The Corrections Health System and Continuity of Care for Former Inmates

By

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ABSTRACT

There are nearly 2 million individuals incarcerated in the United States at any given point. The Corrections Health System provides care for inmates who are typically underserved when not incarcerated. Inmates have a unique culture and a high prevalence of specific health problems. Using the Multnomah County Correctional Health Department in Portland, Oregon as an example, this article provides an overview of the correctional health system, health care services available in the correctional system and the interface between health care in the correctional system and community based health care. The article also provides suggestions for improving the continuity of health care for people released from the correctional system. Knowledge of the Correctional Health System and disease prevalence among inmates will enhance the ability of the Advanced Practice Nurse to help these patients.
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A Case Study

Sam Hearthurts, a 28-year-old male, presents to your clinic with a reported history of endocarditis. He has just been released from the county jail and has no records. He was also in the state penitentiary system during the last year. Sam has a 14 year history of intravenous drug abuse (IVDA) with methamphetamines. He developed endocarditis and was on some kind of IV antibiotic for about three weeks while in the jail. He has a 3-4/6 holosystolic murmur. His lungs are clear. The rest of his physical exam is negative except for some numbness over his right pectoral area. Now what happens? How do you find out what was done for him in the jail? What kind of information can you obtain and how do you go about it? What health concerns should you be looking for and asking Sam about because he has been in the Corrections system?

There are nearly two million individuals incarcerated in the United States at any given time.¹ Many of these individuals are released into the community with acute and chronic medical problems. This can have a huge impact on the health of the community and on the community’s healthcare dollars. Knowledge of the Correctional Health System and the problems inmates face upon release will enhance the ability of the nurse practitioner to help these patients. This article provides an overview of the correctional health system, health care services available in the correctional system and the interface between health care in the correctional system and community based health care. The article also provides suggestions for improving the continuity of health care for people released from the correctional system. The author will use Multnomah County Correctional System in Portland, Oregon as an example based on her seven years as a
Correctional Health Nurse. Multnomah County is the largest and most populous county in Oregon.

The Correctional System

In 2004, there were nearly 1.5 million people in state and federal custody throughout the United States. Additionally, there were approximately 714,000 inmates in local jails. A jail is a local facility funded by a county or city. Inmates are held in jail while awaiting trial or when sentenced for less than one year in duration. Inmates can be housed in the jail for more than a year if they are not sentenced, while they are awaiting trial or if they have consecutive sentences of one year each. Inmates are not allowed out of their units without an escort, guards are always present and inmates are always supervised. Most jails do not have educational or job retraining programs.

Prisons or penitentiaries are operated and funded by the state. Many state inmates will spend several years to the rest of their lives incarcerated. There are 13,254 inmates including juveniles housed in 13 facilities in the State of Oregon Correctional System. Inmates are free to wander from place to place during certain hours of the day. There are programs to help inmates with job skills, to increase their education and engage them in productive activities. The Oregon Prison Reform and Inmate Work Act of 1994 (Ballot Measure 17) amended the state constitution mandating that all inmates in the State Department of Corrections either work forty hours per week or have forty hours per week of work, education or treatment combined with either substance abuse or behavioral treatment. Work programs were to be developed to offset the cost of the programs and the state is free to benefit from inmate work. This law was designed to help reduce recidivism. The act specifies that county and city correctional facilities are not mandated
to provide the work and education opportunities that the state is. The only inmates affected by this amendment are under the jurisdiction of the state; inmates under the jurisdiction of county or municipal corrections are not affected by this. In Multnomah County, there are no monies dedicated to this important transitional program of work, education and treatment. 8

**Correctional Health Care**

Health care in the corrections system is mandated by law. The Supreme Court case Estelle v. Gamble (1973) was brought by an inmate who felt he was denied proper health care. He had suffered a back injury, was evaluated and given pain medication but no further diagnostic testing was ordered. He was subsequently ordered back to work by the correctional staff. When the inmate refused because of his pain, he was placed in administrative segregation, which is similar to solitary confinement but more restrictive. During this time, he developed chest pain, hypertension with headaches and his back pain worsened. He was not allowed to see a health care provider for 12 hours. The Supreme Court felt that this constituted “torture and other barbarous forms of punishment”, a denial of rights protected by the Eighth Amendment. It further interpreted this clause as a right to medical treatment for convicted inmates and found that pretrial detainees have the same right to healthcare under the Fourteenth Amendment which prohibits the government’s denial of "life, liberty or property without due process of law". 9

