

**HEALTH CARE  
IN  
CALIFORNIA STATE PRISONS**

**By**

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# CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>1</b>
<b>INCREASED PRISON POPULATION AND HEALTH CARE COSTS.....</b>	<b>5</b>
LEGAL STANDARDS OF HEALTH CARE IN STATE PRISONS .....	7
ESTABLISHMENT OF COMMUNITY HEALTH CARE STANDARDS IN CORRECTIONS .....	9
<b>HEALTH CARE SCREENING FOR MALE PRISON INMATES .....</b>	<b>15</b>
CLASSIFICATION AND SECURITY SCREENING AT PRISON RECEPTION CENTERS .....	15
RECEPTION CENTER IDENTIFICATION AND PROCESSING.....	15
MENTAL HEALTH SCREENING AT PRISON RECEPTION CENTERS .....	18
<b>PRISON HEALTH CARE SERVICES FOR FEMALE INMATES.....</b>	<b>21</b>
RECEPTION CENTER SCREENING FOR FEMALE INMATES.....	21
MENTAL HEALTH SCREENING FOR FEMALE INMATES IN RECEPTION CENTERS .....	22
PREGNANCY .....	23
MOTHER INMATES AND INFANT PROGRAMS .....	25
HIV CARE .....	26
INMATES WITH TUBERCULOSIS .....	27
<b>HEALTH CARE FOR MALE INMATES IN ASSIGNED PRISON SETTING .....</b>	<b>29</b>
ACUTE CARE FACILITIES.....	29
CORRECTIONAL TREATMENT CENTERS AND COMMUNITY HOSPITALS .....	31
SICK CALL .....	33
INMATES WITH HIV AND THE AIDS DISEASE.....	34
TREATING INFECTIOUS AND COMMUNICABLE DISEASES.....	37
MENTAL HEALTH CARE IN ASSIGNED PRISON SETTINGS.....	39
SUBSTANCE ABUSE TREATMENT .....	39
<b>CENTRALIZED HEALTH CARE MANAGEMENT .....</b>	<b>43</b>
STANDARDS OF CARE .....	43
RECRUITMENT OF MEDICAL PERSONNEL.....	44
MEDICAL AUTONOMY IN PRISONS .....	45
MEDICAL RECORDS MANAGEMENT .....	46
<b>LEGISLATIVE AND ADMINISTRATIVE OPTIONS.....</b>	<b>47</b>
COUNTY JAILS AND STATE PRISONS.....	47
HIRING AND RECRUITMENT OF MEDICAL PERSONNEL.....	48
GERIATRIC CARE.....	48
PRIVATIZING PRISON HEALTH CARE SERVICE .....	49
SUBSTANCE ABUSE.....	49
MEDICAL AND VOCATIONAL TRAINING .....	50
PROGRAMS FOR INMATE-MOTHERS .....	51
FEMALE INMATE MEDICAL SERVICES .....	51
HIV DISEASE AND OTHER COMMUNICABLE DISEASES.....	52
<b>ENDNOTES .....</b>	<b>53</b>
<b>APPENDIX A.....</b>	<b>55</b>
CALIFORNIA MEDICAL ASSOCIATION ACCREDITATION REQUIREMENTS FOR PRISON HEALTH CARE FACILITIES.....	57
<b>APPENDIX B.....</b>	<b>59</b>
HEALTH CARE SERVICE DIVISION ORGANIZATIONAL STRUCTURE .....	61
<b>APPENDIX C.....</b>	<b>63</b>
CHRONIC VIRAL HEPATITIS GUIDELINES.....	65

## EXECUTIVE SUMMARY

It is no news that California's prisons have become more numerous and more crowded, nor surprising that the inmate population will nearly double within this decade. The state's constellation of prisons has scrambled to accommodate this population boom, providing not just beds and bars, but also meals, laundry, and health care. This paper examines several aspects of California's prison health care experience.

Essentially, the context is that prison health care is not altogether under California's control. In 1974, the nation's Supreme Court told us that the eighth amendment's admonition about "cruel and unusual punishment" meant, among other things, that prisoners must get sufficient medical care. Court decisions have begun to define the standard required, and more will surely follow. In addition to ordinary medical care, these decisions tell us that inmates are entitled to considerable treatment for mental disorders, and even that a nonsmoking inmate cannot be forced to double-cell with a chain-smoking roommate.

### Reception Centers

Incoming prisoners, around 200,000 this fiscal year, are first taken to a reception center. The principal reception task is to determine the prisoner's security risk level: level one is comparatively low risk and level four is very bad. Prisoners also undergo a medical evaluation, including questionnaires, blood tests, and tuberculin tests. In theory, and as required by state law, the prisoners will already have had a similar evaluation in the county jail from which they came. There are two problems with the theory. One is that counties, strapped for funds, may not be medically evaluating their prisoners very thoroughly. The second is that county medical records for prisoners seem not to get transferred to the state prison, so that even if a county did a thorough evaluation, it would not help at the state prison. One example of the consequence is that the state prisons last year identified 65 prisoners newly arrived from county jails who had active tuberculosis, a decidedly contagious disease. Forty-two of those were from Los Angeles County. There was no warning from the counties about these cases. Both county and state officials estimate that this county/state duplication and non-communication wastes at least \$5 million each year.

Incoming prisoners also undergo a mental health diagnostic test at the reception center. According to prison medical staff, between 10 to 18 percent of the prisoners passing through the reception center need mental health attention (more than 20,000 each year). Prisoners are roughly four times more likely to have serious mental problems than is the general population, often because of extensive drug use. This reception center screening has been considerably beefed up as a result of a federal court order issued in *Coleman vs. Wilson* (1992), a lawsuit which alleged that California's prison system's mental health services were so bad they constituted cruel and unusual punishment. Prisoners suffering from acute mental disorders can be treated for a short time at the reception center, and are then transferred to one of the prison system's specialized treatment centers, such as the one at Vacaville. The reception centers are not equipped to deal with drug addicted inmates, on the theory that counties will have identified and

treated these prisoners before passing them along to the state prisons. This theory also appears to be counter-realistic, because many county jails do not have drug and alcohol treatment programs.

### **Health Care for Female Prisoners**

The number of female prisoners in state prisons has increased by 39 percent since 1992, to nearly 11,000. Over a third were sentenced for drug use. Nearly 70 percent are mothers. According to Corrections officials, about six percent of arriving female prisoners are pregnant, and up to 85 percent of these are “high-risk” pregnancies, mostly because of drug use. Pregnant females are sent to one of two prisons that have appropriate prenatal care facilities and a contract with a nearby hospital for deliveries and complications. Each inmate also receives family planning information and may choose an abortion during the first 22 weeks of her pregnancy. During 1998, prisoners will have about 220 babies in state prison and undergo about 160 abortions.

What happens to the babies? The Department of Correction’s Community Prisoner Mother Program allows some inmate mothers to live with their new children in supervised housing outside of prison walls. The mothers must have less than six years to serve and have no history of child abuse or drug-related violence. A total of 94 “slots” are available in this program, so fewer than half of the mothers giving birth in prison each year have this option. The rest have a few choices. Some send the babies to relatives or close friends. Some put the children up for adoption. Some of the babies are placed by court order in the custody of county child protective services departments. Unfortunately, no data are collected about what happens to these children.

### **Health Care in Prisons**

California’s prisons spend around \$500 million each year on health care for inmates, up from \$310 million in 1992. This rapid cost growth, together with a series of court decisions critical of health care provided, attention from news media, and legislative interest, have focused Department attention on health care. In 1992, it created a new Health Care Services Division. In many ways, the Division’s efforts resemble the creation of a private HMO, only this one is entirely within the state prison system. They have struggled to identify an appropriate package of medical services, distinguishing between services, which are really “necessary” and those, which are not. They established a system wide management review system, which is likely to disapprove medical care, which falls outside the standard range. They have negotiated master contracts with hospitals and other medical service providers. They have attempted, unsuccessfully so far, to establish a comprehensive data collection system that would allow them to monitor costs and use levels. These arrangements have the same tensions about whether the “benefit package” is sufficient, and between health service decisions made by doctors and decisions about whether services will be provided made by “management,” as private HMOs. Conflicting priorities between security and medical personnel is another complicating factor. Some other consequences of these efforts are:

- The effort has been fiscally successful, in that health care costs per inmate have fallen several percent since 1993.
- Hospital care for inmates is provided through medical facilities within prisons and through contracts with community hospitals. The portion of this kind of treatment provided in prison

facilities increased from 46 percent of all admissions in 1994 to 63 percent in 1997. This shift is partly because security arrangements are easier and relatively cheaper in the prison facilities.

- Private medical facilities are usually “accredited” if they meet standards of equipment and staffing developed by the medical profession, and also must be licensed by the state. Most prison facilities have neither. The Department has now developed a new set of licensing standards for prison medical infirmaries. Only one prison facility has been able to obtain this license so far, but Corrections officials are hoping that another three will make the grade by the end of the year.

## **Particular Problem Diseases**

### *HIV/AIDS*

Nearly 1,400 inmates have been diagnosed with HIV, the precursor to AIDS. The number is increasing by two percent per year. Prison medical staff estimate that a considerably higher number, between 5,000 and 8,000 inmates, may have HIV. But state law prohibits prison officials from requiring inmates to be tested for HIV except where guards or inmates have come into contact with an inmate’s bodily fluids and a few other instances.

HIV positive inmates are moved to segregated quarters.

### *Tuberculosis*

Tuberculosis occurs more frequently in prison than in California’s civilian population, but there were still only 96 active cases in the state prison system in 1995. Most of those, 65, were newly arrived inmates from county jails, and 42 were from Los Angeles County.

Tuberculosis is contagious, and prison officials take the threat seriously. Every inmate is tested for the disease upon entering the reception center. Guards are tested annually. Inmates cannot be moved from one prison to another without medical records showing test results. Inmates who show active tuberculosis are kept in an isolated holding area until they are treated. This careful treatment is in marked contrast to the way HIV is handled in the prison system.

### *Hepatitis*

Hepatitis, a liver disease, is common in prison. A study done in 1994 found that 41 percent of newly arriving inmates had a form of hepatitis. Infected needles associated with drug use and tattooing are probably the main causes. Inmates are not systematically tested for hepatitis.

There is controversy about the way hepatitis is treated in prison. Some public health officials argue that each inmate should be tested for hepatitis and every case should be treated. But treatment with the drug interferon alpha is expensive. Prison officials estimate that it would cost an additional \$269 million to treat all the hepatitis cases in the state prisons. Treatment also requires a rigid 90-day treatment protocol, which all prisoners may not tolerate. Treatment will do little good if prisoners continue re-infecting themselves with needles, which appears likely in

many cases. Prison officials argue that universal treatment of hepatitis cases would often be wasted effort.

### *Substance Abuse*

State prisons only recently started treating drug and alcohol abuse. Now there are several six month programs offered to inmates nearing their release date, with follow-up in a halfway house after release. All involve intensive group therapy. Preliminary evaluations suggest a substantial reduction in recidivism for inmates that participate.

### *Inmates with Disabilities*

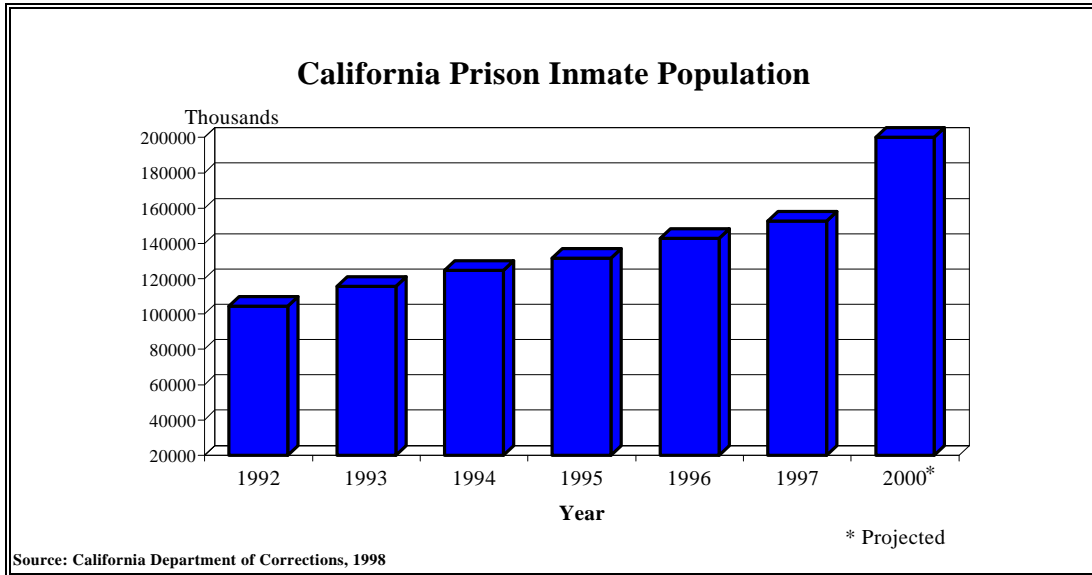
According to a June 15, 1998, U.S. Supreme Court decision (*Yeskey vs. State of Pennsylvania*), the 1990 Americans with Disabilities Act which prohibits discrimination against people with disabilities applies to state prison inmates. This decision could dramatically impact the level of prison services that must be made available to California prison inmates with disabilities. Observations conducted for this study indicate that state prison reception center protocols do not identify inmates with disabilities. This is an essential first step to identifying the needs of this population.

This paper includes several policy options that legislators might want to pursue in this subject area.

