes; prison division, Ministry of Justice and National Security (officers are trained and perform as para medics	All medication are ordered by the Prisons Medical Officer. It is obtained on request from the Prison Pharmacist who obtains his supply from the Government Stores, when medication is not available, it is purchased by the Commissioner of Prisons on the open market. It is administered by Para Medics.	Medical History Sheets are used for convicted inmates, cardiac cases, diabetics, hypertension cases, Post operation cases are kept on record. For non-convicted inmates records are kept in a Medical Journal	Our para medics are trained in emergency care. Others may have had previous experience and training as Health Care Workers. No family members or inmates area afforded this facility.
UKRAINE	Yes; they fulfilled health care officers functions	Yes; they fulfilled health care workers functions	The qualified medical helps to the convicted persons is given at the medical help office of the correctional institution or at the hospitals of imprisonments. The urgent medical help can be given at the health care institutions of local health care organs with the guarding to be provided.	Every convicted person has a single medical card which is kept during the whole penalty period. Every stationary patient has his private disease history card	The officers of the correctional institutions are taught the basics of self-help and mutual help when they are being professionally trained for the first time as well as in the work process. The convicted persons are taught the sanitary hygienic practice.
USSR	Yes; prison administration, most of them are uniformed	Yes; prison administration	A prisoner has to arrange to see a doctor (by himself or through the staff)	There are special individual books in hard cover	All officers have a special medical training (mostly lectures). Some prisoners take part in prisoners' voluntary medical board (voluntary organization).
UNITED REPUBLIC OF TANZANIA (DOCTOR IN CHARGE OF PRISON MEDICAL SERVICES)	Yes; prison department	Yes; prison department	A prescription is made, a medical record kept and the medicine given in repeated single doses as per Rx.	In central prisons, better health care records are being kept, in small prisons there are medical cards some of which remain with the prisoners themselves.	Occasional seminars on AIDS, communicable diseases, vaccinations and regular meetings for health professionals
UNITED REPUBLIC OF TANZANIA (SECRETARY GENERAL)	Yes; for prisoners	Yes; for prisoners	It is ordered by the doctor and obtained from the dispensing department and be administered as directed by the doctor	They are kept at the dispensary	Health care training is always given to all members of the staff and to prisoners for self protection

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	CONTROL PROBLEMS OF COMMUNICABLE DISEASE & SUBSTANCE ABUSE		PROVISIONS FOR EVALUATION & TREATMENT FOR MENTAL ILLNESS	HEALTH CARE STANDARDS USED IN PRISONS & JAILS	FAMILY ACCESS TO HEALTH CARE WORKERS
	COUNTRY	PRISONS			
AUSTRALIA	Yes	Yes	Prison Hospital has 90 psychiatric beds	As available to the community; not achievable in the setting.	Rarely, if ever occurs
	Alcohol and drug abuse, the usual problem as in the Western Countries.				
AUSTRALIA, NORTHERN TERRITORY	Yes	No	Prisons have access too broad range of mental health personnel; treatment and programs and services-that are followed through to discharge back into the community.	A minimum standard to that accorded to the general community including medical, mental health, dental, dietetic, optometry, surgical, accident, and emergency (the latter in conjunction with community hospitals and health services)	Families are not used to assist ill prisoner.
	Not a major problem although problems are constantly monitored and managed accordingly				
AUSTRALIA, TASMANIA	Yes (no in state)		Forensic health team (full time-2 psychologists, 1 psychiatrist, social worker); 24 hr. a day nursing cover; 29 bed prison hospital (total average population, 250)	High	Open
AUSTRALIA, VICTORIA	Yes	Yes	Psychiatric reception screening; acute assessment unit (short term) psycho-social unit; community psych trained nurses or session psychiatrists	Community standard or better; access to consultant staff at prison (sessional); access to general hospital services (out-patient); access to general in-patient ward (9 beds: full range of services)	Not used
	Entry of drugs difficult to control at country borders and at prison walls alike.				
BELIZE	Yes	Yes	They are visited weekly and treatment provided by the professional staff who are employed by the government.	A satisfactory standard of health care should be used, in my opinion, it needs to be improved.	Not applicable
	Drug users should not be sent to prison, they should be sent to drug rehabilitation centers.				
BOTSWANA	Yes	No	Nurses have basic mental health care preparation. Clients are referred accordingly to M/O, Community Mental Health Clinics or Mental Hospital. Controlled conditions are treated in the prison's health facilities.	That primary health care be basis of out health care; Skilled health personnel man prison health facilities; availability of health education programs; provision of nutritional food; provision of enough and safe water for drinking; provision of physical exercise; provision of proper toilets; provisions of medical assessment of all inmates, etc.	In Botswana prison, sick prisoners are taken care of by health workers not families when hospitalized in a community hospital and very sick, relatives are informed. They are allowed to visit them.
	Inmates do not have access to alcohol and drugs. Communicable diseases are detected and effectively controlled.				
CHILE	Yes	No	There is a mental health team that includes psychiatrists, psychologists, etc, for the management of these patients	We follow the standards and programs of our country's ministry of health	The information is given when it is required
	Because it is a closed off population, and the detention and control of these problems is easier.				
COLOMBIA	Yes	Yes	Individuals with mental illness are kept in separate centers but under very poor conditions and with sad health perspectives.	Health and clean environments are a priority in our prisons. We have everything to work for in these areas.	There is no official program involving inmates families.
	We have serious problems of alcoholism and drug abuse in our prisons. AIDS is becoming a significant problem in the country, being still reduced in prisons				
CZECHOSLOVAKIA (Director of Prison Health Care)	Yes	Yes	Mentally ill are not detained in prisons; doesn't have any knowledge of foreign health care and their standards	The same as in civil health care	Doesn't exist
	The problem is growing in the last 2 yrs. (compared to the totalitarian system)				

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INTERNATIONAL PRISON HEALTH CARE

COUNTRY	CONTROL PROBLEMS OF COMMUNICABLE DISEASE & SUBSTANCE ABUSE		PROVISIONS FOR EVALUATION & TREATMENT FOR MENTAL ILLNESS	HEALTH CARE STANDARDS USED IN PRISONS & JAILS	FAMILY ACCESS TO HEALTH CARE WORKERS
	COUNTRY	PRISONS			
CZECHOSLOVAKIA (MUDr.)	The control of communicable diseases and alcoholism is no problem, however, the control of drug abuse is a big problem. The situation in prisons is similar.		Mental illnesses are diagnosed by psychiatrists and are treated either in out-patients departments or mental hospitals. Every prison hospital has its psychiatric department.	Providing health care in prisons is conducted by generally accepted regulations and norms as in a case of other citizens.	Care of ill prisoners by their relatives is not allowed, nevertheless, they are kept informed about the health condition of a prisoner
ECUADOR	Yes	Yes	They are evaluated psychologically, psychiatrically and then follow with treatment	Each health professional acts according to their personal criteria/judgement	Yes
	There is neither ways nor means to exercise this control				
ENGLAND	No	Yes	Every prisoner has a visiting psychologist; prisoners who are mentally ill have transferred to NHS hospitals	Health care is specified in prison standard codes or currently being drafted	Families not used
	Drug abuse is becoming worse presently				
ESTONIAN REPUBLIC	Yes		Examination by psychiatrist and treatment of mental illness in hospital	Such standards as in usual hospital	Family members have the possibilities for visits to prisons and speak with doctors
	This is the significant problem				
FRANCE	Yes	Yes	We have a special psychiatrist in each prison	The code of procedure penal medication is what the doctor must follow. Rules and relationship with the judges, etc.	It is not accepted. We have procedures of measure.
	Specially alcoholism and drug use have and increase of HIV disease.				
GREECE		The problem of contagious illnesses and drug related problems are being controlled in prisons supervised by the Ministry of Justice	There is no specific regulations	The prison administration is responsible to secure health and cleanliness of prisoners. They are also responsible in keeping the rest-rooms clean, providing all the necessary things according to prison regulations. Furthermore, the administration is responsible in maintaining all the facilities. The prisoners have to follow the rules of personal hygiene and cleanliness for public areas according to the prison regulations and the directions of the employees. The prisoners' medical care is cared for by doctors and dentists who work in the detention houses and the public hospitals.	Families are not used in order to help a sick prisoner
GUAM	No		In the absence of a Forensic Unit which will be established in the near future, patients needing psychiatric care are referred by Correctional Officers to the Infirmary Physician for initial evaluation, subsequently refers the patient to Department of Mental Health, Guam. Following treatment, patient is brought back to DOC to monitor progress and medications. Follow-ups are done by DMH. In-patient not done by DMH.	Locally accepted medical practice as sanctioned by the Guam Board of Medical Examiners, Guam Commission on Licensure, Executive Committee of Guam Memorial Hospital, Guam Medical Society and Public Health and Social Service of Guam.	Utilizing families to assist all ill prisoner is very seldom done if ever as far as I know. I would call for the family, if I find difficulty in obtaining important aspects in the history, if history is unreliable and vague.
	Although drug abuse and alcoholism is not much of a problem in prison, I believe that Department of Corrections needs assistance in establishing policies and procedures with regard to infection control and addressing communicable disease in prison.				