After this landmark case, the American Medical Association commissioned a survey of the nation’s correctional health care system. The survey found inadequate care and a lack of national standards 10 As a result of this survey, the National Commission on Correctional Health Care (NCCHC) was founded. This group sets standards for the
treatment of diseases in jails and prisons. The standards are consistent with the standards set by other medical organizations. Most of the standards have been adapted to the correctional health system from other medical organizations. Further, NCCHC has become an accrediting board similar to the Joint Council on Accreditation of Healthcare Organizations for prisons, jails and detention facilities for juveniles.10

**Correctional Health in Multnomah County**

In Oregon, with a population of 3,641,056 in 2005, 3 there were just over 20,000 incarcerated persons; 13,000 in prison and 7000 in jails as of March, 2006.4 The State of Oregon Department of Corrections' budget for 2005-2007 is just under $1.1 billion.5 In the Oregon State Correctional system, less than 1% of those in custody are women.5

Multnomah County Corrections Health, a division of the Multnomah County Health Department, is accredited by the NCCHC. The fiscal year 2006 budget for the Corrections Health Division is $13,786,234 with 92 full time equivalent (FTE) employees that includes medical staff for two jails, one juvenile detention facility and nine FTEs for the mental health program. This staffing level is required based on the average inmate population of 1674 and approximately 44,000 yearly inmate bookings.11 This budget is driven by the type of medical care that is mandated by the federal government.9

In Multnomah County in 2005 nearly 44,000 individuals were booked into the county jail with the length of incarceration ranging from mere hours to several years. There were over 9,000 clinic provider visits including 2396 mental health visits.11 Most of the health problems relate to diabetes, hypertension and depression.5 Dental visits constituted a large proportion of visits. The National Survey on Drug Use and Health
2002-2004, reports that 1% to 2% of Oregon’s population has used methamphetamines. Extreme corrosion of teeth, or “meth mouth”, is one consequence of methamphetamine use either injected or smoked. Inmates have more missing teeth and have more unmet dental needs than the employed population.

Prevalence of Disease in US Correctional Facilities

Inmates have acute and chronic problems similar to those of the general population although certain health problems are disproportionately represented. The prevalence of chronic illnesses, typically associated with aging, is generally lower in the incarcerated population. However, the prevalence of chronic diseases is still higher than one would expect in a population whose average age is under 40; two-thirds of all prisoners were younger than 40 at the end of 2003. Uninsured and poor people have a higher incidence of chronic diseases and more severe illnesses.

The rate of incarceration for drug offenses has grown tremendously from 13% in 1985 to 32% in 1990, a 240% increase. Self reports of drug use by state inmates prior to their initial offense during 2002 was 83% and use at time of arrest was reported as 33%. Inmates with mental health issues comprise approximately 16% of the total inmates or about 350,000 people. When disorders such as anxiety disorders are factored in, the percentage of inmates with mental health issues increases up to 36%, which means about 720,000 people in the correctional system. Mental illness is estimated to be 3-5 times greater in the inmate population than among those not incarcerated. HIV infection is 8-9 times higher, hepatitis C is 9-10 times higher, and tuberculosis is 4 times higher among inmates than the general population. Methicillin resistant staph aureus (MRSA) has recently become a nationwide problem in correctional facilities. Tuberculosis has a
higher prevalence among the incarcerated than the un-incarcerated population. Further, the physical environment of jails and prisons can increase the incidence of tuberculosis. The high numbers of homeless, HIV positive inmates and intravenous drug users increases the risk of transmission of tuberculosis. 20

The Correctional Health Process – The Multnomah County Experience

Health care provided in the Multnomah County jail is an example of how health care is delivered in the correctional system. 10 When a person is booked into jail, a Registered Nurse (RN) conducts a health history to assess if the inmate has acute or chronic medical health needs, prescription medication use, allergies, and if he uses illegal drugs, alcohol or other substances. Inmates may fear that this information will be conveyed to the legal authorities or may be angry enough to deny everything. The inmate might be asked to sign a release of information (ROI) form to obtain records from his health care provider or from a pharmacy for verification of these medications. Of the 4,000 people booked into the jail in December 2005, over 40% had psychiatric problems. Nearly a third of the people booked were drug or alcohol affected 11.