## INCREASED PRISON POPULATION AND HEALTH CARE COSTS

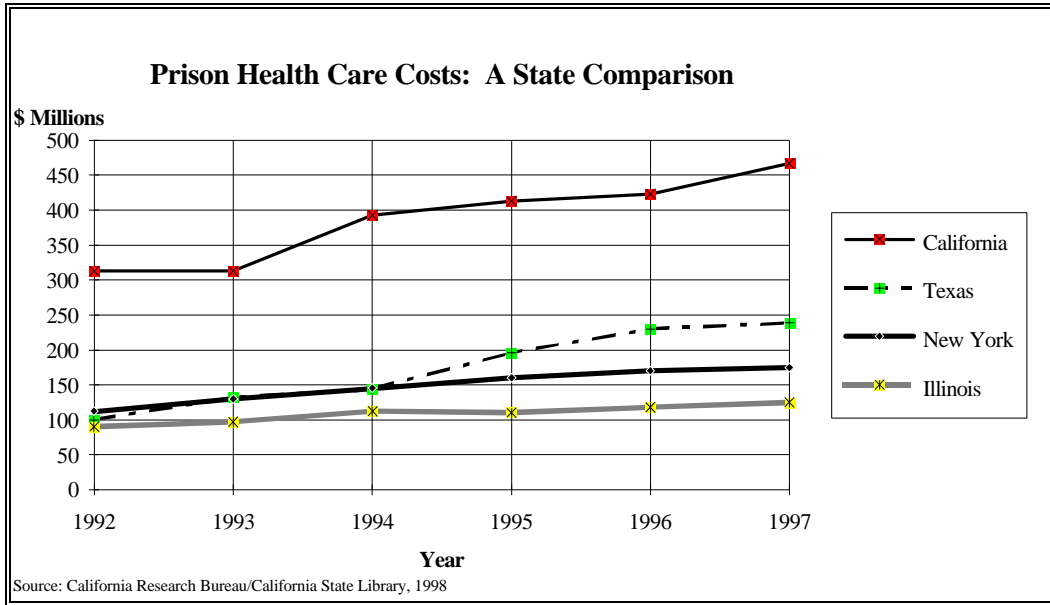
California's state prison population has experienced substantial growth in recent years. Currently there are about 153,000 inmates housed in institutions managed by the Department of Corrections. Some officials estimate that by the end of the decade there will be 200,000 inmates in California state prisons, which were designed to accommodate less than 100,000 inmates. The Department of Correction's policy is to double-bunk additional inmates. This crowding has a clear impact on facilities and services.

Chart 1



California spends more money on prison health care than any other state (see Chart 2 below). In Fiscal Year 1997-98, California will spend \$463 million on prison health care, compared to other large states like Texas (which spent \$239 million), New York (\$175 million) and Illinois (\$125 million). Since 1992, California prison health care costs have increased by 33 percent.

Chart 2

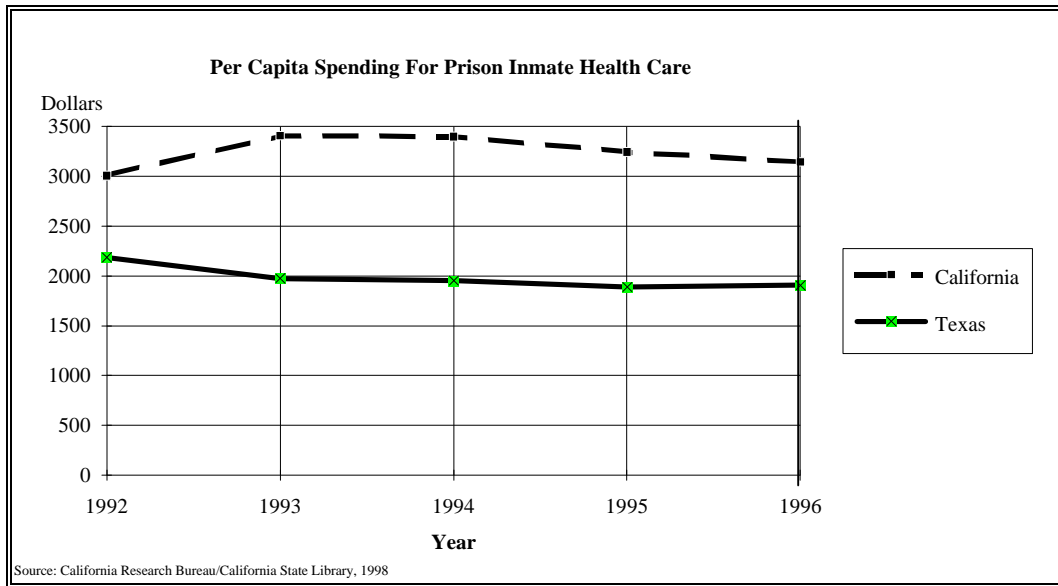


A number of factors have contributed to the growth in the California prison health care budget over the last five years, including inmate population growth, lawsuits involving medical access for disabled inmates to the prison mental health delivery system, and the rising cost of health care in general. For example, according to the latest available figures from the Health Care Financing Administration, government health care spending in the United States increased 21 percent from \$284.2 billion in 1992, to \$360.4 billion in 1995. In comparison, California's prison health care budget increased from \$313 million in 1992 to \$413 million in 1995, an increase of 24.3 percent (see Chart 2 above).

Chart 3 compares per capita health care expenditures in the Texas and California prison health care systems. Texas prison health care facilities are fully accredited, whereas California facilities are not. Expenditures per inmate in California increased by only six percent from 1992 to 1996. The growth in total California prison health costs is driven primarily by an increasing caseload of prisoners.



Chart 3



Correctional health care is an important yet often unrecognized component of the national and state debate on health care. The same issues of access to medical services, quality, and cost, which affect medical care for the general population also, affect correctional health care. In the general population, private insurance (pre-paid care, managed care, and fee-for-service care) and public programs (Medicare and Medicaid) pay for health care. The health care services provided to inmates in prison, however, are not included in these programs. People who are incarcerated lose eligibility for private and public health insurance benefits even though they may have been eligible prior to sentencing. Prison health care costs are paid by state general revenue funds.

### Legal Standards of Health Care in State Prisons

A unique mix of state and federal legislation and judicial decisions governs health care in California's prison system. Legislation covers specific subjects such as HIV disease, abortion, birth control and tuberculosis. The courts have affirmed through the Eighth and Fourteenth Amendments that jail and prison inmates are protected from the deprivation of their constitutional rights, and have established minimum standards of decency for conditions of confinement. The courts have granted the institutions the ability to establish their own regulatory standards and accreditation procedures for health care in cooperation with the medical community.

The Eighth Amendment protects an inmate from cruel and unusual punishment. In a landmark 1974 United States Supreme Court case, the Court concluded that deliberate indifference to the serious medical needs of prisoners constitutes an unnecessary and wanton infliction of pain, proscribed by the Eighth Amendment (*Estelle vs. Gamble*, 429 U.S.C. 97, 105). "Deliberate indifference to serious medical needs" remains the Eighth Amendment test today. Statutory standards reinforce the Eighth Amendment test. California law prohibits inadequate medical care which would injure or impair the health of the inmate (*California Penal Code, Section 673*). In addition, an inmate is protected against the deprivation of medical care and other constitutional rights by U.S. law (*42 USC Section 1983*)<sup>1</sup>.

The Fourteenth Amendment to the U.S. Constitution in part extends the protection of the Eighth Amendment to the states. The U.S. Supreme Court has found that, "a refusal to furnish medical care when it is clearly necessary could well result in the deprivation of life itself. Since these rights are protected by the Fourteenth Amendment to the Federal Constitution, the complainant sufficiently alleges the deprivation of a right, privilege or immunity secured by the Constitution and laws of the United States" (*McCullum vs. Mayfield, 1955*).

In California, major class action lawsuits have relied on the Eighth and Fourteenth Amendments to challenge the standards of inmate medical care provided by the Department of Corrections. In *Gates vs. Deukmejian, 1988*, the plaintiffs successfully argued in U.S. Federal Court that the Department subjected inmates to deficient conditions of confinement at the California Medical Facility at Vacaville by denying them access to medical and mental health care, and by segregating HIV-infected inmates.

In *Coleman vs. Wilson, 1992*, the plaintiffs successfully argued in U.S. Federal Court that inmates throughout the California state prison system were subjected to cruel and unusual punishment because they could not obtain adequate treatment for serious mental disorders. In another case with health care implications, the U.S. Supreme Court held that inmates who can demonstrate that exposure to cigarette smoke is a threat to their health have a constitutional right not to be confined with a chain-smoking inmate (*Helling vs. McKinney, 1993*).

In *Shumate vs. Wilson, 1996*, the plaintiffs successfully argued that the medical screening afforded to California female inmates entering the prison system, and the medical care afforded to female inmates in general, was inadequate throughout the state correctional system. As a result, the Department of Corrections has established medical screening protocols that systematically identify and treat both the mental health and general health care needs of female inmates. Through these and other cases, the courts have firmly established minimum constitutional standards for conditions of confinement.

In *Clark vs. Wilson, 1997* the plaintiffs allege that California female and male inmates with developmental disabilities entering the prison system cannot obtain the necessary and adequate accommodations, protection and services required by their disabilities. The plaintiffs contend that as a result, these inmates are unable to adapt to prison conditions, and are more likely to be beaten, raped, and/or manipulated by other inmates. The case is before the U.S. District Court in California.

A very recent U.S. Supreme Court decision (*Yeskey vs. Pennsylvania, 1998*), upholds the right of inmates with disabilities to have wheelchair access, interpreters for the deaf, and special education for learning disabilities, as needed. This decision could have a significant impact on prison health care services and costs. Currently, California prisons do not screen to identify this population.

Medical regulatory standards, professional accreditation and licensing procedures, state law, and a series of court cases define specific health care standards in California prisons. These prison health care standards are discussed in the following section.

## **Establishment of Community Health Care Standards in Corrections**

The movement to establish a comprehensive set of standards and guidelines for jail and prison medical facilities began in earnest in the 1970s, led by professional medical associations working with law enforcement officials and federal executive agencies. Many of these efforts were in response to court decisions mandating improved correctional health care. The goal was to promulgate self-regulatory standards and accreditation procedures to help jail and prison health care facilities improve through voluntary action.

The effort has generally been successful. No prison or jail health care facility that has received professional accreditation has been successfully sued in court for failure to provide adequate health care to inmates. Currently, there are 46 juvenile and adult health facilities in 19 counties that are accredited through the California Medical Association process. However, California state prison health care facilities are not required by state law to be accredited, although recently the California Youth Authority begun to undertake the health care accreditation process for its camps and institutional facilities.

### ***Licensing and Accrediting of California Prison Health Care***

The California Medical Association has developed 59 specific community standards of medical care for prison and jail inmates, which are similar to other national health care standards. The standards draw from the current medical practice policies of the American Medical Association and portions of minimum state jail regulations (*California Administrative Code, Title 15, Section 1200*). To receive accreditation, a California prison or jail facility must meet at least 70 percent of the California Medical Association (CMA) standards on prison medical, psychiatric, and dental care. A CMA team of physicians, nurses, pharmacists, and other medical personnel conduct accreditation evaluations. Accreditation awards last for two or three years and must be updated after expiration (see appendix A for a list of standards).

Accreditation differs from licensing. Accreditation ensures that a process is in place to deliver medical, dental, and mental health services in a correctional setting. A correctional facility might not have any hospital beds and yet still meet accreditation standards, provided there is a defined system to ensure the rapid identification and transfer of ill or injured inmates to a medical facility. In other words, accreditation addresses the entire process of custody and health care, rather than one specific health care unit within a correctional setting.

The licensing process ensures that all aspects and functions of delivering care within a defined unit (e.g. a clinic, acute care facility, or a skilled nursing facility) meet a community standard. State law prescribes that no person or entity shall operate a health facility without licensed approval from the state Department of Health Services.

The Department of Corrections did not receive a license from the Department of Health Services for any of its acute care hospital facilities until 1989, when the California Men's Colony at San Luis Obispo received a license. Since then, the Department of Health Services has licensed acute care prison facilities at the California Medical Facility at Vacaville, the California Institute For Men at Chino, and the California State Prison at Corcoran. A total of 28 California state prison

health care facilities are not licensed (see Table 1 below for a list). Successful legal challenges to the quality and level of inmate health care services at these institutions gave impetus to the licensing efforts (*Durrigan vs. McCarthy, 1987*).

The Department of Corrections recently developed a new "correctional treatment center" licensing category for prison infirmaries, as required by 1989 legislation (*California Health and Safety Code, Division 2, Section 1250 (j) (1)*). It took the Department nearly eight years to promulgate regulations for the new correctional treatment centers. Correctional treatment centers are authorized to provide the following health care services: medical, surgical, psychiatric, psychological, nursing, pharmacy, dental, dietary, laboratory, radiology, prenatal, and others as approved by the Department of Health Services.

Currently, Pleasant Valley State Prison in Coalinga is the only prison in the state system to receive a correctional treatment center license (despite psychiatric and nursing vacancies). Hiring sufficient medical staff to meet state licensing standards and to upgrade treatment facilities is an ongoing problem. Nonetheless, correctional officials are confident that as many as three correctional treatment centers will be ready for licensing before the end of 1998, and that most of the remaining facilities will receive licenses over the next five years.

For female inmate health care services, the Department of Corrections has a licensed skilled nursing facility at the Central California Women's Facility in Chowchilla. The other three women's prisons do not yet have licensed health care facilities, but one (Valley State Prison) is scheduled for licensure in the next five years. Inadequate staffing of medical personnel is a key factor in the delay.