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	CONTROL PROBLEMS OF COMMUNICABLE DISEASE & SUBSTANCE ABUSE		PROVISIONS FOR EVALUATION & TREATMENT FOR MENTAL ILLNESS	HEALTH CARE STANDARDS USED IN PRISONS & JAILS	FAMILY ACCESS TO HEALTH CARE WORKERS
	COUNTRY	PRISONS			
HONG KONG	No	No	In the case a prisoner exhibiting signs of mental illness, he will be assessed, in the first instance, by the institutional Medical Officer who will, depending on individual case, refer to the Psychiatrist or Clinical Psychologist for assessment/treatment. In Hong Kong Correctional Services has a separate Psychiatric Centre for the assessment, treatment and rehabilitation for prisoners and remands with mental illness or psychological problems.	Prisoners in the penal institution in Hong Kong enjoy the same health care as any other general citizens. They receive comprehensive medical and health care far better than the minimum standard rules of United Nations for prisoners.	In Hong Kong, we do not use families to assist an ill prisoner. The prisoner has all the care from qualified medical and nursing professionals. In addition, Correctional Officers performing welfare duties are qualifies social workers and they will offer assistance to the prisoner and his families in case of need.
	Alcoholism is not a significant problem in Hong Kong. Such problems never exist inside the penal institutions. Communicable disease is well controlled by the Department of Health and it seldom causes problems inside the penal community. As for drug abuse, there is a special programme run by Correctional Services. Drug Addiction Treatment Centre for offenders who are drug addicts. Drug is not a problem in penal instituions and is well under controlled through measures. Spot urine checking for narcotics on prisoners are carried out in every penal institution. Searching and rectum test are also carried out on admission in order to detect drug from trafficking into the penal institution. Prisoners with acute drug withdrawal symptoms will be treated by the Medical Officer in penal institutional hospitals.				
IRELAND, NORTHERN	No	No	A psychiatric assessment unit is provided in our remand prison. A psychiatric unit under the charge of an independent forensic psychiatrist is provided in another prison. Legislation allows transfer to Health Service hospitals for those who require it.	The principal objective of the Prison Medical Service is to ensure that the standard of health care provided to all prisoners is at least that available to the general community.	Families are not used to assist ill prisoners. However, when prisoners are suffering from terminal illness and death is imminent there is provision to allow them to be released.
	Alcoholism is a significant element in the Commission of crimes and counseling services are available for those who wish to take advantage of them.				
IRELAND, REPUBLIC OF	Yes	Yes	Psychiatric assessment is available from non-prison psychiatrists	The ideal is that health care in prison should be equivalent to that in the community. In many situations we fall short of this.	
	One prison contains a concentration of IV drug abusers who in some cases, continue to abuse drugs.				
ITALY (UNIVERSITY OF PADOVA PSYCHOLOGY DEPARTMENT)	Yes	Yes	By law every prison should be attended by a Psychiatrist, in practice a private sector. Psychiatrist is called upon only id mental illness is pre-diagnosed or emerges, and the patient is not already in a prison mental hospital.	Health care comes under the law 34512 July 1975 and should be guaranteed by the Public Hygiene Service to theoretically make periodic visits to check institutes uphold the law	None
	80% of the prison population is dependent on drugs, of whom a high percentage are HIV positive				
ITALY (PRISON ADMINISTRATION)	Yes	Yes	It is decided on a psychiatric investigation by specialists and where necessary, on the removal to mental psychiatric hospital, where they will be given psychiatric treatment	Screening, isolation for health security reasons, admission to sick ward, removal to outside health care facilities, hygienical tests to be effected either by the Local Health Unit or by the provincial medical officer.	When a prisoner suffering from a serious illness, the next of kin or relatives will soon notified. Attendance by families is not allowed by prisons.
	Drug addiction and HIV infection are deemed to be a significant problem				

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INTERNATIONAL PRISON HEALTH CARE

COUNTRY	CONTROL PROBLEMS OF COMMUNICABLE DISEASE & SUBSTANCE ABUSE		PROVISIONS FOR EVALUATION & TREATMENT FOR MENTAL ILLNESS	HEALTH CARE STANDARDS USED IN PRISONS & JAILS	FAMILY ACCESS TO HEALTH CARE WORKERS
	COUNTRY	PRISONS			
JAPAN	Yes	Yes	Psychiatrists are in charge of diagnosis and treatment. We send inmates with mental problems, if necessary, to a medical prison.	We have general standards of health care covering general health care, medical treatment, exercise, bathing and others	We provide advice for family members assisting an ill prisoner. However, we allow them to assist an ill prisoner only in special cases.
KUWAIT	Yes	Yes	Is to be transferred to the mental and physiological hospital	Before the Iraqi Invasion, there was a capacity of 32 beds and they have then test eye care, lab and all other facilities. In the mean time, Ministry of Interior with Ministry of Health are re-establishing the facilities to its last high standard	We don't have programme in the mean time for family to assist in prison, if a prisoner need special medical care, local hospital are the authority to take care and the families will have their chances to help their patients
	There is special hospital for communicable disease				
LEBANON	Yes	Yes	A physician would make a general checkup and prescribe medicines	Low standards, i.e. barely what is necessary. Toilets, for example, are situated far from the cells, and one toilet usually serves more than 25 prisoners.	None
	A lot ought to be done in this regard. People seem to be ignorant that such control is mandatory.				
LESOTHO	No	No	They are sent to mental hospital for observation or sent to his majesty pleasure prisoners institution. The problem arises due to shortage of doctors.	Provision of basic necessities such as medical care, balanced diet, clothing and also inviting member of other agencies to lecture on communicable diseases. .. .	When the prisoner is ill, his family is immediately informed probably for supplying any necessary medical history of the prisoner.
	We have not had such cases in prisons.				
LUXEMBOURG (GRAND DUCHY OF)	Yes	Yes	Treatment given by a psychiatrist	We try to give the same treatment to prisoners as given to other persons	
	Drug abuse is a very important problem				
MALTA	No	No	Psychiatrist visit prison every week, on call at other times.	High	If prisoner is too ill to be treated in prison, he is transferred to the main hospital; families are not used to assist ill prisoners.
	No cases of AIDS in drug abusers reported. Active prevention programme.				
NETHERLANDS	Yes	Yes	Each institution provides psychological and psychiatric consultation facilities, to be asked for by the medical service (physician or nurse) or by the detainee himself.	The aim is using standards being at least at the same level as community health care provisions.	Full access on request. Ill prisoners are usually admitted to a penitentiary or community hospital.
	Drug addicted detainees are a problem in the correctional system.				
NEW ZEALAND	No	No	Psychiatrists are available for consultation and treatment advice-this may be by contracted psychiatrists or by regional health board forensic psychiatric teams. Psychologists are employed by the department to assist also, particularly in the area of behavioral problems.	Every effort is made to ensure they are in line with standards of care available in the community. Primary health care is provided within prison, secondary and tertiary care normally at local or regional public hospitals.	Families are not used to care for ill prisoners. However, assistance in the way of information relating to the prisoner may be sought. Assistance for inmates with cultural health needs is sought from their own cultural groups.
	There is no problem with control of communicable disease and alcoholism in prisons. There is some difficulty controlling illicit drug use in prison.				
NICARAGUA	Currently the problem is contagious diseases and the others, but they are low on the scales of priorities in the prisons contagious diseases reach the highest rate.		At the present time, they have only done studies to determine the death rate or mental unbalances caused by being incarcerated	Currently about 66% of the prison population has a health "suffering/pain" or problem	These visits take place in hospitals

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	CONTROL PROBLEMS OF COMMUNICABLE DISEASE & SUBSTANCE ABUSE		PROVISIONS FOR EVALUATION & TREATMENT FOR MENTAL ILLNESS	HEALTH CARE STANDARDS USED IN PRISONS & JAILS	FAMILY ACCESS TO HEALTH CARE WORKERS
	COUNTRY	PRISONS			
NORWAY (PROJECT SUPERVISOR OF PRISON HEALTH)	Yes	Yes	The treatment of mental disorders is covered by Mental Health Act, and the rules laid down there apply inside as well as outside the prison. Psychiatric treatment is offered in prison or in the public psychiatric hospitals.	The health authorities aim is to assure that prisoners are given the same standards of health care as the civil population. To a certain extent we have managed to realize this.	Not relevant for Norway.
	These matters are of great concern to prison and health authorities				
NORWAY (RONNAUG AABERG ANDRESEN)	Yes	Yes	The need for treatment is assessed and organized by the prison physician	The same as for the rest of the population	Not relevant
	Both alcohol and drugs are in circulation in the prisons, although prohibited				
PAPUA NEW GUINEA	Yes	Yes	None	Normal prevention and treatment	Families are not allowed
PHILIPPINES	Yes	Yes	A psychiatrist (MD) is available to evaluate and treat individual held in detention inhibiting signs of mental illness. If required, a prisoners with signs of mental illness are confined in the hospital for further evaluation, isolation and management.	A) physical examination to newly arrived prisoners; B) daily consultation for OPD prisoners; C) physicians daily rounds to admitted patients; D) Laboratory examinations/chest x-ray, ECG and other blood examination (spinal); E) other spinal x-ray procedures; F) occasional referral to outside hospital for further evaluation.	Ill prisoners who are admitted in the hospital are being taken care of by the nurses, other hospital staff including the inmate attendant. Families (non-prisoners) of an ill prisoner may visit the patient, but are not allowed to stay overnight to take care of their patient. Cases for seriously ill prisoner, their relative are being notified to inform them the patient's health condition so they could come to the hospital any day regardless of the visiting privilege given to them.
	It is a problem due to over-crowding, poor sanitation, (low cost of food) insufficient and imbalanced food, high cost of medicines (jail setting) thus control of communicable diseases is quite a problem. Control of alcoholism/drug abuse as a problem due to relatives of prisoners are able to visit with alcohol/hard drinks brought inside without being caught/noticed by prison officials, prisoners have the capacity to make some "drinks".				
SAUDI ARABIA (Assistant Director General, Medical Services Directorate, Ministry of Interior)	No	No	The visiting psychiatrist will evaluate the care and manage it either in prison if possible or refer the patient to the mental hospital in the area.	Primary health care standard of services available in most prisons. Secondary health care services in large jails.	The treating doctor will communicate with the family, discuss the problem and the type of help required from the family members.
SAUDI ARABIA (Arab Security Studies & Training Center in Riyadh)	Yes	Yes	Turn him to the hospital	Normal standards	
	Only related to drug abuse				
SIERRA LEONE	Yes	No	Such prisoners are examined by a doctor and if there are signs of mental illness are sent to a mental hospital for treatment and follow-up.	Primary health care in most jails. Secondary health care in Freetown Prison.	Families do not assist in health care of prisoners, except the purchase of drugs, etc. when not available
	Like many developing countries, communicable diseases are common, alcoholism and drug abuse are on the increase.				
SLOVENIA, REPUBLIC OF	Yes	Yes	they are delivered over to t he institution for mental illnesses to be properly treated and observed	The same standards of health care are used in our prisons and jails as in other health care institutions in our country.	
	Alcoholism is the outstanding problem				