In the jail setting, tuberculosis (TB) is a significant public health issue. Testing for TB is essential among people who are incarcerated as they are often part of high-risk populations: the homeless, intravenous drug users and people who have a positive HIV status. 19 If the inmate has not had a Mantoux test in the past year, the test is administered. If the inmate does not want the test, he may refuse but he will be kept in solitary confinement until he agrees to one. 21

If it is determined that the medication an inmate takes is critical, such as cardiac, antiretroviral or some psychiatric medications, the RN will contact the on-call provider
for an order. If it is not deemed critical, the inmate is encouraged to submit a medical request form (MRF) that is both a request and consent for treatment for that particular problem and costs the inmate $10. The complaint can be handled using a protocol or an appointment with a mental health, medical or dental provider can be made for the inmate.

Over-the-counter (OTC) medications can be administered by the RN through the use of protocols. Nurse practitioners (NPs), physicians (MDs) and physician assistants (PAs) work Monday through Friday and are available on-call 24 hours a day. There is mental health coverage most days for inmates who are in crisis or suicidal. RNs are available 24 hours a day, seven days a week. Medication rounds are three times a day during which inmates receive medications and may ask the nurse questions. Inmates may also request an HIV test, Hepatitis C test or Hepatitis A and B vaccines at no cost.

Before being released from jail, inmates may request prescriptions for 2 weeks to assure that they have an adequate supply of medication until being seen by a primary care provider (PCP) "on the outside". These can be filled at no cost at a Multnomah County Health Department pharmacy.

Multnomah County Corrections Health is a division of the Multnomah County Health Department (MCHD). This linkage provides for programs in the jails that are related to public health. MCHD outreach workers do the AIDS/Hepatitis C testing in the jail. Other areas of collaboration with the Health Department include TB surveillance, STD partner notification, case reporting and disease outbreak investigation.

Pregnant inmates are offered prenatal care by medical residents from the local medical school and followed by a MCHD nurse who provides care after the inmate’s
release. This RN helps arrange care for the babies after birth, arranges for clearance for birth coaches, or for a therapeutic abortion if that is what the pregnant inmate desires.

Inmates are often released at 12:01 am into downtown Portland wearing the clothes they had at the time of booking so they may only have shorts and sandals when released in winter. The early morning release time is scheduled at that time as it fulfills the sentencing requirements but the county does not have to incur costs for the inmate for the day, such as meals. Public transportation at this time of day is sparse and the shelters are filled. At the discretion of the RN, NP or MD, inmates with medical or psychiatric issues can have release holds placed on their file so that they can be released during the day. There is a discharge planner who is responsible primarily for inmates that have mental illnesses. She can arrange for post release housing, follow-up psychiatric care and medical care. There are no discharge planners for inmates without chronic mental illnesses because of budgetary constraints.

**Continuity of Care**

The number of releases from state and federal prisons is climbing every year and average about 600,000 people back into the community annually. This results in thousands of people with diseases, some diagnosed, some not, being released into their communities, most without medical insurance or follow up care.\(^1\) "The 630,000 people who migrate back and forth across the 'border' between prisons and communities represent a public health opportunity that can be addressed if and when there is a safety net that serves these citizens while they are detained and when they return to their communities".\(^1\)\(^{(p1678)}\) Many inmates have no health insurance and their health care is obtained while in jail. Upon release the treatment that began in jail may continue the
length of time for which a release prescription was written. After that, if there is no follow up scheduled, the former inmate usually forgoes further treatment, most often due to lack of funds.