- |   |   |   |
|---|---|---|
| 1. Avenal State Prison–Avenal                             | 12. California State Prison–San Quentin   | 23. Ironwood State Prison–Blythe  |
| 2. California Correctional Center–Susanville              | 13. California State Prison, Solano–Vacaville   | 24. Mule Creek State Prison–Ione  |
| 3. California Correctional Institution–Tehachapi          | 14. California Substance Abuse Treatment Facility and State Prison at Corcoran–Corcoran | 25. North Kern State Prison–Delano                                      |
| 4. California Institution for men–Chino                   | 15. Calipatria State Prison–Calipatria  | 26. Northern California Women’s Facility–Stockton                       |
| 5. California Institution for Women–Frontera              | 16. Centinela State Prison–Imperial   | 27. Pelican Bay State Prison–Crescent City                              |
| 6. California Medical Facility–Vacaville                  | 17. Central California Women’s Facility–Chowchilla                                      | 28. Pleasant Valley State Prison–Coalinga                               |
| 7. California Men’s Colony–San Luis Obispo                | 18. Chuckawalla Valley State Prison–Blythe  | 29. Richard J. Donovan Correctional Facility at Rock Mountain–San Diego |
| 8. California Rehabilitation Center–Norco                 | 19. Correctional Training Facility–Soledad  | 30. Salinas Valley State Prison–Soledad                                 |
| 9. California State Prison–Corcoran                       | 20. Deuel Vocational Institution–Tracy  | 31. Sierra Conservation Center–Jamestown                                |
| 10. California State Prison, Los Angeles County–Lancaster | 21. Folsom State Prison–Represas  | 32. Valley State Prison for Women–Chowchilla                            |
| 11. California State Prison, Sacramento–Represas          | 22. High Desert State Prison–Susanville   | 33. Wasco State Prison Reception Center–Wasco                           |

# California Department of Corrections

## Prison Addresses and Phone Numbers

1. **Avenal State Prison (ASP)**  
#1 Kings Way, 92104  
P.O. Box 8  
Avenal, CA 93204  
(209) 386-0587
2. **California Correctional Center (CCC)**  
711-045 Center Road  
P.O. Box 790  
Susanville, CA 96130  
(530) 257-2181
3. **California Correctional Institution (CCI)**  
24900 Hwy 202, 93561  
P.O. Box 1031  
Tehachapi, CA 93581  
(805) 822-4402
4. **California Institution for Men (CIM)**  
14901 South Central Ave., 91710  
P.O. Box 128  
Chino, CA 91708  
(909) 597-1821
5. **California Institution for Women (CIW)**  
16756 Chino-Corona Rd.  
Frontera, CA 91720  
P.O. Box 6000  
Corona, CA 91718  
(909) 597-1771
6. **California Medical Facility (CMF)**  
1600 California Dr., 95687  
P.O. Box 2000  
Vacaville, CA 95696  
(707) 448-6841
7. **California Men's Colony (CMC)**  
Highway 1  
P.O. Box 8101  
San Luis Obispo, CA 93409-8101  
(805) 547-7900
8. **California Rehabilitation Center (CRC)**  
5<sup>th</sup> Street and Western  
P.O. Box 1841  
Norco, CA 91760  
(909) 737-2683
9. **California State Prison, Corcoran (COR)**  
4001 King Ave.  
P.O. Box 8800  
Corcoran, CA 93212-8309  
(209) 992-8800
10. **California State Prison, Los Angeles County (LAC)**  
44750 60<sup>th</sup> St., West  
Lancaster, CA 93536-7620  
(805) 729-2000
11. **California State Prison, Sacramento (SAC)**  
P.O. Box 29  
Represa, CA 95671  
(916) 985-8610
12. **California State Prison, San Quentin (SQ)**  
San Quentin, CA 94964  
(415) 454-1460
13. **California State Prison, Solano (SOL)**  
2100 Peabody Rd., 95687  
P.O. Box 4000  
Vacaville, CA 95696-4000  
(707) 451-0182
14. **California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF)**  
900 Quebec Ave.  
P.O. Box 7100  
Corcoran, CA 93212  
(209) 992-7100
15. **Calipatria State Prison (CAL)**  
7018 Blair Rd.  
P.O. Box 5001  
Calipatria, CA 92233  
(760) 348-7000
16. **Centinela State Prison (CEN)**  
2302 Brown Rd., 92251  
P.O. Box 731  
Imperial, CA 92251-0731  
(760) 337-7900
17. **Central California Women's Facility (CCWF)**  
23370 Road 22, 93610  
P.O. Box 1501  
Chowchilla, CA 93610-1501  
(209) 665-5531
18. **Chuckawalla Valley State Prison (CVSP)**  
P.O. Box 2289, 92226  
19025 Wileys Well Rd.  
Blythe, CA 92225  
(760) 922-5300
19. **Correctional Training Facility (CTF)**  
Highway 101 North  
P.O. Box 686  
Soledad, CA 93960  
(408) 678-3951
20. **Deuel Vocational Institution (DV)**  
23500 Kasson Rd.  
P.O. Box 400  
Tracy, CA 95376  
(209) 466-8055
21. **Folsom State Prison (FSP)**  
Prison Road  
P.O. Box 71  
Represa, CA 95671  
(916) 985-2561
22. **High Desert State Prison (HDSP)**  
475-750 Rice Canyon Rd.  
Susanville, CA 96130  
P.O. Box 750  
Susanville, CA 96130  
(530) 251-5100
23. **Ironwood State Prison (IRON)**  
19005 Wileys Well Rd.  
P.O. Box 2229  
Blythe, CA 92226  
(760) 921-3000
24. **Mule Creek State Prison (MCSP)**  
P.O. Box 409099  
4001 Highway 104  
Ione, CA 95640  
(209) 274-4911
25. **North Kern State Prison (NKSP)**  
2737 West Cecil Ave.  
P.O. Box 567  
Delano, CA 93215-0567  
(805) 721-2345
26. **Northern California Women's Facility (NCWF)**  
715 E. Arch Rd., 95025  
P.O. Box 213006  
Stockton, CA 95213-9006  
(209) 943-1600
27. **Pelican Bay State Prison (PBSP)**  
5905 Lake Earl Dr., 95531  
P.O. Box 7000  
Crescent City, CA 95531-7000  
(707) 465-1000
28. **Pleasant Valley State Prison (PVSP)**  
24863 West Jayne Ave., 93210  
P.O. Box 8500  
Coalinga, CA 93210-1135  
(209) 935-4900
29. **Richard J. Donovan Correctional Facility at Rock Mountain (RJD)**  
480 Alta Road  
San Diego, CA 92179  
(619) 661-6500
30. **Salinas Valley State Prison (SVSP)**  
31625 Hwy. 101, 93960  
P.O. Box 1020  
Soledad, CA 93960-1020  
(408) 678-5500
31. **Sierra Conservation Center (SCC)**  
5100 O'Byrnes Ferry Rd.  
P.O. Box 497  
Jamestown, CA 95327  
(209) 984-5291
32. **Valley State Prison for Women (VSPW)**  
21633 Ave. 24, 93610  
P.O. Box 99  
Chowchilla, CA 93610-0099  
(209) 665-6100
33. **Wasco State Prison-Reception Center (WSP)**  
701 Scofield Ave., 93280  
P.O. Box 8800  
Wasco, CA 93280-8800  
(805) 758-8400

The following table lists which California prison medical facilities are licensed, which are not, the number of beds, and type of facility.

**Table 1**  
**California State Prison Medical Facilities**

Name	Facility Type	Beds	License
High Desert State Prison, Susanville	CTC	32	No
California Correction Institute, Tehachapi	INFIRM	16	No
California Men's Institute, Chino	ACH	80	Yes
Centinela State Prison, Imperial	CTC	15	No
Central California Women's Facility, Chowchilla	SNF	39	No
Valley State Prison For Women, Chowchilla	INFIRM	20	No
California Institute For Women, Corona	CTC	17	No
Calipatria State Prison, Calipatria	INFIRM	20	No
Ironwood State Prison, Blythe	CTC	15	No
Chuckawalla Valley State Prison, Blythe	INFIRM	14	No
California Training Facility, Soledad	INFIRM	30	No
Deuel Vocational Institute, Tracy	INFIRM	27	No
Mule Creek State Prison, Ione	CTC	12	No
Northern California Women's Facility, Stockton	INFIRM	4	No
Pelican Bay State Prison, Crescent City	CTC	22	No
R. J. Donovan Correctional Facility, San Diego	CTC	21	No
Wasco State Prison, Wasco	CTC	18	No
North Kern State Prison, Delano	CTC	18	No
California Medical Facility, Vacaville	ACH	65	Yes
California Medical Facility, Vacaville	HOSPICE	17	No
California Men's Colony, San Luis Obispo	ACH	39	Yes
California Rehabilitation Center, Norco	INFIRM	13	No
Avenal State Prison	INFIRM	29	No
California State Prison, Corcoran I	ACH	75	Yes
California Conservation Center, Jamestown	INFIRM	25	No
California State Prison, Corcoran II	CTC	22	No
California State Prison, Folsom	INFIRM	18	No
California State Prison, Los Angeles	CTC	18	No
California State Prison, San Quentin	INFIRM	31	No
California State Prison, Sacramento	CTC	17	No
California State Prison, Solano	CTC	15	No
Pleasant Valley State Prison, Coalinga	CTC	17	Yes
Salinas Valley State Prison	CTC	<u>24</u>	<u>No</u>
		<b>839</b>	<b>5</b>
 <b>Correctional Treatment Center (CTC)</b>			
<b>Infirmery (INFIRM)</b>			
<b>Acute Care Hospital (ACH)</b>			
<b>Skilled Nursing Facility(SNF)</b>			

Source: Department of Corrections, Health Care Service Division, 1998





## **HEALTH CARE SCREENING FOR MALE PRISON INMATES**

One of the basic responsibilities of the Department of Corrections is to ensure that an inmate remains healthy while in custody. The following section focuses on how, when, and under what circumstances male inmates receive medical care. Health care provision is structured according to an inmate's security, or level of risk status. Female inmate care, general standards of care, resources, and responsible personnel within the department are discussed later in the report.

### **Classification and Security Screening at Prison Reception Centers**

Male inmates first encounter the Department of Corrections when they arrive by bus from a county facility and are driven through the prison gates into a reception center.<sup>2</sup> Upon arrival, an inmate is directed to follow clearly painted lines on the ground to an initial screening. Before the California Department of Corrections assigns an inmate to a prison within the system, he must go through a lengthy security screening process at a reception center. The top priority of the screening process is to determine an inmate's security status. A "level four" inmate is considered the highest security risk, while a "level one" inmate is considered the least risk. Generally speaking, those inmates sentenced to life in prison will be classified as level four. Inmate security classification is a very complicated process that is under constant scrutiny.

An inmate's security classification dictates the prison in which that inmate will be housed and where he will receive acute health care or psychiatric care when needed. There are a number of prison facilities which house most of the prison system level four male inmates: New Folsom State Prison, Calipatria State Prison, California Correctional Institution, California State Prison Corcoran, California State Prison Los Angeles, High Desert State Prison Susanville, and Pelican Bay State Prison.

Level four female inmates are housed at the California Institute for Women in Frontera and the Central California Women's Facility in Chowchilla. Most level 1 through 3 female inmates are housed at the Northern California Facility for Women in Stockton and Valley State Prison in Chowchilla.

### **Reception Center Identification and Processing**

During the medical stage of the initial reception center screening, inmates are examined to determine if they have a medical or mental health condition, and are administered a tuberculin test. If an inmate answers "yes" to any of the health questions asked on the form, a registered nurse is required to assess the situation for immediate action. If an inmate answers the questions without raising a "red flag," he will move into the standardized identification and security classification process. It takes about 10 to 15 minutes to complete the medical stage of the initial screening.

Inmates are then placed in holding cells that are located directly around the circumference of the reception area. There they await their turn to process the personal belongings they brought with them from county jail (Los Angeles and Orange are the only counties which allow inmates to take their personal belongings to the Department of Corrections).

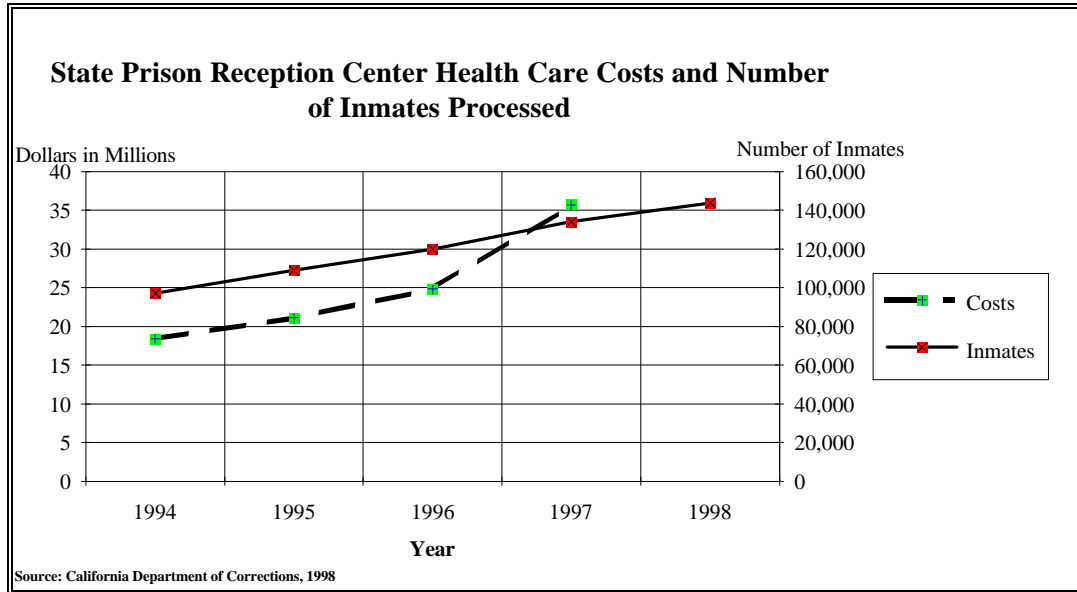
Since 1993, the number of new felons and parole violators entering state prison reception centers has increased from 98,000 to over 134,000 per year. Already this fiscal year, nearly 144,000 inmates have been processed in state prison reception centers and the number could reach over 215,000 before the end of June 1998. Despite efforts by the California Department of Corrections and the Board of Corrections to streamline the process for transferring health information from counties to the state correctional reception centers, medical record information often does not accompany an inmate from either the committing county nor the Department of Corrections Regional Parole Division. On four different occasions during visits to state prison reception centers, not one inmate was observed bringing a prior medical record to the medical and mental health screening areas. Moreover, reception center medical staff did not expect any medical record information to be forwarded from the state parole division or the county jails before inmate screening was completed.