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	CONTROL PROBLEMS OF COMMUNICABLE DISEASE & SUBSTANCE ABUSE		PROVISIONS FOR EVALUATION & TREATMENT FOR MENTAL ILLNESS	HEALTH CARE STANDARDS USED IN PRISONS & JAILS	FAMILY ACCESS TO HEALTH CARE WORKERS
	COUNTRY	PRISONS			
SPAIN	Yes	Yes	If a diagnosis of mental illness is made at detention, the inmate is treated by the prison's physician; if necessary, specialized care is provided by the local psychiatrists. When hospitalization is needed, inmates a re taken to any of the 2 penitentiary psychiatric hospitals available.	In ever prison, there are 2 or more physicians, depending on the number of inmates, as well as nurses. Health care is provided according to the usual standards in Spain. Local specialists, paid by the Ministry of Justice, are available for consultation.	Families are not used to assist ill prisoners. Those are assisted by physicians and nurses.
	In Spain, drug abuse and alcoholism are significant problems, but control of communicable diseases is not				
SURINAME	Yes	Yes	Part-time psychiatrist	World Health Organization	Not used
	No test can be done in alcohol/drugs abuse; medication too less				
SWITZERLAND	Yes	Yes	Evaluation of the prisoner when he first gets in, then regular controls, tests.	Standards of modern medicine of principle. The prisoner has the same rights as free citizens.	Families of the prisoners are not allowed to assist them.
	There is a high proportion of toxicomanics (serapositives) in prison.				
TONGA	No	No	Same as for all other persons with mental illness, responsibility of the Ministry of Health	Same as for the rest of the country	All health care workers and facilities are readily accessible
TRINIDAD & TOBAGO		Yes	When inmates display signs of mental illness, they are placed before the Prison Medical Officer, who refers them for psychiatric assessment by a Specialist, if the situation warrants same. They may or may not be transferred to an Institution for more treatment.	The standards within our prison are similar to that which exist at our Nation's minor Health Institutions i.e. Clinics and Health Centers.	The family of inmates are not allowed to visit physically an ill prisoner. At times they are allowed to assist financially in providing specialist treatment.
	In terms of alcohol we get some measure of counseling from AA, but in drug abuse, there is a need to train persons to run the necessary programs. The control of communicable diseases are kept in check.				
UKRAINE	Yes	Yes	The qualified psychiatrists work in every correctional institution and prison. That helps to reveal mental diseases of convicted persons in good time and carry out their dynamic examination. there are psychiatry departments in with the hospitals of the imprisonment places as well as the specialized psychiatry hospital.	The penitentiary medicine uses the same standards as the health care system	No
	The diagnosis and laboratory capabilities of the penitentiary medicine is not sufficient.				
USSR	Yes	Yes	Every prison is officially provided with a professional psychiatrist (but there are some vacancies). We have special mental hospitals for treatment and testing.	The standards are the same as in other governmental health care services (officially adopted by the ministry of health care)	It is not a common case when relatives have real possibility to assist an ill prisoner. The access to a doctor depends on the will of prison administration.
	Especially TB is an awful problem in prisons				

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	CONTROL PROBLEMS OF COMMUNICABLE DISEASE & SUBSTANCE ABUSE		PROVISIONS FOR EVALUATION & TREATMENT FOR MENTAL ILLNESS	HEALTH CARE STANDARDS USED IN PRISONS & JAILS	FAMILY ACCESS TO HEALTH CARE WORKERS
	COUNTRY	PRISONS			
UNITED REPUBLIC OF TANZANIA (DOCTOR IN CHARGE OF PRISON MEDICAL SERVICES)	Yes	Yes	Usually we have a special hospital for all mental prisoners which is at called Isanga Mental institution.	Primary Health Care is available in all prisons	This is only possible when the prisoner is admitted to a government civilian hospital where they are cared by civil doctors. No family help other than visits and bringing medicine is possible in prison.
	No funds for National Seminars on drug abuse prisoners who usually suffer withdrawal.				
UNITED REPUBLIC OF TANZANIA (SECRETARY GENERAL)	Yes	Yes	There is a medical check-up and should any signs be seen is automatically treated by a doctor concern as a specialist for	We supply soap to wash their hands; we supply anti-malaria tablets; fumigation is conducted all round the prison and jails	There is still poor response
	It is a big problem since conduction of drug abuse and others is still a very big problem				

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	FEELINGS OF IDENTIFYING INDIVIDUALS WITH COMMUNICABLE DISEASES	FEELING OF HEALTH CARE TRAINING BY QUALIFIED PROFESSIONALS	PRIORITY OF HEALTH SERVICES FOR POSSIBLE IMPLEMENTATION	COMMENTS
AUSTRALIA	Yes	Yes; status quo.	Psychiatry-more therapeutic time and programs; dental services-better access and range of treatment; behavior modification units for personality disorders.	
AUSTRALIA, NORTHERN TERRITORY	Not known	Yes; but with no real guarantee of expected outcome	1. education; 2. improved personnel; 3. equipment and facilities.	
AUSTRALIA, TASMANIA	Yes	Yes	Facilities improved; nutrition (although standard still reasonably high); further educational opportunities for nursing staff; other areas are well catered for.	
AUSTRALIA, VICTORIA	Yes; unfortunately this is often the prison stimulus	Yes	General standard is good in Victoria. Some areas (psychiatry, education, dentistry) would improve with increased finances (more staff)	Australia is an overwhelmingly affluent country with severe pockets of poverty and inequity: Victoria is aware of a need for good prison medical services run by health with a reasonable working relationship with correctional services through a conjoint board
BELIZE	Yes	Yes	Basic nutrition; sanitation; other health services, medical, mental, educational, dental	As a result of out new facilities, which the government of Belize is providing, in about 2-3 yrs. we should be providing better and improved health care and services for those incarcerated.
BOTSWANA	There already are health care service facilities. These came about since prison authorities believe inmates have a right to proper health care.	Yes; prison health care providers are trained in the local health institutions. Other health (workers) students do their practicum in prison institutions.	Intensify health education and nutrition, have enough family nurse practitioners for proper clients' medical assessment, dental health, environmental sanitation, mental health officers.	Generally, prisons render comprehensive health services. Due to shortage of both space and staff, I feel we do not render quality care. Our community would still do with a lot of motivation on various aspects of health. We also need health research to evaluate and improve the service.
CHILE	Yes	Yes	Implement adequate health education and improve the mental health units	
COLOMBIA	Yes	Yes	Basic health care, dental services, nutrition and sanitation. this Ministry just finished a draft for the new prison's law in which this basic needs are referred to. The law is clear. We need to work on reality.	Colombia would need a serious and organized program under which basic health conditions could be established in all prisons. An international support and monitoring of a program like this one would be essential.
CZECHOSLOVAKIA (Director of Prison Health Care)	Yes	No	Medical, mental, sanitation, educational	We are seriously limited by finances and personnel and lack of concern from the community
CZECHOSLOVAKIA (MUDr.)	Yes	Yes	All services stated in this point are provided in our health-care institutions	The Medical Service of the Corps has established precisely elaborated network or health-care institutions, the norms of material and technical equipment and appropriate number of staff. Health care of prisoners is secured in our institutions as well as in the institutions of the National Health-Care Administration to the full extent.
ECUADOR	Yes; the authorities are concerned about improving the jail system	Yes	Education, environmental sanitation, nutrition and creating responsibility in the professionals	At the moment they are working on projects to change the current health structure. The intent is to totally reform this service to require the direct support of the authorities and to obtain the independence of the medical department which currently depends on the Department of Diagnosis and Evaluation. The health service in the jails is not so negative but requires permanent control

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	FEELINGS OF IDENTIFYING INDIVIDUALS WITH COMMUNICABLE DISEASES	FEELING OF HEALTH CARE TRAINING BY QUALIFIED PROFESSIONALS	PRIORITY OF HEALTH SERVICES FOR POSSIBLE IMPLEMENTATION	COMMENTS
ENGLAND	Health care is provided to all prisoners		All provided	Prisoners should at least have access to health care of equivalent quality to that available in the community of the country in which they are a resident
ESTONIAN REPUBLIC	Yes	Yes	We agree with all kind which we have plus setting of false teeth and basic nutrition	We have no additions
FRANCE	Yes; certainly	Yes; certainly in the University or in the main hospital penitentiary	Education of the doctors and specially good relation with the justice.	Apply the oath of Altius against torture and experimentation. try human contact and help to remain serving but keep strong and firm.
GREECE	Yes	Yes	Medical, dental and educational	
GUAM	Yes	Yes	Dental-preventive dental care, fillings, extractions. Mental establishment of an in-patient facility and out-patient facility within the Correctional Facility. Also, detoxification services - in and out patient basis. Medical availability of emergency equipment and supplies, re-screening and update of immunization 3 to 4 yrs. after admission. Routine chest x-ray, PPD skin tests, HBS AG, HIV testing, pap smear, AU, CBC, routine PE, Physical fitness programs, stress reducing programs, cancer screening. Educational-proper arrangement of charts, proper dispensing and control of narcotic, system of appointments.	Our Correctional Facility is badly in need of a dentist to treat patients in the facility. Proposed Forensic Unit must be achieved. Dietician diets and to see that nutritional quality of food served is maintained. Policies and Procedures in Infection Control of Communicable diseases is needed. Assistance is needed in this area. How family could assist in evacuating ill inmates.
HONG KONG	Yes; In Hong Kong, we have qualified Medical Officers and qualified nursing staff to take care of the prisoners' health as well as health of the staff and their dependents.	No; all staff working in the Correctional hospitals a re qualified registered nurses, enrolled nurses or hospital in-service trained who are also trained for custodial duties. A Medical Officer will oversee the medical and health of prisoners, staff and their dependents of the penal institution.	In Hong Kong, we have a very effective Correctional Services which consist of all such services in every institution. Although we have Specialist Clinics in the larger penal institutions or institutions in urban areas, we would like these services be extended to smaller penal institutions or those institutions in remote areas.	In Hong Kong, the Correctional Services Department is running a very effective Medical Service for the prisoners, staff and their dependents. A separate forensic institution is purposely built for prisoners who are mentally ill. A hospital or sick bay with hospital beds, dispensary and treatment room are kept in every institution. Some institutions even have own dental consultation facility, x-ray system with film developing machine, minor operation room, and urine laboratory (testing for narcotic and drugs). Clinical Psychologists are employed by Correctional Services and are readily available to assess and treat prisoners/remands present with psychological problems. A special programme is run for the Geriatric prisoners in view of their old age during detention. Medical Officers are seconded from the Hospital staff with qualified registered nurses, enrolled nurses, psychiatric nurses, hospital in-service trained staff are directly employed by the Correctional Services who have to undergo custodial duties training as well.
IRELAND, NORTHERN	Yes	No applicable	We believe that the health care provision for prisoners is adequate for the needs of prisoners and is more than comparable to the provision anywhere else in the world.	In 1991, delegates from the service attended the World Conference on prison health care in Alaska and the European seminar on prison health services in Finland under the auspices of the Council of Europe where it became apparent that our arrangements for the provision of health care in prisoners was of a very high standard.