Collaborations between correctional facilities and public health systems are being developed across the United States. This is fueled by the knowledge that public health is responsible for all persons in the community, both behind bars and outside of corrections facilities. One program was piloted in Massachusetts from April 2000 through September 2001 and involved the Hampden County Correctional Center (HCCC), four community health centers and the Massachusetts Department of Health. Inmates who participated in this study had a serious chronic disease and lived within the areas served by the community health centers. Teams of physicians, nurse practitioners, and case managers managed care throughout the inmates’ incarceration. Follow-up appointments were made in the community health center with one of the providers that had seen the inmates while incarcerated.22

Although limited by its small sample, the study demonstrated that the program was moderately successful in linking inmates to community health. The key factors were having appointments scheduled prior to release and development of a relationship with providers at the community health centers. Another important consideration was the location of the health clinics to which the inmates were assigned. This program evolved into the Transitional Intervention Program, which has helped over 1,200 HIV positive inmates find post-release care.22

Obtaining health care services upon release can be especially challenging to a former inmate without work and without health insurance. Medicaid benefits are typically
lost while incarcerated. Maryland allows inmates to stay enrolled in the Medicaid program although claims cannot be processed while they are incarcerated. Medicaid benefits are resumed upon release. In states without this policy, Medicaid eligible former inmates are without medical assistance for several weeks while the paperwork is processed.

Prison Culture and Building Trust for Continuity of Health Care

It generally takes time for a therapeutic relationship to develop between a patient and nurse practitioner. This may be even more difficult when working with a former inmate. The prison culture is based on power: who has it and who does not. The official culture is a structure of rules and regulations imposed by the correctional system. The subculture of the prisoners is a hierarchal system based on who is the most powerful, who is owed the most favors and who can garner the most muscle if need be. This is a culture based on violence and the subjugation of the weak and vulnerable. According to Hufft and Kite there are five basic elements to the inmate code:

1. Do not exploit offenders. Do not steal. Do not break your word, be right.
2. Do not whine. Be a man.
3. Do not interfere with the interests of other offenders. Never rat on a con.
4. Do not lose your head; play it cool and do your own time.
5. Do not be a sucker. Do not trust the guards or the staff.

Though these are the basic elements of the culture, there are other more ominous aspects to this culture. It is a culture that focuses on punishment and subjugation. While incarcerated, the offender becomes acculturated to this way of life, expecting violence as a rejoinder to any slight. Relationships with others, especially those who are perceived to
be more powerful, become fraught with problems. Overcoming this with an acculturated ex-inmate is a slow and delicate process of trust building. Understanding the prison culture and its tenets can help make it easier to develop a more therapeutic provider-patient relationship. Nurse practitioners are ideally suited to provide care to former inmates as they are educated and prepared to empower people to assume control of their care.

**Sam and his Health Care After Release from Jail**

As with any other healthcare facility, Sam must sign a Release of Information (ROI) and then contact the jail for records. After an ROI has been signed, the provider who cared for Sam during his incarceration will be allowed to discuss Sam’s case. The medical records technician at the corrections facility can fax the pertinent information that is needed. There may be additional release consents necessary in certain jurisdictions. For example, further releases may be necessary for psychiatric records or records pertaining to drug and alcohol issues. In Oregon, there is a statute that allows for sharing of medical records between correctional facilities and county and state health departments for purposes of continuity of care. 26

Because of Sam’s incarceration and his intravenous drug use, he needs to be tested for Hepatitis B and C and HIV if not already done. His Mantoux test should be brought up to date if not already done so in the jail. If he has developed any skin lesions these must be cultured for MRSA.

Provider-patient relationships are founded on basic assumptions: that there is trust, mutual respect and caring between the provider and the patient. 27 Establishing a relationship based on trust with a patient who has been incarcerated can be difficult,
especially if the patient has been in prison for many years. One of the basics of prison
culture is trust no one, especially staff.\textsuperscript{25} Showing respect for the ex-offender is a way to
help establish trust in this relationship. This can be facilitated by acknowledging
nonjudgementally his illness and the causes. For example, Sam’s illness was caused by
using IV methamphetamines. Acknowledging this without rancor and in a matter-of-fact
way furthers that trust. Encouraging the ex-offender to take charge of his own health also
increases the trust level. Problems arise when providers’ boundaries are not firm.
Understanding that health care decisions are totally at the discretion of the former inmate
and that these decisions may be based on fear, lack of trust and lack of insight into the
medical issue can stress those boundaries.