Department of Corrections officials estimate that 30 percent of the medical testing procedures undertaken at prison reception centers might duplicate county medical tests. Since 1993, health care costs at reception centers have increased by over 48 percent, which is more than twice the rate of increase for the general prison population over that time period. Several county and state health care officials roughly estimate that the annual medical cost of duplicated county/state health care services at state prison reception centers is \$5 million.

State prison reception centers for men are located in the following areas throughout the state:

- California Correctional Institution, Kern County.
- California Institution for Men, San Bernardino County.
- Deuel Vocational Institution, San Joaquin County.
- Donovan State Prison, San Diego County.
- High Desert State Prison, Lassen County.
- North Kern State Prison, Kern County.
- San Quentin State Prison, Marin County.
- Wasco State Prison, Kern County.

Chart 4



Given the common lack of any background medical information, the Department of Corrections must thoroughly examine each new inmate to prevent the spreading of blood pathogen and other diseases among the inmate population. State prison officials contend that some of society's indigents, homeless, or "marginally functioning" people who do not receive health care on the outside find their way into the prison system because they know they will receive health care.<sup>3</sup>

Due to high recidivism rates (approximately 60 percent in 1996), there is a significant probability that a former inmate will return to a prison reception center. However, there is a slow turnaround rate in forwarding/accessing medical records from parole archives to prison reception centers (one to six weeks), which effectively requires a complete medical evaluation of returning parolees due to their potential high-risk behavior. Correctional officials state that a significant number of healthy inmates leave prison, are re-arrested (sometimes within weeks), are brought back to reception centers and test positive for a communicable disease.

Another reason for the complete state prison health care screening is that many jails are overwhelmed and do not fully test inmates, as required by law (*California Administrative Code, Title 15, Section 1207*). Officials state that this is particularly true of returning parolees and inmates from Los Angeles county jail. One prison official asserted that prison reception centers are becoming the "medical dumping ground" for county jails because county jails do not provide adequate health care to inmates prior to sentencing by the courts. Scabies, venereal disease, hepatitis, mental health illness, and tuberculosis are among the diseases most commonly found in inmates sent to prison reception centers from county jails (see page 37 for a discussion of treating infectious diseases). In addition, mentally ill offenders may not be on medication when they arrive at reception centers and can suffer as a result.

Within 72 hours after the initial screening and classification process, the results of an inmate's tuberculin test are known. If there are no problems, the inmate will next receive a standard health examination and a psychometric personality assessment, which is used to identify potential behavioral and personality problems. Finally, inmates are given an education skills assessment test

that is the equivalent of a high school education test. The purpose of the skills assessment test is to determine an inmate's ability to learn rules and follow orders. At present, the skills test results do not serve an educational or vocational purpose. Department officials indicate that over half the inmates do not score high enough on the test to graduate from high school.

Recently, the issue of an inmate's mental and developmental capabilities were raised in a class-action lawsuit against the Department of Corrections (*Clark vs. Wilson*). The lawsuit contends that the Department of Corrections does not identify female or male inmates with major learning problems such as developmental disabilities and mental retardation. Persons with mental retardation are usually defined as those with an IQ below 70, having a childlike quality of thinking, and slowness in learning new materials.<sup>4</sup> Although the Department of Corrections has a vocational training program (Category K program) for men located at the California Men's Colony, inmates are rarely placed in the program despite their disability. The lawsuit alleges that inmates with developmental disabilities are abused or manipulated by other inmates to commit wrongful acts which may result in disciplinary action, higher security level classifications, and loss of "good time" credits. Lawyers for the plaintiffs in the lawsuit contend that 1,500 inmates in California state prisons are developmentally disabled. No inmates were observed for this report to have been screened for these disabilities during the skill assessment test. The lawsuit is scheduled for trial in June 1998 in U.S. District Court.

### **Mental Health Screening at Prison Reception Centers**

Two major lawsuits focused attention on the condition of mental health care in state prisons: *Gates vs. Dukemjian (1989)* and *Coleman vs. Wilson (1992)*. The Gates case alleged inadequate psychiatric care to outpatient inmates at the California Medical Facility in Vacaville. A Consent Decree was reached by the two parties resulting in better access and treatment for outpatient inmates. The Coleman case alleged that the entire state prison mental health care system (including screening, medical records, treatment and access to care) was inadequate and constituted cruel and unusual punishment. A series of heat and medication-related deaths of prisoners receiving psychotropic drugs at California Medical Facility in Vacaville prompted the law suit. A federal court order was issued requiring the Department of Corrections to develop a plan to remedy this deficiency. The court also appointed a Special Master to oversee the California Department of Corrections' effort to develop a system wide Mental Health Service Delivery System (MHSDS).

Prior to the Coleman Consent Decree, many of the mental health screening and treatment approaches used in reception centers were ineffective in identifying inmate problems. The Department system wide Mental Health Service Delivery plan developed in response to the *Coleman vs. Wilson* lawsuit includes the following elements:

- Procedures for screening and identifying mentally ill inmates;
- Staffing standards for mental health care;
- Access to mental health care in mainline prisons;
- Proper use and monitoring of psychotropic medication;

- A committee process (medical and custodial staff) to place and/or retain a mentally ill inmate in administrative segregation or segregated housing units (custody staff previously had sole responsibility);
- Monitored use of tasers, 37mm guns, mechanical restraints, and involuntary medication;
- Regular maintenance of mental health records; and
- Development of a mental health information tracking system.

Pre-screening reviews and psychometric evaluations for mental health are now a standard part of the reception center screening process. The process begins after an inmate arrives on a bus from a county staging area, as described above. Inmates are immediately screened for tuberculosis and for any possible psychiatric condition. They answer a simple question and answer form. If a “red flag” is raised by an inmate response, a psychologist can intervene to determine an appropriate level of care. If there are no “red flags” the inmate will immediately continue with other custodial and administrative processing requirements. Many of the custodial staff at reception centers go through an annual series of mental health training classes which are designed to help identify and treat inmates with mental health problems.

After 72 hours an inmate will receive a more thorough health care screening, including a diagnostic test which identifies most of the expected 10 to 13 percent of inmates requiring psychiatric evaluations. A psychiatric evaluation should take place within 18 days, provided the inmate has completed all required health care screening. The result is that inmates are screened or evaluated for mental illness at four different levels within the reception center process, to prevent them from falling through cracks in the system.<sup>5</sup>

According to the 1992 Scarlett Carp Report (system wide mental health needs assessment), the average number of mentally ill inmates in the state prison system at any one time is about 7.9 percent.<sup>6</sup> California Department Corrections medical staff interviewed for this report say that 10 to 18 percent of the inmates passing through reception centers require some form of mental health service. (That figure is less than the 29 percent cited in the *Coleman vs. Wilson* case, in which the court found that inmates with serious mental disorders were receiving inadequate psychiatric care and treatment.) Based upon California Department Corrections staff estimations, on any given day up to 27,600 inmates housed in Department of Corrections’ facilities could require mental health services. According to a recent national study by U.S. Department of Justice, as many as ten percent of all prison inmates suffer from one or more of the most severe mental illnesses: schizophrenia, manic depression or major depression. This incidence is four times greater than that found in the general population.

### ***Levels of Mental Health Care at Prison Reception Centers***

If an inmate requires immediate placement in a secured bed for observation of mental illness, he will be removed from the mainline reception area and placed in a correctional treatment center or infirmary crisis bed on an outpatient basis. Patients in correctional treatment (CTC) crisis beds generally require short term stays of less than 10 days. In most cases, the patients are suicidal, severely depressed, acutely psychotic, or suffering panic attacks. In an extreme case in which an inmate has serious mental disorders requiring intensive care, he will be immediately referred for

inpatient treatment to either the California Medical Facility in Vacaville, the California Men's Colony in San Luis Obispo or Atascadero State Hospital, depending on the availability of beds. Reception center medical staff classifies inmates into broad categories to determine the appropriate level of mental health care. Two of those categories are used extensively: inmates in need of inpatient evaluation and inmates with major mental disorders. Each type of inmate is placed in a separate housing group.

Seventy percent of the inmates with major mental disorders suffer from psychosis resulting from chemical reactions in the brain. Mind-altering drugs such as LSD, PCP, and methamphetamine are generally the primary causes. These patients can usually heal within six months with proper care. They are then reassigned from the reception center to the mainline prison population. Very few inmates are held longer than six months at state prison reception centers for mental health reasons.

Inmates on psychotropic drugs who are awaiting assignment to a mainline prison are required to participate in a "heat plan" (as required by the *Coleman vs. Wilson* decision) designed to prevent adverse reactions. On warm days, for example, these inmates must come inside their residential units to cool down and prevent any type of heat reaction or stroke. When the temperature exceeds 85 degrees in their cells they are required to take cool showers to lower body temperatures.

Prison reception centers are not equipped to treat drug addiction. The general operating assumption is that most inmates have already been screened and treated for drug related problems in county jail detoxification facilities prior to sentencing as required by law (*California Administrative Code, Title 15, Division I, Section 1213*). However, there is no local or state monitoring to ensure that county jails comply with this process. Anecdotal information suggests that when county level offenders volunteer for drug or alcohol treatment there often is no program available in county jails.

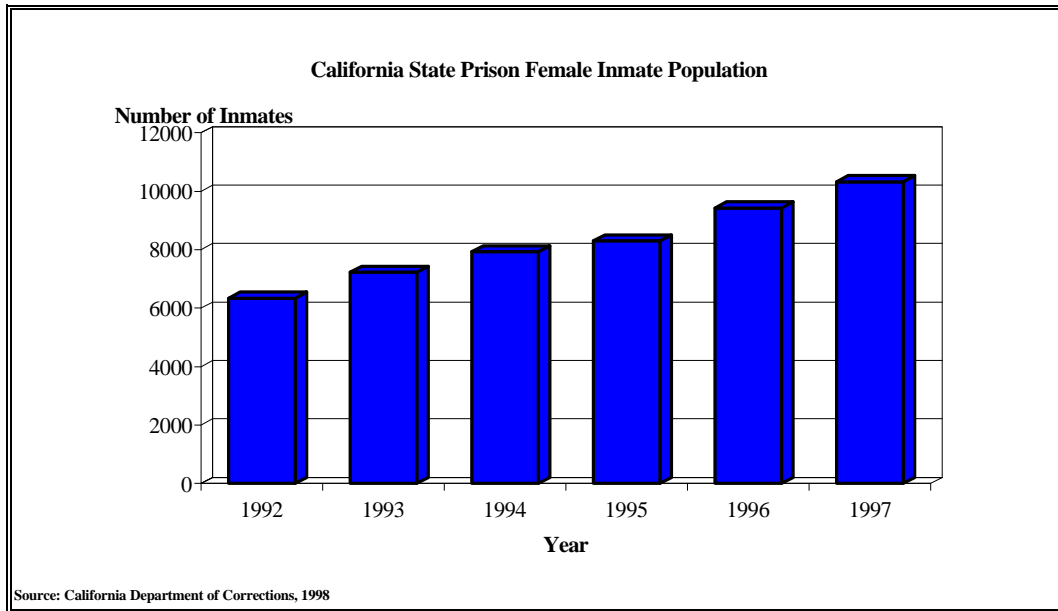
Felon parole violators also enter the state prison reception centers under the jurisdiction of the Department of Corrections Parole Division. The Department estimates that 85 percent of all parole violators are substance abusers. Substance abuse is clearly a substantial program for parolees.

## PRISON HEALTH CARE SERVICES FOR FEMALE INMATES

The number of female inmates housed in state prisons has increased by 39 percent since 1992. This is a faster rate of increase than that of the male inmate population, which increased by 31 percent over the same period. Nonetheless, the number of male inmates exceeds the number of female by a ratio of ten to one.

Nearly 70 percent of the female inmates are mothers of children under 18 years of age. Over a third (36 percent) were sentenced for drug-abuse related crimes.

**Chart 5**



The rapid increase of female prison inmates has focused attention on their health care needs, particularly for substance abuse and pregnancy. There have been a series of administrative, legislative and judicial actions which have resulted in substantial health care improvements for the female offender population, beginning with the reception center screening process.

### Reception Center Screening for Female Inmates

In the last fiscal year, 9,908 new female inmates passed through the Department of Corrections' four reception centers for women. The reception center process usually takes from 30 to 60 days to complete, absent any major medical or physical complications. Recent litigation (*Shumate vs. Wilson, 1996*) and recommendations from a Department of Corrections task force have resulted in improved screening protocols for female inmates entering all prison reception centers. Upon arriving at the reception center gate, a female inmate is immediately administered a preliminary medical screening by a medical technical assistant for any medication needs, health records, or any potential medical condition which warrants attention. This immediate attention is necessary, according to officials, because the inmate may have a condition such as pregnancy that must be addressed. For example, if an inmate answers positive to any of a series of questions during the

initial screening process, a registered nurse is contacted for an assessment and disposition. If the nurse requests a referral, the inmate will be taken from the screening area and sent to a special housing area for immediate evaluation.