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	FEELINGS OF IDENTIFYING INDIVIDUALS WITH COMMUNICABLE DISEASES	FEELING OF HEALTH CARE TRAINING BY QUALIFIED PROFESSIONALS	PRIORITY OF HEALTH SERVICES FOR POSSIBLE IMPLEMENTATION	COMMENTS
IRELAND, REPUBLIC OF	Yes	Yes	1. 24 hr. access to sanitation/washing facilities; 2. all medical care to be provided by professionally qualified staff; 3. all prisoners should have a through physical and psychiatric assessment on reception; 4. specific treatment to be available for sub-groups by sex-offenders, drug abusers.	I believe that there is a need for an international code of ethical standards in relation to prison medicine. This needs to re-enforce the principle that prisoners do not lose the right to medical confidentiality, access to equivalent health care, etc.
ITALY (UNIVERSITY OF PADOVA, PSYCHOLOGY DEPT)	Yes	Yes	Basic medical sanitation by an independent body, including screening and a program for the treatment of drug addiction and AIDS, including psychiatric assistance	Answers were taken from an article written by in response to this questionnaire, a copy of which is available in Italian.
ITALY	Yes; such measures should be taken for health security reasons	Yes	HIV infection control; drug addiction phenomenon control; mental health care services; educational services; dental services	(Sent the last edition of the "Prison in Italy" describing their health care)
JAPAN	Yes	Yes	No listing is possible because everyone of these is important	
KUWAIT	Yes	Yes; all member of health care team are fully trained and professional staff and appointed by the Ministry of Public Health	All services, dental, educational, medical, basic neurological are provided in the prison hospital. But as mentioned before and because of the invasion, we expect the services come back into its past standard in short time.	Doctors are available in the Central Jail for 4 days a week and in the female prison the same and in other prisons twice a seek. However, all prisons have medical staff in daily basis and the pharmacy is available in the Central Jail only and if medications are needed, it can be obtained from this pharmacy or local hospitals. Moreover there is a Department with the Ministry of Interior Structure (Department of Police Health) is in charge of the staff who works in the prisons as well as providing medical services tc the police personnel.
LEBANON	Yes	Yes; the Lebanese are receptive to new ideas and programs. They are open-minded and see continual development. Resources, however, are minimal.	Sanitation, nutrition, medical services	Action is needed as soon as possible
LESOTHO	Yes	Yes; because they are keen and have great concern in helping prisons.	Mental, medical, sanitation, education, dental, basic nutrition.	There is a great demand for training of a personnel in order to standardize health care in prisons.
LUXEMBOURG (GRAND DUCHY OF)	Yes	No	Educational, mental, sanitation	
MALTA	Health care service available	Nil	Rehabilitation services for addicts and other prisoners, limited by personnel	
NETHERLANDS	Not applicable; there is no way of identifying individuals suffering from any disease, except T.B.	Yes; this is actually the way training is offered in our system.	One of the core issues is the health education of detainees, in particular education on alcohol and drug abuse and addiction, education on nutrition, education on sexually transmitted diseases and on HIV and AIDS.	Attention is to be paid to foreign (non-dutch) prisoners and immigration detainees. A program for early detection of suicidal behavior and prevention of suicide is to be worked out.
NEW ZEALAND	Yes; this is already policy	As the department provides facilities for the health care of prisoners, this is not an issue	It is difficult to be specific with this. Current policy is to provide a service equivalent to that which is available in the community. Attention is therefore given to ensuring that is fulfilled. Extra emphasis would be targeted to increase: health education/promotion and in depth counseling; assessment/programs for mentally ill offenders; drug and alcohol programs.	

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	FEELINGS OF IDENTIFYING INDIVIDUALS WITH COMMUNICABLE DISEASES	FEELING OF HEALTH CARE TRAINING BY QUALIFIED PROFESSIONALS	PRIORITY OF HEALTH SERVICES FOR POSSIBLE IMPLEMENTATION	COMMENTS
NICARAGUA	Yes	Yes; the prison chiefs are willing to train medical personnel, they are aware of the problems.	Antibiotics; analgesics; anti-fungus; local anesthetics; dental anesthetics; amalgam; zinc oxide; laboratory chemicals; laboratory glassware; medicine text for training; electrocardiogram; x-ray materials; clinical lab equipment; health education materials & equipment.	
NORWAY (PROJECT SUPERVISOR OF PRISON HEALTH)	Not relevant	Not relevant; the prison health care is an integrated part of the ordinary public health services	1. mental health service; 2. sanitation (1/3 of the prisons were built in mid-victorian times; 3. dental care.	The Prison Health System in Norway is at present undergoing great changes. The responsibility for health care of prisoners was transferred from the Ministry of Justice to the Ministry of Health and Social Affairs as from 1988 with the main objective to assure that inmates would receive the same service as the general population. The Prison Health municipal or the regional health administration. The Chief County Medical Officer has, on behalf of the Ministry of Social Affairs, negotiated with the municipal and regional health administration on a voluntary basis to fulfill the reform. All expenses are covered by the state when it comes to primary health care and are partially covered as to psychiatry and dental care. The Prison Health System is now part of the municipal and regional health and social plans. The Chief County Medical Officers have the inspection responsibility of health care in prisons. The Directorate of Health has published a booklet with some professional guidelines concerning this field. The reform is continually being revised by the health authorities and important adjustments in relation to regulations and laws are required.
NORWAY (RONNAUG AABERG ANDRESEN)	Irrelevant	Not relevant	These services are implemented whenever necessary today.	
PAPUA NEW GUINEA	Yes	Yes	Every prisoner to be tested on admission and provided treatment and medication while in prison by qualified medical officers.	The standard of health care and treatment facilities for detainees as well as staff in correction needs improvement.
PHILIPPINES	Yes	Yes	Dental (oral prophylaxis); education (offer more courses other than commerce); medical (consultation on part-time basis, neuro-surgeon, ortho-surgeon, defibrillator, ECG monitoring); mental (comprehensive psychiatric testing	
SAUDI ARABIA (Assistant Director General, Medical Services Directorate, Ministry of Interior)	Yes	Yes	Educational, sanitation, medical, mental, dental	
SAUDI ARABIA (Arab Security Studies & Training Center in Riyadh)	No	No	All	Health care is a problem in the third world. It is necessary to begin with the society, then with the jail or prison milieu.

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	FEELINGS OF IDENTIFYING INDIVIDUALS WITH COMMUNICABLE DISEASES	FEELING OF HEALTH CARE TRAINING BY QUALIFIED PROFESSIONALS	PRIORITY OF HEALTH SERVICES FOR POSSIBLE IMPLEMENTATION	COMMENTS
SIERRA LEONE	Yes; it is obvious that any health care extended to the sentry forces and families will enhance the care of prisoners.	Yes; training facilities of health care workers are very limited and any international assistance will be welcomed	Feeding programs, medications, sanitation (open buckets are still used in prisons), training of medical and health care workers (only 1 doctor in the prison health service and very few nurses)	We are in the process of establishing a prison medical service with doctors and nurses and other health workers which will be virtually independent of the general health service but with the ministry of health responsible for the ethics and conduct of all health workers.
SLOVENIA, REPUBLIC OF			All the above stated services have already been implemented in our prisons and jails.	The organization of health care in our prisons and jails has already reached substantially high level, especially considering the relatively small number of prisoners, i.e. altogether approximately 600 (convicts and remand prisoners), if compared to the total Slovenian population which amounts to approximately 2,000,000.
SPAIN	Health care is already provided for in al Spanish prisons by physicians and nurses working for the Ministry of Justice.	Specialized health care is already provided by local specialists: internists, dentists, psychiatrists, etc. Basic health care is provided by the prison' physicians.	Due to the fact that some prisons are very old, some reforms are needed on the kitchen and laundry services. Thus, if given unlimited resources this would be my priority. The other areas are covered in Spain.	The idea of doing this survey is very good, since I think that the results will be very interesting. Nevertheless, if the survey is going to be repeated, I think the questions should be made more specific and an effort should be made to close the answers
SURINAME	Yes	Yes	Mental; sanitation; educational; dental services	Health care in third world prisons is not comparable with prisons of rich countries; it should be compared at the same level.
SWITZERLAND	No	Yes; why not?	All prisons for long detention have well equipped health services and offer possibilities of scholarly or professional formation for the prisoners. The education aspect of the sentence could be reinforced by the introduction of more personalized approaches. Besides some prisons must be improved architecturally notably to allow group execution (more than 200 million francs have been invested for the next 10-15 yrs.	
TONGA		Yes; is being done	Services in these areas are quite satisfactory, but there is always room for improvement	
TRINIDAD & TOBAGO	Yes	Yes	Educational, medical, sanitation, basic nutrition, mental, dental	The establishment of a Psychiatric Unit within the Compound of the prison to be serviced by personnel trained in this field is necessary. This will provide an avenue whereby mentally ill inmates as well as drug addicts and alcoholics will be given specialist/ professional treatment. Also, it is necessary to have Psychologist and Psychiatrist appointed full time to work in the Prison Service.
UKRAINE	No; there are certain difficulties concerning the acquisitions of necessary medical equipment and medicines for the places of imprisonment. In case of serious disease the convicted persons are examined at hospital of health care system on condition the proper guarding to be provided.	Yes; the local health care authorities concern the material supply of the penitentiary medicine with understanding. However, due to the existing deficit, the imprisonment with the required equipment is still a problem	General medical examination of the convicted persons, preventive medication, sanitation, basic nutrition, mental, medical, educational and others	
USSR	Yes	No; all sorts of prison staff have very poor social status	We are greatly limited by all kinds of resources	There is a real disaster with tuberculosis

ALLIANCE OF NGO's ON CRIME PREVENTION AND CRIMINAL JUSTICE

INTERNATIONAL PRISON HEALTH CARE

COUNTRY	FEELINGS OF IDENTIFYING INDIVIDUALS WITH COMMUNICABLE DISEASES	FEELING OF HEALTH CARE TRAINING BY QUALIFIED PROFESSIONALS	PRIORITY OF HEALTH SERVICES FOR POSSIBLE IMPLEMENTATION	COMMENTS
UNITED REPUBLIC OF TANZANIA (DOCTOR IN CHARGE OF PRISON MEDICAL SERVICES)	Yes	Yes (for sure)	1. good basic nutrition (prison diet scale); 2. water supply (state water to drink, wash); 3. sanitation, mainly supply of toilets in prisons and not buckets; 4. preventive medicine; 5. curative medicine.	Prison is not given any priority in health matters including nutrition. AIDS has terribly affected prisons but no support from nation AIDS committees. Prisoners are being discharged from governmer' hospitals for terminal care in prisons where you have congestion.
UNITED REPUBLIC OF TANZANIA (SECRETARY GENERAL)	There is a very big possibility of being receptive	Yes; they easily accept and that could be done at once	Basic nutrition; education; sanitation; dental	Would wish to supply the inmates with powdered milk that is to be used, especially to breast feeding mothers and supply them with medicated soap.