While it is public knowledge why someone has been incarcerated, when dealing
with a former inmate, it is often better not to ask about the reason for incarceration.
Dealing with ex-offenders can become very difficult for the provider, if, for instance, the
patient has a history of child abuse. It is important to view the patient as a person with a
disease who incidentally has been incarcerated.\textsuperscript{25}

The former inmate who is ill and seeks help is already breaking one of the tenets
of prison culture: be a man. Allowing oneself to be open and vulnerable can be life
threatening to an inmate during incarceration.\textsuperscript{25} This thinking does carry over into their
life “outside”. Developing the insight to change this acculturation can be very difficult
for the former inmate. This type of belief will make it difficult for Sam to understand the
gravity of the situation, to follow medication regimes and to keep appointments with the
provider. As with any other patient, education must be tailored to the level of
understanding and education of the particular patient.
Recidivism among former inmates is very high, about 31% in Oregon in 2003 according to the Department of Corrections, so it is feasible that Sam will be re-incarcerated during his treatment. Finding out that Sam is back in jail or prison may be as a result of a call or ROI sent from the facility where he has been booked. This can explain why he has failed to show for his appointments. Placing a telephone call to the correctional facility providers to tell them what treatment Sam received is important to the continuity of his care. Helping Sam plan for the possibility of a return to jail can be handled truthfully by explaining how important it is to continue his treatment. Explain that if, not when, he is sent back to jail he needs to contact the jail’s medical department as soon as possible so his outside records can be accessed by the correctional medical staff. There is a high level of denial about recidivism so reiterating what Sam must do if re-incarcerated is important.

One of the most difficult issues when dealing with former inmates is their manipulative behavior and high-risk behavior. When incarcerated, Sam did not want to be awakened every four hours for IV antibiotics. In jail, the lights are always on (for security) so sleep is difficult most of the time, the steel door clangs open and the nurse comes in to hook up the antibiotic. Awakened by the clanging of the door, Sam decided that if he refused the antibiotic the nursing staff would stop coming in to wake him up. The nurses did not stop coming in but the antibiotic was not administered because he refused. This became a major issue due to Sam’s acute illness. The providers decided that a once a day dosing of another type of antibiotic would be as efficacious as the more frequent dosing. This example illustrates some key principles in dealing with a
manipulative person. First, always be clear on what you are willing to compromise. Second, never get into a power struggle. This struggle has no winners.

In the clinic setting, the decision has to be made whether to be absolutely stringent about the former inmate following the clinic rules about missed appointments and late shows. The NP needs to determine what can be compromised. Remember the former inmate comes from a culture that is fueled both by rules and by power. Some ex-offenders respond well to the clear directions while others do not want to be told what to do. This will depend on how much trust the ex-offender has developed with the provider. However do not be surprised if that patient never schedules another visit.

The keys to treating patients like Sam are respect, honesty, firm boundaries and caring. You must be firm, clear in directions and expectations and above all honest in all your dealings with the ex-offender.

**Implications for Practice**

Correctional systems are mandated to protect and keep its citizens safe from harm by those who chose to break the law. Protecting the public’s health in conjunction with public health systems is an extension of the Corrections System mandate to protect and serve. Incorporating public health services during and after incarceration would decrease the burden of illness among the inmates and protect the public after inmates are released from incarceration. Many of the inmates have been incarcerated because they have a disease; either a mental illness or a substance abuse problem. Incarceration is not the proper treatment for these people with illnesses. It also is important to remember that former inmates released back into the community deserve the same quality care as every other patient.
There are nearly 2 million individuals incarcerated in the United States at any given point. Many of these individuals are released back into the community with acute and chronic medical problems. This can have a huge impact on the health of the community and on the community’s healthcare dollars. Knowledge of the Correctional Health System, disease prevalence and prison culture will enhance the ability of the nurse practitioner to help these patients.
References


24. Lee B, Gilligan J. The resolve to stop the violence project: transforming an in-house culture of violence through a jail-based programme. *AJPH*. 2005. 27(2)149


36. IDU/HIV Prevention


47. Freudenberg N, Daniels J, Crum M, Perkins T, Richie BE. Coming home from jail: the social and health consequences of community reentry for women, male adolescents and their families and communities. AJP H. 2005. 95(10)1725.