Department health care officials estimate that up to 85 percent of the pregnant inmates entering prison reception centers are high health risk. Pregnant inmates at Valley State Prison (VSP) or the Correctional Institute for Women (CIW), remain there for the duration of their pregnancies. If a pregnant female enters a reception center at either of the other two female prisons, she will be transferred to Valley State Prison (VSP).

Pregnant inmates are informed of their right to receive care from the doctor of their choice. They are then assigned to outpatient living quarters for pregnant women. If there are no major medical complications, they will remain in the general population until the sixth month of gestation, and then moved into a special housing unit. If a pregnant inmate is on methadone or withdrawing from heroin, she will be sent immediately to CIW, which has a contract with Riverside General hospital to stabilize and monitor high risk pregnancies. The inmate will remain there for the term of her pregnancy.

Women inmates entering a prison reception center who are not immediately flagged during the bus screening process, are examined for mental and physical illness, given a tuberculosis test, and provided the care and treatment required by law (*California Penal Code, Section 3403*). This includes a pregnancy test along with tests for tetanus and infectious and communicable diseases. If an inmate tests positive for tuberculosis, she can be isolated immediately at any of the reception centers.

Female inmates who volunteer to screen for HIV receive confidential counseling and educational information about the disease and can be treated while incarcerated. Medical staff are trained to withhold confidential information from custody staff. The same is true for drug testing; if someone is impaired at the time of screening, the information will remain confidential.

### **Mental Health Screening For Female Inmates In Reception Centers**

One of the requirements of the *Coleman vs. Wilson, 1992* settlement is that the Department of Corrections develop a tracking and monitoring system as part of the statewide prison mental health delivery system.

Female inmates see doctors six to ten times more than men on the average, according to Department medical personnel estimates. This higher ratio results in part from deep bouts of depression caused by the absence of family, children, and adjustment to prison life, according to psychiatric staff at both women's facilities. Department of Corrections officials estimate that 10 to 15 percent of the female inmates entering prison reception centers are suffering from depression and require treatment.



The California Institute for Women in Frontera treats the majority of female inmates diagnosed at prison reception centers as bipolar, (multiple personality disorder), chronic (manic depressive disorders), and or schizophrenic in the facility's Enhanced Outpatient Program. Female inmates entering the Central California Women's Facility at Chowchilla who suffer from these mental illnesses are usually referred to a contract facility for care. Inmates are allowed to join the mainline prison population after treatment or therapy is completed.

## **Pregnancy**

In 1987, the California Blue Ribbon Commission on Inmate Population was created to look at the issues involved in managing the state's inmate population. The special needs of the female offender population was one of the problem areas identified by the Commission. In 1991, two legislative initiatives addressed the issue of female inmate health care:

- *AB 900 (Roybal-Allard)* created a special task force to develop a five-year master plan for the health care of female prisoners.
- *SCR 33 (McCorquodale)* established a committee to study the needs of female prisoners and to provide alternatives to prison for some offenders who have special child care needs.

These laws have resulted in better medical management of female inmate health care needs and increased resources and services directed to meet those needs. A female inmate who may be pregnant has the right to have a pregnancy test conducted by the doctor of her choice (*California Penal Code, Sections 3403 and 4023.6*). If she is pregnant, she is entitled to be cared for by the doctor of her choice. Logistical questions are raised by these rights to private medical care, as well as the additional expense. Department medical officials interviewed for this report were generally unaware of the law. However, the Department has a long standing policy requiring an inmate to pay for any and all costs associated with personal or private physician-rendered services. In addition, any diagnosis or prescription for drugs rendered by private physicians must be approved by the prison chief medical officer. Department medical officials state that inmates seldom, if ever, exercise their prerogative to be cared for by a private doctor.

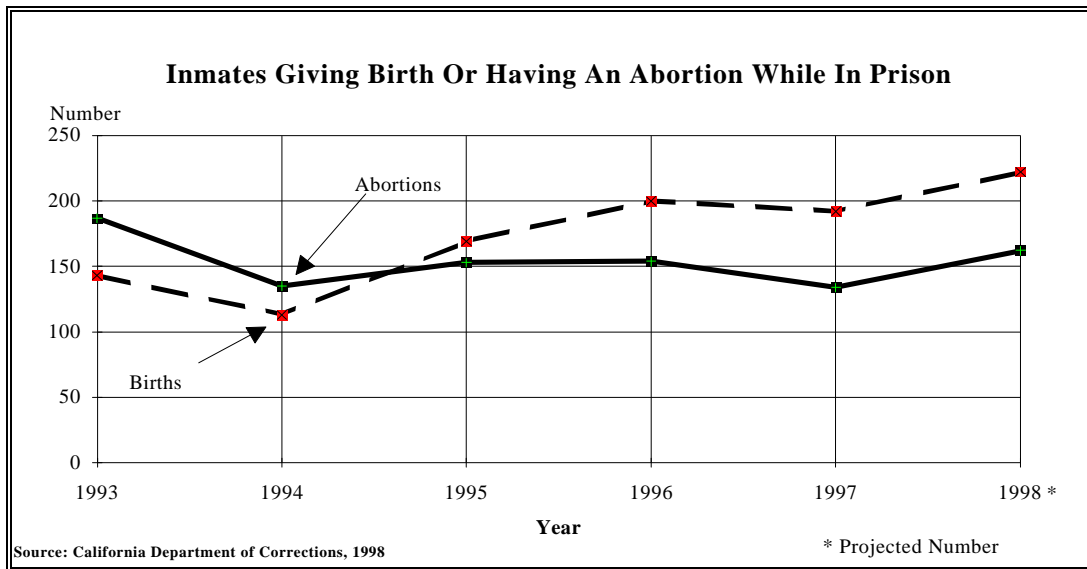
An inmate who is pregnant and chooses to have a baby will usually be cared for throughout her full pregnancy term at a prison facility. The Valley State Prison in Chowchilla has certified medical staff, including obstetric specialists, who work for the institution and provide prenatal care. Madera Community Hospital is under contract to provide birthing and delivery services. Previously, birthing service contracts were spread out across the state, based on the location of the pregnant inmate. Scarce resources and poor coordination led to a change in policy. In Fiscal Year 1996-97, 182 inmates gave birth at Madera Community Hospital and ten inmates gave birth at Riverside General Hospital.

Female inmates are also eligible for abortion under current law (*California Penal Code, Section 3405 and 4028*). It entitles every female inmate to family planning information and abortion services

for up to 22 weeks of gestation of her pregnancy or at least 60 days before her scheduled release date (*California Penal Code, Sections 3409 and 4023.5*).

Department of Corrections medical officials estimate that as many as six percent of the women sentenced to prison are pregnant at the time of arrival. That would be approximately 450 inmates. Department data suggests that this is a high estimate, and that between 350 and 400 female inmates are pregnant upon arrival. While the number of pregnant females entering the Department of Corrections since 1993 has increased, the number of females giving birth or having abortions or miscarriages has fluctuated from year to year.

**Chart 6**



Medi-Cal is the only comparable source of abortion-related data available in California. State law does not require hospitals and clinics to collect data on the number of abortions performed annually. According to the latest tabulated data from the California Department of Health Services, in 1995 the statewide ratio of Medi-Cal births to abortions was 2 to 1 (229,000 births to 113,000 abortions). As shown in Chart 6, the ratio was 1 to 1 in mid 1994, with a subsequent increase in the relative number of births.

The average price for prenatal care and delivery is about \$2,690 per inmate, with even higher costs for intensive care recovery resulting from complications at \$3,300 to \$4,300 per day. Pregnant female inmates who are about to give birth require private ambulance transportation and the accompaniment of one armed correction officer. Both Valley State Prison and the California Institute for Women have contracts with private specialists who are experts in treating pregnancies complicated by HIV and tuberculosis. Some pregnant inmates with HIV may be active tuberculosis carriers who do not test positive for the HIV disease.

## **Mother Inmates and Infant Programs**

After a female inmate gives birth in prison, she must still serve out her sentence. Some inmates allow family relatives or close friends to care for the infant. Still others choose to put their infant up for adoption. The Department of Corrections does not collect data on what happens to the babies, so there is no information as to the number of infants who are cared for by family members, friends or sent to adoption agencies. In addition, children of inmates who do not stay with relatives are placed by the courts under the custody of county Child Protective Services.

The Department of Social Services, which is responsible for licensing foster care and group care homes, collects data on placements but does not distinguish between the children of incarcerated parents and other children. According to Department of Social Services officials, there are 13,000 children in California in foster care or group care homes. Attempts to obtain information about the children of incarcerated parents and their characteristics and placement proved unsuccessful. Some advocates believe that without some kind of county or state-coordinated case management of these children, they may be at risk for many negative outcomes including poor school achievement, substance abuse, delinquency, and even intergenerational incarceration.

Recent law (*Welfare and Institution Code, Section 309 (d)*) requires that any relative of an inmate mother who agrees to care for a child must undergo a criminal background screening and a safety and suitable living assessment by a county social worker. In addition, the Department of Social Services, two counties (Madera and Riverside) with proximate foster care facilities, and the Department of Corrections Community Services Division have agreed to work with each other to coordinate the child placement options available to pregnant inmates and/or inmate mothers. Included in these options are foster care, community care, care by a relative or a friend, and volunteer care by church organizations.

The Community Prisoner Mother Program is offered by the Department of Corrections, Community Services Division, to qualified inmate mothers. The program was established in 1978 to allow qualified inmate mothers to be housed with their new babies or with children under 6 years old in a public or private supervised setting outside the prison walls (*California Penal Code, Section 3410*). Inmates with terms of 6 years or less are eligible to apply for the program.

The number of participating pregnant inmates has grown dramatically since the program was established. Presently, six community correction facilities with 16 beds each (96 total) have program contracts through a competitive bidding process with the Department of Corrections Community Services Division. (The Parole Division administered the program until 1997.) The estimated cost is approximately \$2.86 million, or an annual cost of \$30,513 per inmate bed. These six community contractors are:

- LA CADA-GRACE'S PLACE, Santa Fe Springs.
- PROTOTYPES, Pomona.
- DESERT COUNSELING-MAKIT PROGRAM, Bakersfield.
- VOLUNTEERS OF AMERICA, BOOTH FAMILY APARTMENTS, Oakland.
- FRIENDS OUTSIDE, Salinas.
- EAST BAY COMMUNITY RECOVERY PROJECT, Oakland.

Nearly 200 inmates gave birth in the state prison system in 1997, so more than half did not have the opportunity to keep their infants with them. Previously, up to 30 percent of the eligible spaces in the program were reserved for county-level mother inmates. The criteria for enrollment is restrictive. For example, if a female inmate is convicted of a sex offense, child abuse, or a violent offense which may involve drugs, she is not eligible. The majority of female offenders recently sentenced to prison are of childbearing age; 70 percent were convicted of drug or violent offenses in 1997.

Although no formal evaluation has been conducted, department officials consider the Community Prison Mother Program to be successful based on the number of inmate mothers who complete it. The Community Resources Division, which assumed program responsibility last year, has approved an evaluation proposal in which researchers at UCLA will undertake a recidivism discharge study of the inmate mothers who complete the program, compared to a control group of Department of Corrections female inmates. A preliminary analysis is expected to be completed before the end of 1998.

Department officials state that the program has not expanded beyond six facilities because there are many non-institutional community resources available for mothers on parole with children.

## **HIV Care**

The Department of Corrections has two policies for female inmates who have the HIV disease, depending on the symptoms. Inmates who test positive for HIV are generally placed in special housing units at the California Institute for Women or in the disabled housing unit for inmates at the Central California Facility for Women in Chowchilla. However, if an inmate tests positive for the HIV disease and is asymptomatic, the policy is to allow her be housed with the general population. HIV testing is voluntary except for certain sex crimes, when it is mandatory (*California Health and Safety Code, Section 199.95*).

The California Institute for Women contracts with Riverside General Hospital to treat female felons with the HIV disease after they become sick. If an inmate is gravely ill, the Director of the Department of Corrections may grant a compassion release. If release is not granted, she may be placed in a local unsecured hospice. For example, some female inmates dying of AIDS have been placed in a hospice. These options are also available to female inmates who are dying of other diseases.

Educational materials about the HIV disease are required by law to be available to inmates, subject to funding (*California Penal Code, Section 4018.1*). Recently some prisoner rights advocates have contended that the Department of Corrections does not sufficiently promote health education for asymptomatic inmates with HIV, or sufficiently support healthy living programs within the prison system.<sup>7</sup> According to one department medical official, women inmates are not encouraged enough to participate in health education and health promotion programs.

## **Inmates With Tuberculosis**

Nearly eighteen percent of the state prison female inmate population skin-tested positive for tuberculosis in Fiscal Year 1995-96 (a total of 1,959 inmates). However, only 11 female inmates had active infections that required medical isolation and treatment. Inmates infected with tuberculosis can be cared for in the skilled nursing medical facility of the Central California Facility for Women at Chowchilla, but must be sent to Riverside General Hospital if they are housed at the California Institute for Women in Frontera.