ALLIANCE OF NGOS
ON CRIME PREVENTION
AND CRIMINAL JUSTICE

Alliance de ONGs de la Prevention
du Crime et de la Justice Penale

Alianza de ONGs de la Prevencion
del Delito y Justicia Penal

October 9, 1991

Dear Sir/Madame/Minister:

The results of a recent informal international survey of prison personnel reveal interest in standardizing health care in prisons. There is evidence that community health professionals could be available to assist in the implementation and utilization of such standards once they come into existence.

The Alliance of NGOs on Crime Prevention and Criminal Justice at the United Nations in New York has formed a working group to address this interest.

the enclosed questionnaire represents your opportunity to be involved in the process. We are asking you to help identify the strengths and weaknesses of the prison health care system in your country. The working group, with such information, will endeavor to codify the needs and recommend basic global standards. These will be accompanied with suggestions and recommendations for local improvements.

Thank you for your attention and for taking the time to respond to these few questions. Please note that the responses should be returned by January 1, 1992, to:

Su Perk Davis
Research Specialist
PO Box 81826
Lincoln NE 68501
USA

Your participation will help guarantee a broad based consideration of health needs in order to develop a comprehensive report and a feasible set of standards. You will be kept informed and involved in the efforts of the working group. Your prompt and accurate response is greatly appreciated.

Sincerely yours,

Gary Hill
Director, Information Center

QUESTIONNAIRE

1. Country Name: _____

2. Are medications readily available in your country? Yes _____ No _____ In prisons? Yes _____ No _____

   Additional comments: _____

   _____

3. Is basic health and nutrition a significant problem in your country? Yes _____ No _____ In prisons? Yes _____ No _____

   Comments: _____

4. In general, what health care screening measures are used in your prisons or jails?

   _____

   _____

   _____

   _____

5. How do you test prisoners for communicable diseases? _____

   When does this take place? _____

   What do you test for? _____

   _____

   _____

6. If communicable diseases are detected, what provisions are taken for isolation or treatment?

   _____

   _____

   _____

   _____

7. Do you use physicians in your prisons or jails? Yes _____ No _____

   If yes, whom do they work for? _____

8. Do you use nurses or other health care workers in your prisons or jails? Yes _____ No _____

   If yes, whom do they work for? _____

9. When a prisoner requires medication, how is it ordered, obtained, and administered?

   _____

   _____

   _____

10. What health care records, if any, are kept on persons held in detention?

11. What healthcare training, if any, is offered to persons working in your prisons and jails, including family members or other prisoners?

12. Is control of communicable disease, alcoholism, and drug abuse a significant problem in your country? Yes _____ No _____
In prisons? Yes _____ No _____ Comments: _____

13. What provisions are made to evaluate and treat individuals held in detention exhibiting signs of mental illness?

14. What standards of health care do you currently use in your prisons and jails?

15. When families are used to assist an ill prisoner, what access to healthcare workers, for guidance, is provided?

16. Do you feel that the local prison authorities would be receptive to the provision of basic healthcare services in their facilities if it was geared toward identifying individuals who might spread disease to security forces and their families? Yes _____ No _____

17. Do you feel that members of local healthcare teams would be receptive to basic prison healthcare training if offered by qualified professionals? Yes _____ No _____ Comments: _____

18. If you were not limited by either finances or personnel, list in order of priority what dental, educational, medical, mental, or basic nutrition, sanitation, and other health services you would implement in your prisons or jails:

(CONTINUED)

19. Please add any further comments or suggestions: _____

_____

_____

_____

_____

_____

Name (Please Print): _____

Date: _____ Title: _____

Please send you response by January 1, 1992 to:

Su Perk Davis
Research Specialist
PO Box 81826
Lincoln, NE 68501
USA

Thank you for your prompt response. It will ensure that your input is part of the feedback report which we will be sending to all who participate in this process. We trust that our feedback will be useful to you. You opinions and input are very important to the success of this effort!

ALLIANCE OF NGOS ON CRIME PREVENTION AND CRIMINAL JUSTICE

Alliance de ONGs de la Prevention du Crime et de la Justice Penale

Alianza de ONGs de la Prevencion del Delito y Justicia Penal

March 9, 1992

Señor (a)/Ministro (a)

Los resultados de una reciente encuesta internacional realizada con el personal de las prisiones reveló el gran interés que existe en establecer programas de salud en todas las prisiones. La información existente revela que existen profesionales de salud en la comunidad que estarían dispuestos a asistir a la implementación y utilización de estas unidades de salud una vez ellas hayan sido creadas.

La alianza de ONGs de la Prevención del Delito y Justicia Penal de las Naciones Unidas en Nueva York ha formado un grupo de trabajo encargado de llevar a cabo esta meta.

El cuestionario incluido es una oportunidad para Ud. de involucrarse en éste proceso. Solicitamos que Ud. nos ayude a identificar las areas fuertes y débiles que existen en los pprogramas de salud de su país. Esta información será utilizada por un grupo de trabajo para codificar las necesidades y recomendaciones en un patrón básico mundial. Este será acompañado con sugerencias y recomendaciones para mejoras locales.

Gracias por la atención prestada a ésta carta y por el tiempo empleado en responder a éstas preguntas. Por favor devuelva éste cuestionario antes del 1 de Enero de 1992, a la siguiente dirección:

Su Perk Davis
Research Specialist
PO Box 81826
Lincoln NE 68501
USA

Su participación ayudará a garantizar una consideración amplia de las necesidades de salud con el objeto de desarrollar un reporte comprensivo y un grupo de normas apropiadas para cada situación. Lo mantendremos informado e involucrado en los esfuerzos que esta realizando éste grupo de trabajo. Agradecemos su participación.

Sinceramente,

Gary Hill
Director, Centro de Información

Cuestionario

1. Pais:_____

2. ¿Es fáciles conseguir medicamentos en su pais? Si_____ No_____ ¿En las prisiones? Si_____ No_____

   Comentarios adicionales:_____

3. ¿La salud básica y la nutrición Son un problema grave en su pais? Si_____ No_____

   ¿En las prisiones? Si_____No_____

   Comentarios:_____

4. Por lo general, ¿Cuáles son las medidas de salud usadas en sus prisiones?

5. ¿Cómo son evaluan los prisioneros por enfermedades contagiosas?_____

   ¿Cuando se llevadas a cabolas evaluaciones?_____

   ¿Que se evaluá?_____

6. Si enfermedades contagiosas son encontradas, ¿Cuáles son las medidas tomadas para aislarlas o tratarlas?

7. ¿En las prisiones, es personal médico normalmente usado? Si_____ No_____

   Si la respuesta es afirmativa, ¿para quien(es) trabaja(n) ellos?_____

8. ¿Utilizán Uds. enfermeras u otra clase de personal de salud en las prisiones? Si_____ No_____

   Si su respuesta es afirmativa, ¿para quién(es) trabaja(n) ellos?_____

9. Cuando un prisionero requiere medicinas, ¿Cómo es este ordenado, obtenido y Administrado?

10. ¿Que clase de registros en cuidados de salud, si hay alguno es llevado de las personas detenidas?

(CONTINUED)

11. ¿Qué entrenamiento en cuidados de salud, si hay alguno, es ofrecido a las personas que trabajan en las prisones, incluyendo miembros de la familia u otros prisioneros?

12. El control de enfermedades contagiosas, alcoholismo y abuso de drogas, ¿Es un problema grave en su país?
Si_____ No_____ ¿Es un problema grave en su país? Si_____ No_____
Comentarios:_____

13. ¿Que estipulaciones son hechas para evaluar y tratar individuos detenidos que exhiben signos de enfermedades mentales?

14. ¿Cuales son los métodos de cuidados de salud frecuentemente usados en las prisiones?

15. Cuando las familias asistin a un prisionero enfermo, ¿Qué acceso al personal de salud, como guias es provisto a estas?

16. ¿Piensa Ud. que las autoridades locales deberían ser mas receptivas en las estipulaciones en los servicios de salud básicos? ¿En sus facilidades como una forma para identificar individuos quienes podrían esparcir alguna enfermedad a las fuerzas de seguridad y a sus familias? Si_____ No_____

17. ¿Piensa Ud. que los grupos locales de salud deberían ser mas receptivos a recibir entrenamiento en cuidados de salud básicos para prisiones si esta es ofrecida por profesionales calificados? Si_____ No_____

18. Si Ud. tuviera los medios económicos y personal, a continuación enumere en orden de importancia, ¿Cuales servicios de salud, dental, médico, mental, nutrición básica, sanitaria y otros servicios de salud, Ud. implementaria en las prisiones?

(CONTINUED)

19. Por favor agrege cualquier otro comentario o sugerencia:_____

_____

_____

_____

_____

Nombre (letra imprenta):_____

Titulo:_____ FECHA:_____

Por favor envie su respuesta antes del 1 de enero de 1992:

Su Perk Davis
Research Especialist
PO Box 81826
Lincoln NE 68501
USA

Muchas gracias por su pronta respuesta. Esta información formara parte del informe que nosotros le enviaremos a todas las personas que participaron en el proceso. Esperamos que el informe le sea de mucha utilidad. Su información y opiniones son muy importantes para el éxito de este gran esfuerzo!

ALLIANCE OF NGOS
ON CRIME PREVENTION
AND CRIMINAL JUSTICE

Alliance de ONGs de la Prevention
du Crime et de la Justice Penale

Alianza de ONGs de la Prevencion
del Delito y Justicia Penal

December 5, 1991

Monsieur/Madame/Ministre

Les résultats d'un récent questionnaire international informel du personnel des prisons, révèlent un intérêt général au niveau des critères de soin de la santé dans les prisons. C'est évident que la communauté professionnel de la santé publique peut être utile et prête à aider dans l'usage de tels programmes une fois qu'ils existent.

L'Alliance de NGO's de la Prévention du Crime et de la Justice Pénale aux Nations Unies à New York a formé un groupe du travail pour faire face à ces intérêts.

Le questionnaire ci-joint vous offre l'occcasion de faire partie de ce processus. Nous Vous demandons de nous aider à indentifiez les forces et los faiblesses du systéme de soin de la santé des prisons dans votre pays. Le groupe de travail, avec de tels renseignements, s'efforcera de codifier les besoins et recommandera des normes fondamentales globales. Ils seront accompagnés de suggestions et de recommandations pour des améliorations locales.

Merci de votre attention et de prendre le temps pour répondre à ces quelques questions. S'il-vous-plaît notez que les réponses doivent être rendues autour du 1 janvier 1992, à:

Su Perk Davis
Research Specialist
PO Box 81826
Lincoln, NE 68501
USA

Sentez-vous libre de nous contacter pour n'importe quels autres renseignements ou clarifications dont vous avez besoin. Votre participation aidera à garantir une large considération des besoins de la santé pour développer un rapport compréhensif et des normes réalisables. Nous continuerons de vous informer et de vous impliquer dans les efforts du groupe de travail. Vos réponses rapides et précises sont beaucoup appréciées.

Je vous prie de croire à mes sentiments
les meilleurs

QUESTIONNAIRE

1. Le nom de votre Pays:_____

2. Est-ce que les médicaments sont promptement disponibles dans votre pays? Qui_____ Non_____ Dans les prisons? Qui_____ Non_____ Autres Commentaires:_____

3. Est-ce quo la santé fondamentale et la nutrition sont des problèmes significatifs dans votre pays? Qui_____ Non_____ Dans vos prisons? Qui_____ Non_____ Commentaires:_____

4. En général quelles measures d'évaluation de la santé des prisoners sont utilisées dans vos prisons?

5. Comment est-ce que vous mettez los prisonniers à l'épreuve pour les maladies communicables?_____

   Quand est-ce que ca a lieu?_____

   Quelles sont les maladies quo vous cherchoz?_____

6. Si des maladies communicables sont decouvertes, quelles mesures sont prises pour l'isolement ou le traitement des prisoniers?

7. Est-ce que vous utilisez des médecins dans vos prisons? Qui_____ Non_____

   Si oui, pour qui est-ce qu'ils travaillent?_____

8. Est-ce quo vous utilisoz des infirmiéres ou d'autres employées de la santé publiquo dana vos prisons? Qui_____ Non_____

   Si oui, pour qui est-ce qu'ils travaillent?_____

9. Quand un prisonier exige des médicaments, comment est-ce qu'ils sont ordonnés, obtenus et administrés?

10. Quelles sorte de notes/observations sont retenues sur la santé des personnes tenues en détention?

_____

_____

_____

11. S'il est offert, quelles sorte de préparation/stage au niveau de la santé, est offert aux personnes qui travaillent dans vos prisons, y compris la famille du prisonnier ou d'autres prisonniers?_____

_____

_____

12. Est-ce que le contrôle des maladies communicables, l'alcoolisme, et l'abus des drogues est un problème important dans votre pays? Oui_____ Non_____ Dans vos prisons? Oui_____ Non_____ Commentaires:_____

_____

13. Quelles mesures sont prises pour évaluer et traiter les individus en détention pour les signes de maladie mentale?

_____

_____

_____

14. Quals critères de santé publique utilisez vous couramment dans vos prisons?

_____

_____

_____

_____

15. Quand les familes sont utilisées pour assister les prisoniers malades, quel directions et accès aux professionels leur est accordée?

_____

_____

_____

16. Sentez vous que les autorités locales des prisons seraient réceptives à la provision des services alimentaire de la santé pour identifier les individus qui peuvent étendre la maladie aux forces de la sûreté et leurs familles? Oui_____ Non_____ Commentaires:_____

_____

_____

17. Sentz vous que les membres des équipes locales de la santé publique seraient réceptifs à l'entrainment dans la provision des services alimentaire dans les prisons si c'est offert par des professionnels qualifiés pour cela? Qui_____ Non_____ Commentaires:_____

18. Si vous n'étiez pas limités par les finances ni par le personnel, enregistrez, par ordre de priorité, quels services dentaires, educatifs, médicaux, mentaux, ou services de nutrition fondamentale, de l'hygiène, et d'autres services de la santé que vous aimeriez utiliser dans vos prisons:_____

19. Veuillez ajouter vos commentaires et vos suggestions:_____

Imprimez votre nom, s'il vous plait:_____

La date:_____ Votre Titre:_____

S'il vous plait envoyez vos résponses, si possible, à la date:

A: Su Perk Davis
Research Specialist
PO Box 81826
Lincoln, NE 68501
USA

Merci pour vos réponses ponctuelles. Grace à votre rapidité, vos informations feront partie du rapport d'action de contrôle qui sera envoyé a tous ceux qui participent à ce processus. Nous sommes confiants que ce rapport vous sera utile. Vos opinions et les informations que vos nous donnez sont très importantes pour le succés de cet effort!

MEDICAL CONFIDENTIAL

Medication Log Sheet

Name_____ I.D. #_____

Date	Medication	Time dispensed and initials (giver & inmate)											
		Time	Given by: Init.	Inmate Init.	Time	Given by: Init.	Inmate Init.	Time	Given by: Init.	Inmate Init.	Time	Given by Init.	Inmate Init

(after completion—file with the medical record)

SAMPLE INITIAL HEALTH SCREENING FORM - LONG FORM

Date _____
Time _____

Person's Name _____ Sex _____

Date of Birth _____ Identification Number _____

Examiner's Name _____

Examiner's Observations
(where applicable, circle specific condition)

	Yes	No
1. Unconscious?	_____	_____
2. Visible signs of trauma or illness requiring immediate emergency or doctor's care?	_____	_____
Describe: _____		
3. Obvious fever, swollen lymph nodes, jaundice other evidence of infection that might spread through the facility?	_____	_____
Describe: _____		
4. Poor skin condition, vermin, rashes, or needle marks?	_____	_____
Describe: _____		
5. Under the influence of alcohol, barbiturates, or other drug(s)?	_____	_____
6. Visible signs of alcohol or drug withdrawal (extreme perspiration, pinpoint pupils, shakes, nausea, cramping, vomiting)?	_____	_____
Describe: _____		
7. Behavior suggesting risk of suicide or assault?	_____	_____
8. Carrying medication or reporting being on medication?	_____	_____
List: _____		
9. Visible signs of dental problems?	_____	_____
10. Visible Signs of physical deformities?	_____	_____
List: _____		

Examiner Questionnaire

10. Admits to the following (indicate by number and letter below):

1 (over one year ago) H (hospitalized)
2 (within past year) M (medications, current)
3 (present now)

_____ allergies
_____ arthritis
_____ dental problems
_____ diabetes

_____ asthma
_____ delirium tremens (DTs)
_____ heart condition
_____ hepatitis
_____ high blood pressure
_____ lethargy/weakness/night sweats
_____ mental illness
_____ epilepsy
_____ fainting
_____ tuberculosis
_____ ulcers
_____ urinary tract
_____ weight loss
_____ other (specify) _____

11. Use alcohol?

a. How often? _____ b. How much? _____

c. When were you drunk last?_____ d. When did you drink last? _____

12. Use any "street" drugs?

a. What type(s)? _____

b. How often? _____ c. How much? _____

d. When did you get high last? _____

e. When did you take drugs last? _____

13. Prescribed medications or special diets? _____

14. (For female)

a. Are you pregnant? _____ Number of months _____

b. Have you delivered recently? _____ Date _____

c. Are you on birth control pills?_____

d. Any gynecological problems? (specify)_____

15. Immunization history (specify dates and diseases)

_____

_____

16. Was a test for tuberculosis administered? Yes _____ (date_____) No _____

Remarks (e.g., unusual behavior, special diet, type of VD, etc.)

_____

_____

_____

Disposition or referral (circle appropriate response)

general population emergency care sick call

medical isolation other (specify) _____

(A copy of this form should be included in the individual's medical record.)

SAMPLE INITIAL HEALTH SCREENING FORM - SHORT FORM

(This form is to be used when the full health assessment is likely to be performed within the first 48 hours of a person's admission. A copy of the form should be included with the inmate's medical record.)

Date:_____ Time:_____

NAME OF INSTITUTION

Person's Name _____ Sex _____

Date of Birth _____ Identifiction Number _____

Examiner's Name _____

EXAMINER'S OBSERVATIONS (where applicable, circle specific condition):

	YES	NO
1. Does person have obvious pain or injury?	_____	_____
Describe: _____		
2. Is there obvious sign of infection (e.g., fever, sweating)?	_____	_____
Describe: _____		
3. Does person appear to be under the influence of alcohol or drugs?	_____	_____
Describe: _____		
4. Are there visible signs of alcohol and/or drug withdrawal?	_____	_____
Describe: _____		
Does person appear to be despondent?	_____	_____
6. Does person appear to be irrational or crazy?	_____	_____
Describe: _____		
7. Is the person carrying medication?	_____	_____
List:_____		

EXAMINER'S QUESTIONNAIRE:

8. Are you taking any medications?	_____	_____
9. Are you on a special diet?	_____	_____
10. (If female) Are you pregnant?	_____	_____
11. Is this the first time you have been detained?	_____	_____
12. Have you ever tried to kill yourself or done serious harm to yourself?	_____	_____
13. Do you have any serious medical or mental problems that you haven't told me about? (If yes, specify under remarks)	_____	_____

Remarks

_____

_____

Disposition or referral (circle appropriate response)

general population emergency care sick call
medical isolation other (specify) _____

Note: Each "yes" answer requires a response. Guidelines for disposition that tell the examiner what to do or whom to call for each of the items on the form should be developed.

Name & Number _____

Date: _____

Medical Confidential

Health History

HAVE YOU EVER?	YES	NO
Lived with anyone who had TB		
Coughed up blood		
Bled excessively after injury		
Attempted suicide		

HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW
Asthma			
Tuberculosis			
Cancer or Tumor			
Diabetes			
Emphysema			
Ear, Nose, or Throat Trouble			
Hearing Loss			
Chronic or Frequent Colds			
Hay Fever			
Severe Tooth or Gum Trouble			
Shortness of Breath			
High Blood Pressure			
Pain or Pressure in Heart			
Pounding Heart			
Arthritis or Bursitis			
Fractures (Broken Bones)			
Bone, Joint, or Other Deformity			
Painful or Trick Shoulder			
Foot Trouble			
Recurrent Back Trouble			
Swollen or Painful Joints			
Kidney Trouble			
Frequent or Painful Urination			
Blood in Urine			
Recurrent Infections			
Rheumatic Fever			

DO YOU?	YES	NO
Wear glasses or contact lenses		
Have vision in both eyes		
Wear a brace or back support		

HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW
Night Sweats			
Tumors, Cysts, or Growths			
Cramps in your Legs			
Rupture or Hernia			
Recent gain or loss of Weight			
Frequent Indigestion			
Stomach Trouble or Ulcer			
Hepatitis or Jaundice			
Gall Bladder Trouble			
Hemorrhoids or Rectal Trouble			
Head Injuries			
Epilepsy or Seizures			
Frequent or Severe Headaches			
Loss of Memory or Amnesia			
Periods of Unconsciousness			
Paralysis, Numbness, Weakness			
Dizziness, Fainting Spells			
Nervous Problem of Any Type			
Alcoholism			
Syphilis, Gonorrhea			
Drug Allergies			
Lumps, Pain, Discharge on Breast			
Change in Menstrual Pattern			
Pregnancy/Abortion/Miscarriage			
Treated for Female Disorder			
Thyroid Trouble			