## HEALTH CARE FOR MALE INMATES IN ASSIGNED PRISON SETTING

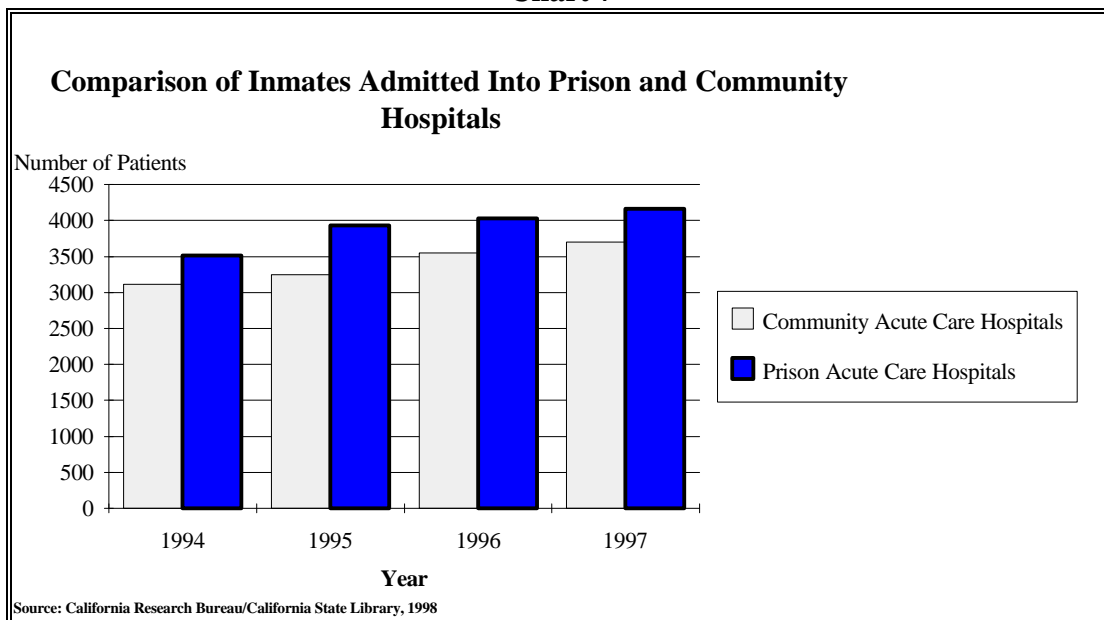
### Acute Care Facilities

The scope and range of health and therapeutic services available in a prison setting varies depending on the security status and the health of an inmate. The Department of Corrections' four licensed acute care prison hospitals have the broadest range of health and therapeutic care available and are the principal inpatient centers for the entire male statewide inmate population, especially level four inmates. Acute care hospitals have an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Licensed skilled nursing services are not provided in any of the Department's four acute care facilities, although the Central California Women's Facility in Chowchilla has a licensed skilled nursing facility for female inmates with sub-acute care needs.

The Department of Corrections began collecting system wide health care data on medical, dental, and psychiatric inpatient and outpatient inmate services in 1992. (See Chart 8, page 31).

Prison health care facilities are experiencing an increasing demand for inpatient health care, in part because of the increasing number of level four high risk inmates and new departmental transfer policies designed to ensure treatment in in-house facilities instead of contract medical facilities. However, the number of inmates admitted into community acute care facilities since 1994 also has grown, as shown in Chart 7 below.

Chart 7



The *California Men's Colony at San Luis Obispo* is a large, combined medical facility and prison. It houses 6,330 inmates classified at security levels one through three. The acute care hospital delivers health care and psychiatric treatment and evaluation to the inmate population. It was the first state prison medical facility to be licensed by the Department of Health Services (in 1989).

All level one through three inmates from other correctional institutions (approximately 89,000 inmates or 60 percent of the prison population) who are in need of acute medical and psychiatric care can be sent to San Luis Obispo when bed space is available. The acute care facility has 39 inpatient beds, with an average occupancy rate of 91.5 percent (4,395 inmate patient census in the 1996-97 Fiscal Year). Interestingly, the California Men's Colony also has a variety of health-related vocational training programs for inmates, including an x-ray technician program whose graduates have the highest civilian job placement of all state prisons.

The *California Institute for Men at Chino* houses an acute care hospital with 80 beds. This facility was also licensed by the Department of Health Services in 1989. The prison has a large minimum custody population, primarily level two inmates and below. In 1996-97 the acute care hospital had an average occupancy rate of 76 percent (or 7,485 patient days).

The *California State Prison at Corcoran* is a security level four facility which is designed for the highest risk inmates. The Corcoran acute care facility received a license for 75 beds in 1993 and is expected to provide an additional 25 beds of level four acute care service in the near future. This facility had an average 42 percent occupancy rate in 1997, with 3,909 patient days.

The *California Medical Facility at Vacaville* serves mostly level four inmates. It generally operates its 65 acute care beds and 150 acute psychiatric beds at or near 90 percent occupancy. Approximately 7,429 patient days of medical care were provided in the facility's acute care hospital during Fiscal Year 1996-97. In addition, over 48,000 acute psychiatric inpatient days were provided at the facility. Security levels one to three inmates in need of immediate medical or psychiatric attention are also sent to Vacaville. The Vacaville facility was licensed by the Department of Health Services in 1989. The California Medical Facility at Vacaville has been the subject of two major lawsuits, each alleging that the facility did not provide adequate resources and medical personnel to treat and care for mentally ill inmates (*Gates vs. Deukmejian, 1989* and *USA vs. Deukmejian, 1988*). The Department negotiated settlements in both lawsuits that continue to be monitored by federal courts.

High security level four prisons, which do not have acute health care facilities, such as Pelican Bay, Folsom, High Desert, Calipatria, and Chuckawalla, for example, provide some ambulatory care in prison infirmaries. Outpatient surgeries and clinical services are the most frequent procedures. Access for high security inmates to certain inpatient services within the state prison system and at contracted facilities is coordinated by the Department of Corrections Health Care Population Management unit. For example, the University of California Davis Medical Center in Sacramento is an acute care hospital under contract to provide the full range of inmate inpatient care, including medical surgical procedures requiring intensive care recovery. The hospital has dedicated a portion of its facility for the express purpose of serving high security inmates. A contract facility with a locked ward like this is a cost-effective alternative to the full custody escorts required by treatment in a regular hospital setting. The estimated cost of a full custody escort for a high risk, level four inmate to a contract facility is \$875 per trip, excluding the hospital stay, due to guard and security precautions in transit.<sup>8</sup>

Due to ongoing lawsuits and press attention, Pelican Bay State Prison is a special case. The Department of Corrections is particularly careful about medical problems and has set up a special

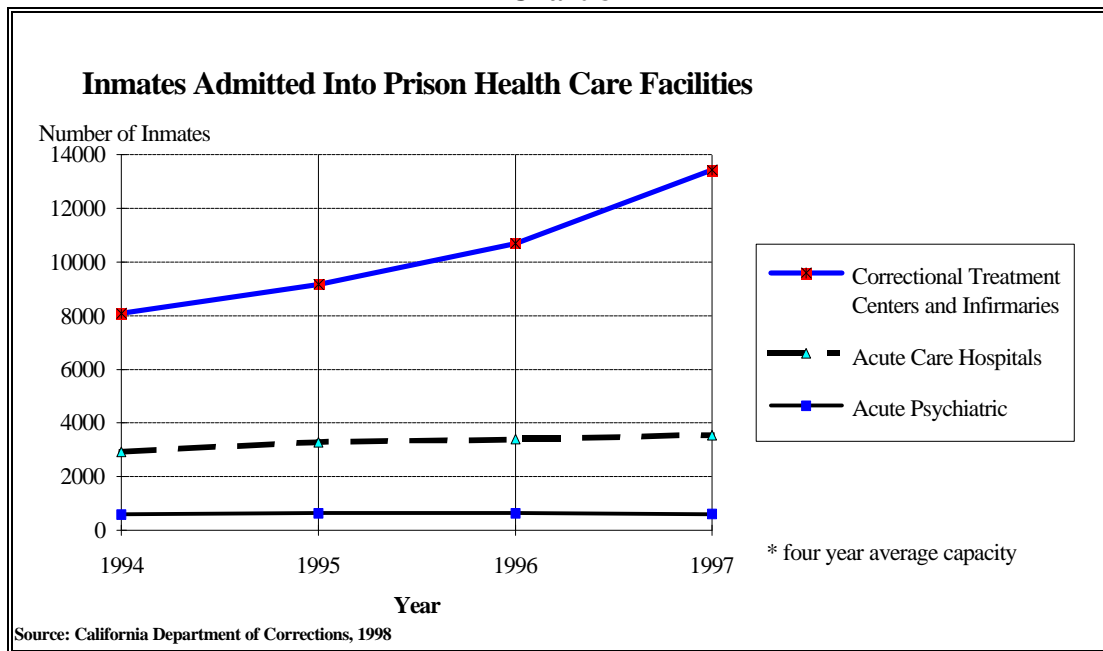


transportation system that requires the central Health Care Population Management unit to be contacted by the institution when any Pelican Bay State Prison level four inmate (or other level four inmates from other institutions) require hemodialysis treatment, acute inpatient care, respiratory isolation, inpatient mental health treatment or psychiatric care.

### Correctional Treatment Centers and Community Hospitals

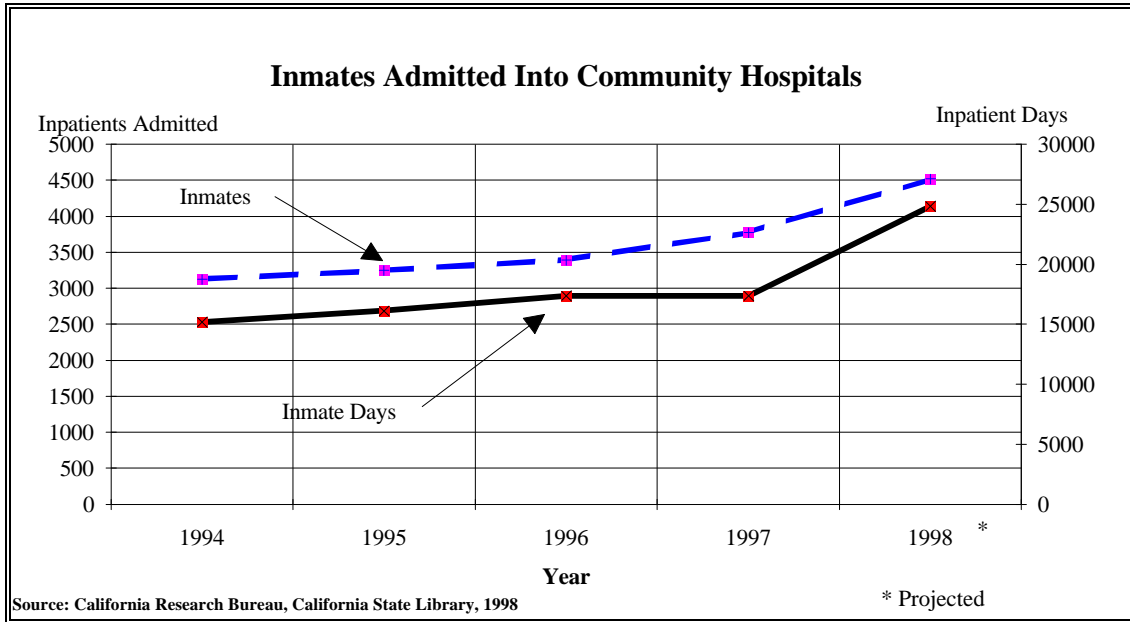
Prison infirmaries and correctional treatment centers are increasingly treating the majority of inmates who require inpatient health care. The number of inmates admitted to correctional treatment facilities increased from 46 percent of all admissions in 1994 to 63 percent in 1997, as shown in Chart 8. Acute psychiatric care demand is at near capacity, with a four-year average bed occupancy of over 90 percent, compared to 80 percent in acute care hospitals, and 50 percent in correctional treatment centers and infirmaries.

**Chart 8**



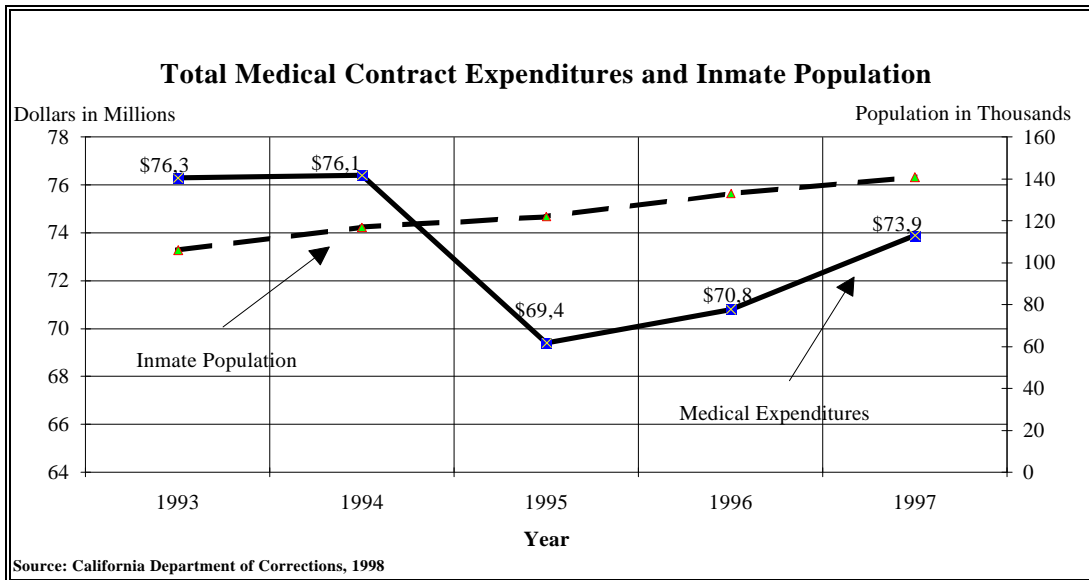
Nonetheless, the Department of Corrections will continue to rely on community hospitals for a major portion of inmate inpatient care in the foreseeable future, especially female inmates who have a much higher utilization ratio than men. (In 1997, one in every five female inmates were admitted as inpatients compared to one in fifty male inmates.) Indeed, projected inmate inpatient utilization at community contract hospitals is expected to significantly increase this year. The Department of Corrections does not employ a full range of specialized medical personnel nor does it have sufficient facilities and equipment to see all inmates. For example, in-house acute medical and psychiatric care is limited, as shown in Chart 8 above. Currently, the Department of Corrections has up to 900 medical service contracts with private physicians and community hospitals. The majority of contracts are for two basic types of care: prenatal care and delivery and medical surgeries that require intensive care recovery.