YOUR PRESENT DOCTOR'S NAME (Address, Phone)

Have you ever been a patient or received treatment in a hospital? (surgery/injuries); state where, when, why & address

Have you ever been treated for a mental condition? (If yes, state reason and give details)

Have you ever taken narcotics? (If yes, state what kind, when you last took it, and if you are in a treatment program)

Highest level of education (years)

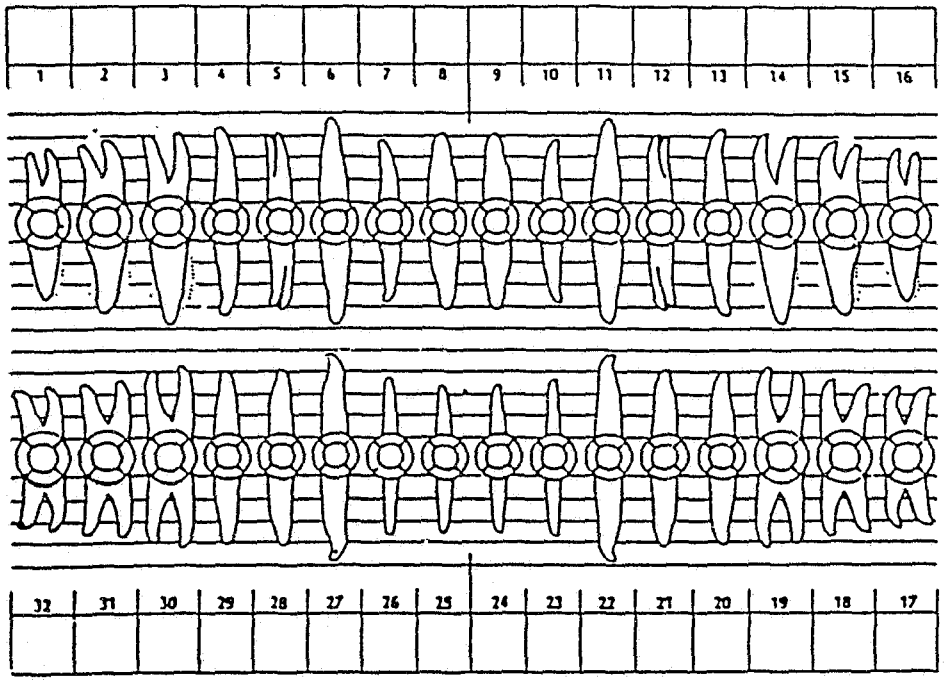
Additional Remarks: (use reverse side)

Have you ever been incarcerated in this jail before? (if so, when?)

LAST NAME _____ FIRST NAME _____ SPOUSE'S FIRST AME _____ HOME PHONE _____ PATIENT NUMBER _____

ADDRESS _____ PHYSICIAN'S NAME AND PHONE NUMBER _____ DATE OF EXAMINATION _____

CITY _____ STATE _____ ZIP _____ COPY OF DIAGNOSIS TO BE SENT _____ BIRTHDATE _____ AGE _____

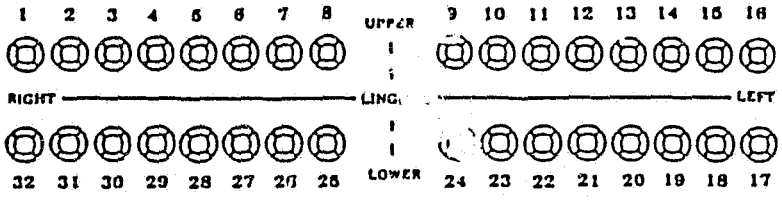


General Health _____
Physician's Care? _____
Medications? _____
Diabetes? _____
T.B.? _____
Hepatitis? _____
Venereal Disease? _____
Radiation Therapy? _____
Anemia? _____
Epilepsy? _____

Reactions to Anesthetics? _____
Rheumatic Fever? _____
Heart Murmur? _____
High Blood Pressure? _____
Heart Disease? _____
Bleeding? _____
Lung Disease? _____
Kidney Disease? _____
Breathing Problem? _____
Other? _____

Last Elective Dental Treatment? _____

CODE: S.C. - Space Closed C.R. - Crow X. - Missing Teeth



MEDICAL HISTORY - SUMMARY

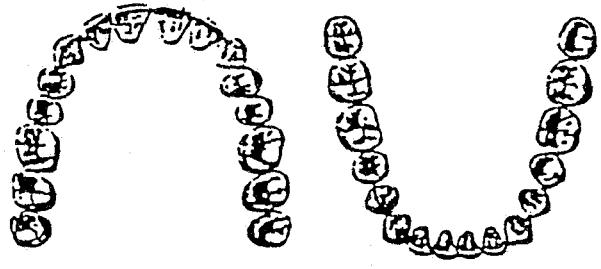
General Health _____
Existing Illness _____
Medicine/Drugs _____
Allergies _____ Blood pressure S ___/ D ___/___

DENTAL HISTORY - SUMMARY

Attitude _____
Home Care _____

CLINICAL DATA

General Condition of Teeth _____
Plaque _____ Stains _____ Abrasions _____
Condition of Present Restorations _____
Overhangs _____ Contact Points _____
Inflammation of Gingival Tissue: Slight ___ Moderate ___ Severe ___
Color _____ Recession _____ Pockets _____
Condition of the Floor of Mouth _____
Palate: Hard _____ Soft _____ Cheeks _____ Lips _____
Frenum _____ Tongue _____ Ridges _____
Presence of Exudate _____ Areas of Food Retention _____ Saliva _____
Calculus: Slight ___ Moderate ___ Excessive ___ Oral Cancer Exam ___
TMJ _____ Neck _____ Occlusion _____
Results of X-Ray: Bone _____ Root Tips _____ Impactions _____
Supernumerary _____ Abscesses _____



X-Rays _____
Study Models _____
Photographs _____
Clinical Exam _____
Vitality Test _____
Mobility _____

Health Status

Transferring Facility:

Date:____/____/____

Time:_____ AM PM

Name:

Number: ☐☐☐☐☐☐

Race: B W H Other

Age:_____ Date of Birth:____/____/____ Sex: M F

Allergies:_____ Food Handler Approved: Y / N Review Date:____/____/____

Current Acute Conditions/Problems:

Chronic Conditions/Problems:

Current Medications - Name, Dosage, Frequency, Duration:

Acute Short-term Medications:

Chronic Long-term Medications:

Chronic Psychotropic Medications:

Current Treatments: Dietary Restrictions:

Follow-up Care Needed:

Chronic Clinics: Specialty Referrals:

Significant Medical History:

Physical Disabilities/Limitations:

Assistive Devices/Prosthetics: Glasses: Contacts:

Mental Health History/Concerns: Substance Abuse: ☐ Alcohol: ☐ Drugs: ☐

- ☐ Hx Suicide Attempt: Date:____/____/____
- ☐ Hx Psychotropic Medication
- ☐ Former MPC/Dixon STC Placement

Signature and Title Date:____/____/____

Transfer Reception Screening

Facility:

Date:____/____/____

Time:_____ AM PM

S: Current Complaint:

Current Medications/Treatment:

O: Physical Appearance/Behavior:

Deformities: Acute/Chronic

T_____ P_____ R_____ B/P_____/_____

A:

P: Disposition: *(Instructions: Check or circle as appropriate)*

- [ ] Routine, Sick Call
  Instructions Given
- [ ] Emergency Referral
- [ ] AIDS Instruction Given
- [ ] Physician Referral:
  Urgent / Routine
  - [ ] Medication Evaluation
  - [ ] Therapeutic Diet
  - [ ] Special Housing
  - [ ] Work/Program Limitation
  - [ ] Specialty Referrals
  - [ ] Chronic Clinics
  - [ ] Other
- [ ] Infirmary Placement

Other:

Signature and Title

DISCHARGE SUMMARY/PLAN
(sign and date all entries)

Name: _____

Number: _____

Unit: _____

Discharged to: _____ Date: _____

Per authority of: _____

Discharge diagnosis:

Vital signs: BP _____ PULSE _____ RESP _____ TEMP _____

Physical limitations:

Diet:

Special Instructions:

Medications (including self-medication instructions):

Follow-up instructions (e.g., diet, appointments, tests, limitations):

Name: _____ Title: _____ Date: _____

American Academy of Family Physicians

Periodic Health Examination

Ages: 13-18 Years

Schedule: *At least one visit for preventive services should occur*[1]

(See Preamble)

Screening

History	*Physical Examination*[2]	Laboratory/Diagnostic Procedures
Interval medical and family history[1] Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices	Height and weight Blood pressure *Tanner staging*[2] High-Risk Groups Complete skin exam (HR1) Clinical testicular exam (HR2)	High-Risk Groups Rubella antibodies (HR3) VDRL/RPR (HR4) Chlamydial testing (HR5) Gonorrhea culture (HR6) Counseling and testing for HIV (HR7) Tuberculin skin test (PPD) (HR8) Hearing (HR9) Papanicolaou smear[3] (HR10) *Total cholesterol*[4] *Lipoprotein analysis*[5]
[1]*An updating of the previously obtained medical and family medical history is recommended by the subcommittee.*	[2]*A physical examination including Tanner stage is recommended at least once in this age group by the subcommittee.*	[3]Every 1-3 years [4]*Child of a parent with a blood cholesterol of 240mg/dL or higher* [5]*Child of a parent or grandparent with a documented history of premature (age less than 55 years) cardiovascular disease*

Counseling

Diet and Exercise	Substance Use	Sexual Practices
Fat (especially saturated fat), cholesterol, sodium, iron[6], calcium[6] *Nutritional assessment* Selection of exercise program	Tobacco: cessation/primary prevention Alcohol and other drugs: cessation/primary prevention Driving/other dangerous activities while under the influence Treatment for abuse High-Risk Groups Sharing/using unsterilized needles & syringes (HR12)	Sexual development and behavior[7] Sexually transmitted diseases: partner selection, condoms Unintended pregnancy and contraceptive options
[6]For females		[7]Often best performed early in adolescence and with the involvement of parents
Injury Prevention	**Dental Health**	**Other Primary Preventive Measures**
Safety belts Safety helmets Violent behavior[8] Firearms[8] Smoke detector *Noise induced hearing loss*[9]	Regular tooth brushing, flossing, dental visits	*Breast self-examination*[10] *Testicular self-examination*[11] High-Risk Groups Discussion of hemoglobin testing (HR13) Skin protection from ultraviolet light (HR14)
[8]Especially for males [9]*Education regarding hearing loss from recreational and personal listening devices is recommended by the subcommittee.*		[10]*The teaching of self-breast examination is recommended by the subcommittee at the time of initiation of pelvic examinations.* [11]*The teaching of self-testicular examination is recommended by the subcommittee for male patients.*

Immunizations and Chemoprophylaxis

Tetanus-diphtheria (Td) booster[2]
High-Risk Groups
Measles-mumps-rubella (MMR) vaccine[3]
Hepatitis B vaccine[4]
Fluoride supplements (HR15)

[2]Once between ages 14 and 16
[3]*A second measles immunization, preferably as MMR (Measles, Mumps, and Rubella Vaccine, Live), is recommended by the subcommittee for all patients unable to show proof of immunity who are entering post secondary school education and for those becoming employed in medical occupations with direct patient care.*
[4]*Homosexually and bisexually active men, intravenous drug users, recipients of some blood products, persons in health-related jobs with frequent exposure to blood or blood products, household and sexual contacts of HBV carriers, sexually active heterosexual persons with multiple sexual partners diagnosed as having recently acquired sexually transmitted disease, prostitutes, and persons who have a history of sexual activity with multiple partners in the previous six months.*

Additional Notes

Leading Causes of Death:	Remain Alert For:
Motor vehicle crashes	Depressive symptoms
Homicide	Suicide risk factors (HR11)
Suicide	Abnormal bereavement
Injuries (nonmotor vehicle)	Tooth decay, malalignment, gingivitis
Heart disease	Signs of child abuse and neglect

High-Risk Categories

HR1 Persons with increased recreational or occupational exposure to sunlight, a family or personal history of skin cancer, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).

HR2 Males with a history of cryptorchidism, orchiopexy, or testicular atrophy.

HR3 Females of childbearing age lacking evidence of immunity.

HR4 Persons who engage in sex with multiple partners in areas in which syphilis is prevalent, prostitutes, or contacts of person with active syphilis.

HR5 Persons who attend clinics for sexually transmitted diseases; attend other high-risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).

HR6 Persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.

HR7 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV-infected, bisexual or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985.

HR8 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.

HR9 Persons exposed regularly to excessive noise in recreational or other settings.

HR10 Females who are sexually active or (if the sexual history is thought to be unreliable) aged 18 or older.

HR11 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR12 Intravenous drug users.

HR13 Persons of Caribbean, Latin American, Asian, Mediterranean or African descent.

HR14 Persons with increased exposure to sunlight.

HR15 Persons living in areas with inadequate water fluoridation (less than 0.7 parts per million).

*This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force *and the AAFP Commission on Public Health and Scientific Affairs*. Clinicians may wish to add other preventive services on a routine basis and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:
Developmental disorders
Scoliosis
Behavioral and learning disorders
Parent/family dysfunction

†*Additional visits should occur as other risk factors are determined such as initiation of sexual activity, experimentation with alcohol or other drugs, or licensure for operating a motor vehicle. Achievement of developmental milestones such as entry to high school may also warrant a visit. Each visit by patients in this age group should be considered an opportunity to assess and address risks.*

American Academy of Family Physicians

Periodic Health Examination*

Ages: 19-39 Years

Schedule: Every 1-3 Years[7]

(See Preamble)

Screening		
History	**Physical Examination**	**Laboratory/Diagnostic Procedures**
Interval medical and family history[1] Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices	Height and weight Blood pressure[2] *Pelvic examination (for women)* *Clinical breast exam (for women)*[3] *Clinical testicular exam (for men)* High-Risk Groups Complete oral cavity exam (HR1) Palpation for thyroid nodules (HR2) Complete skin exam (HR5)	Nonfasting *or fasting* total blood cholesterol[4] Papanicolaou smear[5] High-Risk Groups Fasting plasma glucose (HR6) Rubella antibodies (HR7) VDRL/RPR (HR8) Urinalysis for bacteriuria[6] (HR9) Chlamydial testing (HR10) Gonorrhea culture (HR11) Counseling and testing for HIV (HR12) Hearing (HR13) Tuberculin skin test (PPD) (HR14) Electrocardiogram (HR15) Mammogram (HR3) Colonoscopy (HR16)
[1]*An updating of the previously obtained medical and family medical history is recommended by the subcommittee.*	[2]*At every physician visit, with an minimum of every two years* [3]*Every 1-3 years, starting at age 30 until age 40*	[4]*At least every five years* [5]*All women who are, or who have been sexually active, should have an annual Pap test and pelvic examination. After a woman has had three or more consecutive satisfactory normal annual examinations, the Pap test may be performed at the discretion of the physician and the patient, but not less frequently than every three years.* [6]*The optimal frequency for urine testing has not been determined. In general, dipsticks combining the leukocyte esterase and nitrite tests should be used to detect asymptomatic bacteriuria.*

Counseling

Diet and Exercise	Substance Use	Sexual Practices
Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, iron[7], calcium[7] *Nutritional assessment* Selection of exercise program	Tobacco: cessation/primary prevention Alcohol and other drugs: Limiting alcohol consumption Driving/other dangerous activities while under the influence Treatment for abuse High-Risk Groups Sharing/using unsterilized needles & syringes (HR18)	Sexually transmitted diseases: partner selection, condoms, anal intercourse Unintended pregnancy and contraceptive options *for men and women*

[7]For women

Injury Prevention	Dental Health	Other Primary Preventive Measures
Safety belts Safety helmets Violent behavior[8] Firearms[8] Smoke detector Smoking near bedding or upholstery High-Risk Groups Back-conditioning exercises (HR19) Prevention of childhood injuries (HR20) Falls in the elderly (HR21)	Regular tooth brushing, flossing, dental visits	*Breast self-examination*[9] *Testicular self-examination*[10] High-Risk Groups Discussion of hemoglobin testing (HR22) Skin Protection from ultraviolet light (HR23)

[8]Especially for young males

[9]*The teaching of self-breast examination is recommended by the subcommittee at the time of initiation of pelvic examinations.*
[10]*The teaching of self-testicular examination is recommended by the subcommittee for male patients.*

Immunizations and Chemoprophylaxis

Tetanus-diphtheria (Td) booster[11]
High-Risk Groups
Hepatitis B vaccine (HR24)
Pneumococcal vaccine (HR25)
Influenza vaccine[12] (HR26)
Measles-mumps-rubella vaccine (MMR) (HR27)

[11]Every 10 years
[12]Annually

Additional Notes

Leading Causes of Death:	Motor vehicle crashes Homicide Suicide Injuries (nonmotor vehicle) Heart disease	Remain Alert for:	Depressive symptoms Suicide risk factors (HR17) Abnormal bereavement Malignant skin lesions Tooth decay, gingivitis Signs of physical abuse

(High-Risk Categories listed on following page.)

SAMPLE MENTAL STATUS ASSESSMENT SHEET

Date _____

Institution _____

Person's Name _____

Examiner _____

	Yes	No
1. Depressed mood	_____	_____
2. Suicidal ideation or behavior	_____	_____
3. Agitation	_____	_____
4. Paranoia	_____	_____
5. Loose associations	_____	_____
6. Hallucinations	_____	_____
7. Delusions	_____	_____
8. Bizarre thoughts or behavior	_____	_____
9. Emotional or social withdrawal	_____	_____
10. Violent behavior or threats	_____	_____
11. Other	_____	_____

Specify _____

Descriptions and additional remarks:

_____

_____

_____

_____

SAMPLE SUICIDE PRECAUTION PROTOCOLS

If any staff suspects that an inmate is depressed and/or suicidal, the medical department should be notified. The physician and/or on-call psychiatrist should then be consulted. Any of the following levels of precaution may be recommended:

LEVEL 1

In most circumstances, this level will pertain to persons who have actually recently attempted suicide. The on-call psychiatrist will have been notified. Efforts will be in progress to have the inmate committed to a mental health facility.

The inmate should be in a "safe room" or in the health clinic. Health staff should provide one to one constant attention while the person is awake, with visual checks every five to ten minutes while the inmate is asleep in a safe environment (described in Level 2). Toileting and bathing may or may not be visually supervised, depending on the inmate's mood at the time; if visually unsupervised, staff should be standing close by with the door slightly ajar.

LEVEL 2

This level will pertain to inmates who are considered at high risk for suicide. The on-call psychiatrist will have been consulted. Efforts will probably be made to have the inmate committed to a mental health facility.

The person should be either in a "safe room" or in the health clinic. Safety precautions should be observed. These should include searches of room and clothes for removal of all potentially harmful objects such as glass, pins, pencils, pens, and matches. Plastic bags should be removed. The room should be near the staff office, with no access to breakable glass and no electrical outlets (or outlets that can and should be turned off.) There should be no bed in the room if possible, and no pipes from which sheets could be hung. There may be a mattress and pillow on the floor. The person may have clothes (no belts), linen, and blankets. If the inmate verbalizes or demonstrates immediate intent to harm himself/herself, bedding should be removed and the health staff notified. The person should be checked at least every five minutes while awake and every ten minutes while asleep. He/she should have one to one attention when out of room, if potentially harmful objects (pencils, T.V., etc.) are brought into room, or if he/she seems unusually distraught. Toileting and bathing: same as for Level 1.

LEVEL 3

This level will pertain to persons whom the physician or on-call psychiatrist feel are at moderate risk for suicide. They may be inmates who have previously been on Level 1 or 2 and whose mental status is improving.

Safety precautions should be taken. These should include searches of room and clothes for removal of obviously potentially harmful objects, such as broken glass, pins, and matches. Plastic bags should not be permitted. Bed and linen may be allowed in room. The person may have writing materials (and T.V in the health clinic) at staff discretion, but these should be removed

when not in use. Toileting and bathing may be done as in the normal routine. The person should be checked visually at least every ten minutes while awake, every one-half hour while asleep.

LEVEL 4

This level will most often pertain to inmates who are at risk for becoming severely depressed/suicidal. This assumption may be based on past history.

The person may be dealt with as in the normal unit routine; however staff should observe the inmate for symptoms of depression and signs of suicidal ideation, and should notify health staff if new signs or symptoms occur. The person should be checked visually at least every half hour while awake and asleep.

The mental status of any given inmate may vary greatly from day-to-day and sometimes from hour to hour; therefore, it is imperative that staff have good observational skills and knowledge of signs and symptoms to look for. If any staff member has reason to feel that a person who is already on a precaution level should be moved to a higher level of precaution, the medical department should be notified, and the physician and/or psychiatrist again consulted.