**Chart 9**



Even though the Department of Corrections must rely on contracting out a good portion of inmate medical needs, the cost of that care per inmate has declined (although total costs have risen with the inmate population increase in the last four years).

**Chart 10**



The cost to transfer an inmate patient from a prison to a community hospital is substantial. As noted above, conservative estimate of the cost to transport an inmate to a hospital is \$875.<sup>9</sup> The most typical situation requires a private ambulance to transport an inmate in immediate need of inpatient care, one or two armed correctional officers as security, and a medical technical assistant to monitor the inmate's condition.

The Department of Corrections Health Care Population Management unit recently began tracking inmates in need of community inpatient care who might receive that care in a prison facility. As a result, the unit now coordinates statewide correctional bus schedules with security personnel to facilitate the timely transfer of inmates in need of medical care to a prison facility instead of a community facility. According to department officials, the result is that up to 1,500 inmates requiring some form of health care service have received care in a correctional setting instead of a community, thereby reducing expensive security escorts.

### ***Older Inmates***

In general, the Department of Corrections does not have facilities nor protocols to treat chronic illnesses and diseases which may particularly strike older inmates. Presently, there are approximately 6,300 inmates age 50 years and over in state prisons. Of this figure, 1,364 are 65 years and older. By the year 2000, the Department of Corrections estimates that there will be 2,148 inmates 65 years and older. However, these projections do not consider substantial changes to state felony sentencing laws such as "three strikes," which are likely to dramatically increase the number of inmates sentenced to life imprisonment.

Generally, the older a person is, the more likely it is that he or she will suffer from a chronic illness requiring some form of long-term care. According to the California Department of Health Services, 46 percent of the patients in skilled nursing homes have functional limitations resulting from chronic illnesses. This figure does not include persons with certain cognitive impairments that affect memory, or those persons suffering from other forms of dementia such as Alzheimer's disease.

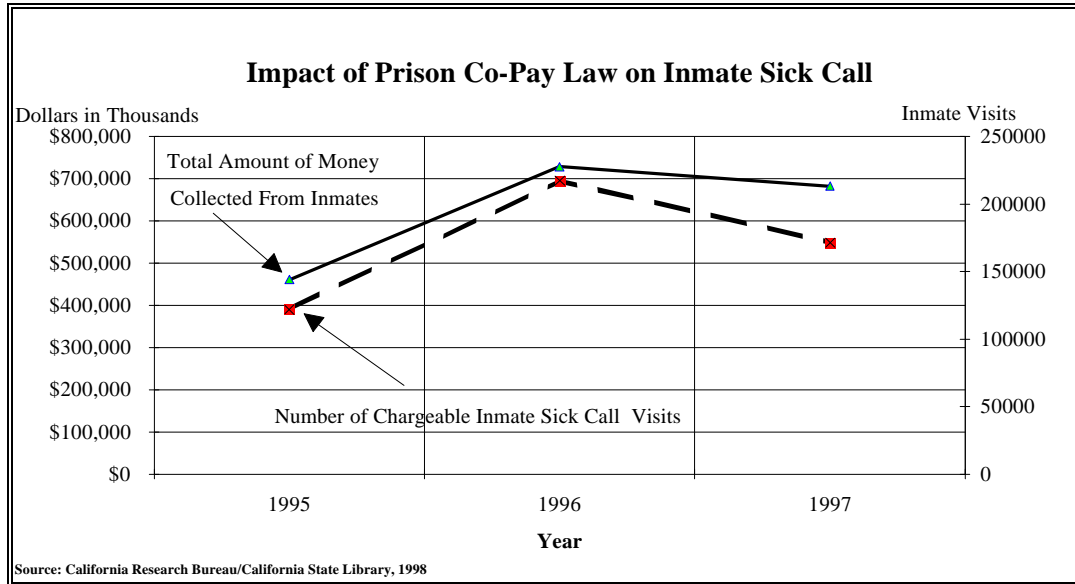
Health problems in older persons can lead to functional limitations that require intensive care. According to recent United States Chronic Disease Prevention Task Force findings, the five leading causes of mortality among persons 65 years and older are cardiovascular disease, lung and colon cancer, lung disease, strokes, and pneumonia/influenza. In California, a person who is 65 years and older is five times more likely to suffer or die from one of these diseases than is a person 55 to 64 years old, and sixty times more likely than is a person 25 to 54 years of age. These diseases are also the leading causes of death for patients in skilled nursing homes. The present average annual Medi-Cal reimbursement rate for skilled nursing care is \$30,338 per person.

### **Sick Call**

Routine medical care for sick inmates is provided on an outpatient basis in California prisons. Inmates must pay part of the cost of these services. Inmate co-payments are required by a 1994 law, in part as a way to discourage frivolous and abusive use of sick call. Department health care officials contend that inmates still have clear access to free medical care when they need it. Moreover, inmates can access sick call by appointment the night before by placing a request in drop boxes located in residential cell blocks. Inmates in need of mental health services can also use sick call medical services free of charge.

The pattern of sick call use does not appear to be closely connected to the imposition of co-payment since use increased the following year (see Chart 11). The Health Care Services Division has not analyzed in any detail the reasons why inmates use sick call or if co-pay has discouraged its use. All co-payment proceeds go to support the Health Care Services Division Support Appropriation Fund.

**Chart 11**

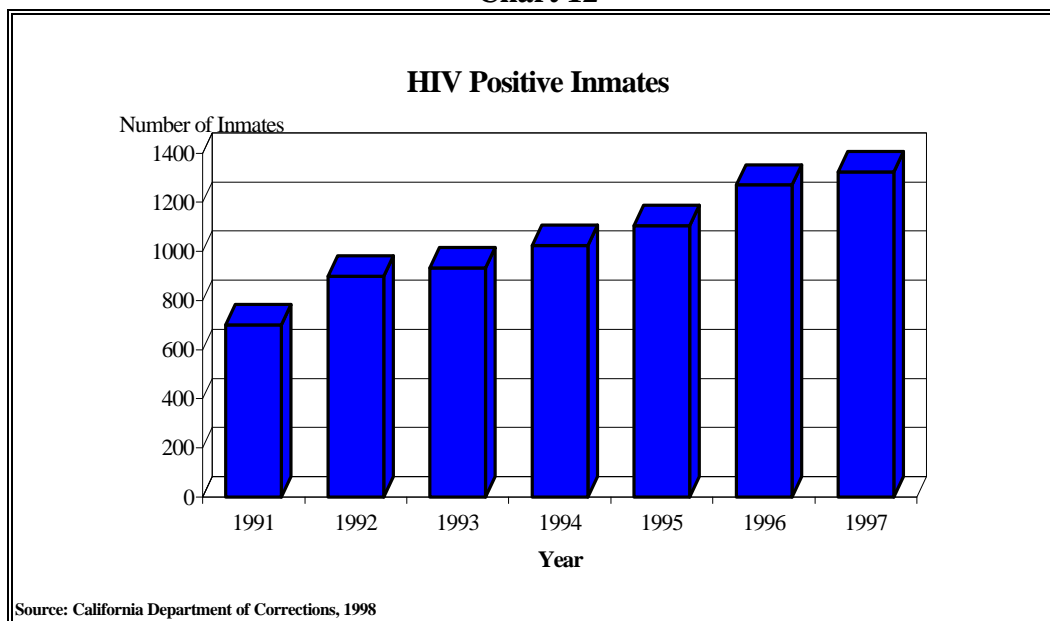


### **Inmates with HIV and the AIDS Disease**

Acquired Immune Deficiency Syndrome (AIDS) is a disease that impairs the body's normal ability to resist harmful diseases and infections. The disease is generally believed to be caused by Human Immunodeficiency Virus (HIV). Persons who have tested HIV-positive may display a continuum of symptoms. A person who has tested positive for the HIV antibody, but does not show signs of the illness, is classified as *asymptomatic*, and may not show any sign of the illness for years. AIDS-related complex (ARC) describes some of the less severe symptoms associated with the HIV disease. This level of infection generally does not require significant medical treatment. AIDS is the third and most severe level of the HIV disease. At this level, an individual's immune system has deteriorated to the point where a number of opportunistic infections can occur.

Inmates who have AIDS generally require significant medical services. Nearly 1,400 inmates in the Department of Corrections have been diagnosed with the HIV disease (approximately nine-tenths of one percent of the total inmate population). Testing is voluntary. The Department of Corrections began tracking the number of inmates identified with HIV in 1991; the number is increasing.

Chart 12



The Department of Corrections policy is to move HIV positive inmates into segregated sleeping quarters where they can be closely monitored by medical staff. The Department estimates that the total identified HIV disease inmate population will grow at an annual average rate of around two percent through the foreseeable future.

The general prison population has not been tested for the HIV disease, pursuant to state written consent laws (*California Health and Safety Code, Section 199.22*) that protect a person, including an inmate, from involuntary testing for the HIV disease. In addition, the civil rights of inmates may not be infringed absent valid and compelling reasons for protecting either the public or the security of the prison (*California Penal Code, Section 2600, et al.*). These two laws severely limit the Department of Corrections' ability to identify all HIV disease inmates. However, there are some instances in which an HIV test may be required of an inmate. For example, inmates who are convicted of certain sex offenses are required to test for HIV (*California Health and Safety Code, Section 199.95*). Law enforcement personnel and inmates who believe that they have come in contact with an inmate's bodily fluids may request an HIV test for that inmate (*California Penal Code, Section 7510*).

Prison medical staff estimate that between five and eight thousand inmates (or about three to five percent of the total inmate population) could carry the virus, based on the prevalence in the general population.<sup>10</sup> Inmates who volunteer to screen for HIV receive confidential counseling and educational information about the disease and can be treated while incarcerated. Medical staff are trained to withhold confidential information from custody staff. The same is true for drug testing; if someone is impaired at the time of screening, the information will remain confidential.

The Department of Corrections is required by state law to distribute HIV disease information to new inmates sentenced for drug-related offenses and to those inmates requesting information, based on funds available (*California Penal Code, Section 4018.1*). Since 1995, the Health Care

Service Division has received \$512,000 for AIDS training. Five Peer Educators develop educational materials and train other educators from among volunteer inmates. Currently, peer education takes place in 9 prisons, including Pelican Bay. Today, over half of the inmates who carry the disease were identified because they voluntarily tested for the virus. According to Health Care Service Division officials, this development is an encouraging sign because over 18,000 inmates voluntarily tested for the HIV virus last year.

The sickest HIV disease inmates are sent to the California Medical Facility, Vacaville. The rest are treated at the California Men's Colony at San Luis Obispo. The HIV program at the California Medical Facility in Vacaville has grown from a small ward in 1991 to three dedicated housing wings consisting of 478 beds in 1998. The HIV Center is staffed by seventy-six clinical positions to provide comprehensive medical, nursing, and psycho-social services, as well as an ombudsman to hear complaints.<sup>11</sup> The California Medical Facility in Vacaville also has a model hospice program for HIV disease inmates who are dying of AIDS. According to medical officials, the prison hospice program is staffed mainly by volunteers. It offers inmates a chance to die with dignity. Since the 17-bed hospice unit was opened in April 1993, the number of patient days has increased from 2,975 to 3,897 per year. The hospice program costs the Department of Corrections about \$1.5 million annually. According to the U.S. Department of Justice, the percentage of all deaths in state prisons across the country attributable to AIDS has grown from 28 percent in 1991 to 34 percent in 1995.<sup>12</sup>

Should mandatory HIV testing be required in the state prison system, there will be a likely impact on prisoner management and security. The identified HIV disease inmate population could swell from over 1,300 to as many as 5,000. Under current policy, the Department would have to reorganize its security classification for all inmate levels one through four, creating a separate class for inmates with the HIV disease. The Department would have to establish separate sleeping quarters within each prison for this new class of inmates, or transfer all newly classified inmates into HIV specific prison facilities. This might require segregating approximately 5,000 prison beds within the prison system. It currently costs approximately \$24,000 a year to house an inmate. It costs an estimated two to three times that amount, or about \$48,000 to \$60,000 per year, to medically monitor and treat an inmate with the HIV disease.

There is a worrisome interaction between HIV and tuberculosis. Inmates with the HIV disease may also be susceptible to multiple complications associated with other diseases such hepatitis, lung disease, heart disease, and hypertension, according to public health officials. These HIV medical complications could severely impact the Department of Corrections' ability to provide adequate and safe inmate health care.

## Treating Infectious and Communicable Diseases

### *Tuberculosis*

The rate of incidence of active tuberculosis disease reported in California in 1997 was 12.1 per 100,000 population. According to the latest mandatory statewide test of inmates in correctional institutions (*California Penal Code, Section 7570 et al.*), the active tuberculosis rate among inmates was 18.1 per 100,000, or 96 active cases reported in the state prison system in 1995. This is a slight increase from the 90 reported cases the previous year. According to Health Care Service Division officials, 65 of the new active tuberculosis cases were newly arrived inmates from county jails who were identified at prison reception centers. Forty-two of these cases were from Los Angeles County. This suggests that tuberculosis testing in county jails may be inadequate. Moreover, 49 of the 96 new active cases of tuberculosis involved HIV positive inmates.

Correctional health care officials attribute their success in identifying new, active tuberculosis cases to improved reception center and prison-wide tuberculosis testing. Correctional employees are also required to undergo annual tuberculosis screening and to be certified infectious free (*California Penal Code, Section 6006 et al.*) to ensure a safe workplace. The results of the 1995 testing found that 9.4 percent of correctional personnel tested positive for tuberculosis, but none were active carriers of the disease.

A "TB Alert" System controls the spread of tuberculosis in the prison system. Any inmate who is infected (or more importantly has tuberculosis) is formally tracked through medical records when moved from prison to prison. The timely transfer of accurate medical record information with an inmate is firmly established and, along with screening procedures, helps control the spread of tuberculosis. No inmate can be moved within the prison system without verified medical records indicating that the inmate has been tested and/or treated for tuberculosis. A clearance form (Number 128) accompanies all inmate transfers. These careful procedures contrast with the voluntary testing of HIV positive inmates. The timely transfer of medical records continues to be a problem for new inmates sent from county jails to prison reception centers and returning parolees, as noted previously.

When an inmate tests positive for tuberculosis and is considered to be infectious, he or she is housed in a respiratory isolation holding area until treated. During this time a number of medical tests are conducted to identify the infectious organism. If medical staff are having difficulty controlling the disease, the infected inmate will be transferred to the California Medical Facility at Vacaville, which has infectious disease specialists.

As mentioned above, inmates known to be infected with HIV are at increased risk for tuberculosis due to their immunocompromised state. This is more difficult to detect, as the tuberculin test reaction in HIV-infected inmates may be minimal and chest X-rays may show diffuse patterns which are not typical of tuberculosis. In addition, HIV-infected inmates are at greater risk for tuberculosis relapse, compared to those inmates with a healthy immune system. Nonetheless, tuberculosis cure rates are about the same if the correct treatment regimen is followed.<sup>13</sup>

Department Health Care Service Division officials recently began more aggressive identification and treatment of inmates suspected of carrying tuberculosis who might be also HIV positive. In addition, Memorandums of Understanding involving the Department of Corrections, Parole Division, Department of Health Services and all 58 county public health officials were recently developed to track parole inmates infected with tuberculosis after they leave the prison setting. The intent is to ensure that county public health departments are monitoring the parolee's tuberculosis treatment regimen until it is complete. If an inmate fails to adhere to county public health requirements, parole agents have the authority to revoke parole and force compliance with the terms of the treatment.

### *Hepatitis*

Two types of viral Hepatitis (B and C) are the major causes of chronic hepatitis and cirrhosis worldwide.<sup>14</sup> Hepatitis B is treatable; C is not. Not all inmates are tested for hepatitis C or B. In a blind study conducted by the Department of Corrections with the Office of AIDS in 1994, 41 percent of inmates entering the prison system tested positive for hepatitis C, but only 3 percent had developed the chronic or end-stage hepatitis which must be treated. The study found similar percentages of inmates with hepatitis B and end-stage hepatitis (34 percent positive and 2.2 chronic).

Intravenous drug use and tattooing with infected needles are the primary causes for inmates contracting the diseases. While there is no known cure for hepatitis C end-stage liver disease, Department of Corrections officials can slow the development of the liver disease among chronic hepatitis C inmates with Interferon-alpha (effective in 5-25 percent of cases) if infected inmates are willing to agree to a rigid 90-day treatment protocol (See Appendix C for treatment protocols). Those inmates with chronic hepatitis B can be cured with interferon treatment if they are willing to undertake the same treatment protocol as required for hepatitis C.

Some public health officials believe that every person who tests positive for hepatitis B or C should be treated, regardless of their stage of deterioration. However, Department of Corrections health care officials contend that prison-wide testing for hepatitis C would not help cure those inmates with the disease or prevent an outbreak from occurring. Cost is also a factor. When asked to estimate the cost of treating inmates who test positive for hepatitis B or C with interferon, Health Care Service Division officials indicated that it would cost the department \$269 million.<sup>15</sup>

According to prison health care officials, 20 percent of the 2.2 percent of inmates who have chronic hepatitis C develop end-stage liver disease and die. The time varies, but if infected and inmates change their high-risk life-styles, it could take up to 20 years to develop end-stage liver disease.

According to Health Care Service Division officials, peer education can be a cost effective alternative for preventing the spread of hepatitis. While most inmates do not participate in health education prevention programs, those that do can serve as role models in the prison system because they are respected by fellow inmates for their knowledge. As one prison health care worker put it, "the bottom line is that inmates must be willing to make life-style changes if



prevention efforts are going to work.” Parolees who commit new crimes or who violate the terms of parole often demonstrate high-risk behavior.

### **Mental Health Care in Assigned Prison Settings**

All inmates who are treated for mental illness or who require some type of mental health care are given another psychological evaluation shortly after arriving at their assigned prison, to determine if they need continuing psychiatric or mental health care. If further care or treatment is needed, there are several possible levels of care available depending on the circumstances. The least intrusive intervention (correctional case management system or CCMS) involves medication and counseling and is available at all prisons for inmates who are capable of living in the general population. Inmates requiring a higher level of care, or who are not adjusting well to prison life, are placed in one of 12 prisons with a special housing unit (Enhanced Outpatient Program or EOP) where they can receive daily supportive and therapeutic care. Inmates are usually identified for placement in one of the 12 EOP prison programs before they leave the reception center.

Many EOP mental health programs rely on contract psychiatric staff to meet minimum EOP program needs. According to Health Care Services Division officials, lack of resources and staff (14 percent psychiatric staff vacancy rate) to treat the mentally ill is related to recruitment problems, staff pay and location.

Drugs are an important aspect of mental health care and treatment. As expensive new and experimental treatment drugs are introduced into the market, inmates are entitled to use them. In some cases, prison EOP programs and acute care hospitals are exceeding or reaching their pharmaceutical allocations. According to observations and discussions with acute care hospital staff, intra-prison budgetary procedures contribute to this process. In theory, each prison facility (especially level four facilities) should know and budget for the number of resident inmates requiring mental health care, including therapeutic drugs. However, when inmates are temporarily transferred to another facility, such as an acute care hospital, that facility assumes all medical and therapeutic responsibility (but does not necessarily receive the necessary budget support).

### **Substance Abuse Treatment**

The Department has only recently dedicated resources within the prison system to substance abuse treatment. In Fiscal Year 1993-94, there was only one state prison substance abuse treatment program, the Amity Right-Turn Substance Abuse Treatment Program (established at the R. J. Donovan State Prison in San Diego in 1990). The program serves 200 eligible volunteer prison inmates who did not commit a violent crime and are nearing their prison release date. The program has an in-prison and aftercare component. First, prison inmates go through an intensive group therapy regime designed to confront their anger and to develop self-esteem. After prison, supervised living is the key to the overall success of the program. While in a residential setting (a halfway house owned and operated by Amity), an inmate/parolee receives counseling, fellowship, and intensive peer group therapy which can last up to 18 months. Program evaluations show a substantial reduction in recidivism for former inmate participants. According to Amity Right-

Turn officials, it costs about \$10 per day per inmate/parolee who successfully completes the program.

Today, there are three other treatment programs providing substance abuse treatment to male and female inmates. Like the Amity Program, they use a therapeutic community model approach with some variations. Therapeutic programs are designed to reinforce positive behavior, help inmates develop social skills through participation in limited self-government, and cope with the rigors of day-to-day living. The Forever Free Program for female offenders has successfully graduated over 300 offenders since 1993. It has both the prison and parole residential treatment programs.<sup>16</sup> Each program cycle lasts for six months and has up to 120 spaces available.

The most interesting new substance abuse program is at Corcoran State Prison. The program is operated by two therapeutic model contractors, Walden House and Phoenix House, at an annual cost of \$8.5 million. These combined programs house up to 1,478 level one and two inmates who are selected by prison officials. What makes this program so unusual is the apparent ability of the program counselors and inmates to break down the racial and gang-related turf barriers that plague the prison system. On any given day, inmates of all colors can be observed walking in the residential yards together, not in segregated racial clusters as is the norm. In one small peer group meeting of inmates observed for this report, it was very clear that this type of interaction is critical. Inmates develop trust among themselves, thereby breaking down racial barriers. One inmate said that program counselors had helped him to peel away his racial hatred and come to grips with his anger.<sup>17</sup>

While participating inmates are generally supportive of the Corcoran treatment programs, problems with the inmate selection process could forestall future expansion. Officials from both Walden and Phoenix Houses express concern that many of the eligible inmates who the Department selects to participate have less than one year to serve when they are assigned to begin the program. Thus they can not successfully complete the various stages of the 12 month program. Consequently, many inmates will serve only 6 to 9 months of the program by the time they are released on parole. Contractors are concerned that inmates who do not complete the entire program could have a dramatic negative effect on recidivism outcomes.

Counselors are also concerned that many of the inmates (one in four) selected by the Department for the program have committed sexually oriented crimes. This may happen because many of these inmates have committed “nonviolent” crimes, as classified by the Department of Corrections, and thus are eligible. One program counselor interviewed for this report said that he was unsure if the substance abuse program could help these inmates.

The Department of Corrections is increasing the number of substance abuse programs at prison facilities. State prisons in Jamestown, Solano, Lancaster, Chowchilla, Fontana, and Norco have each set aside 200 beds for inmates who volunteer to participate in substance abuse programs. These programs have not yet begun operation.

### *Parole Aftercare*

The Department of Corrections Parole Division reserves 510 prison reception center beds throughout the state for short-term substance abuse “dry out” and detoxification. The beds are for drug-addicted parole violators who are sent from county jails because of overcrowded conditions. These parole violators are usually released from prison custody within 30 days and are generally referred to drug treatment facilities sponsored by the Department of Corrections, Office of Substance Abuse Planning. This activity is coordinated in conjunction with other community-based parolee service programs across the state which are operated by partnerships of parolees, community organizations, and local and state governments. Those programs include the Bay Area Services Network Program (BASNP), which has 1,700 beds, the Prison Project Network (PPN) with 350 beds, the Parole Partnership Program (P3) with 350 beds, the San Diego Community Network with 50 beds, and the Central Valley Network (CVN). These programs are funded in part through agreements with the Department of Alcohol and Drug Programs and the Office of Criminal Justice Planning, at an annual cost of approximately \$9.4 million. There were 3,561 parolees admitted into these community-based treatment programs in Fiscal Year 1995-96. The estimated cost per parolee is \$2,639. There are about 90,000 parolees in California, many of whom are eligible for this type of care and treatment because of previous bouts with drug abuse and drug addiction. Clearly, the current level of funding is insufficient to treat more than a small percentage.



## **CENTRALIZED HEALTH CARE MANAGEMENT**

In 1992, the Department of Corrections created a Health Care Services Division (HCSD) to oversee and manage the delivery of health care services to the statewide inmate population. Several successful lawsuits directed at Department of Corrections health care policies, described earlier (see page 4), gave impetus to the creation of the division. The department's objectives in creating the division included:

- developing a health care service management model (standardized system wide medical decision-making process instead of an institutional-based model);
- devising a strategy to recruit medical personnel;
- improving the delivery of health services to female inmates and mentally ill inmates;
- improving public health screening for infectious diseases; and
- upgrading health care facilities to meet state licensing standards.

Additionally, the Department of Corrections committed to the Legislature to develop an automated system wide Correctional Management Information System (CMIS) for all inmate-related activities, including a Health Information Project (HIP) to improve health care delivery, automation, and standardization. The entire system was estimated in 1992 to cost \$20 million. Neither the Health Information Program nor the Correctional Management Information System have yet been accomplished. The biggest impediment, according to Department of Corrections officials, is the state procurement process. Information technology problems encountered by other large state departments (Motor Vehicles, Social Services and Franchise Tax Board) have led the Department of Corrections to seek an alternative procurement process, a discussion of which is beyond the scope of this paper.

Divergent medical and security priorities have long been a source of administrative tension in the state prison system. The Health Care Services Division has shifted some centralized attention to inmate medical priorities. Under the direction of an Assistant Deputy Director, four regional population managers are responsible for overseeing operational functions, including resolving contested medical and resource decisions between health care staff and institutional correctional staff. Prison clinicians (physicians and psychiatrists) are charged with making medical decisions within a standardized framework that is coordinated at a central level. Prison wardens remain in charge of the administrative decision-making process, but are no longer involved in the day-to-day medical decisions involving inmates, as they were prior to 1993 (see Appendix B for a detailed description of the organizational structure of the Health Care Service Division).

### **Standards of Care**

As part of its mission to control health care costs, the Health Care Service Division has developed medical standards of care and a package of services which are available to inmates. The basic approach is to differentiate between essential and non-essential care. A standard health care package is provided within the prisons and through a network of contracted facilities.

In theory, the health care package sets up guidelines intended to control inmate medical health care costs. The inmate has access not only to medically necessary health care services, but the cost of that care is relatively consistent from region to region. In addition to institutional health care staff, the HCSD has an extensive statewide network of over 700 contract service providers.

HCSD develops master contracts for acute care, outpatient care and other specialized services in a manner consistent with the security and in-house health care needs of prisons within a given region. For example, master contract hospitals serve as a preferred provider of inpatient care for prisons lacking a hospital, or as a provider of secondary or back-up care for prisons that cannot meet a particular health care need. Specialized medical services which are not provided by the Department of Corrections are provided in various ways. For example, telemedicine is used at Pelican Bay and in remote sites such as the Ironwood and Chuckawalla state prisons near Blythe, California.

To monitor health care costs, the Health Care Service Division has established a prison-wide utilization management review system which includes a Health Care Cost and Utilization Program (HCCUP). This managed care system examines all diagnostic procedures and patient outcome data, including new and standardized procedures. If a medical procedure falls within the usual scope of services, then it is generally approved. If it does not, it is not likely to be approved. The scope of services applies at all institutions. Elective types of medical procedures for inmates such as plastic surgery or tattoo removal for example, are not done.

The managed care program is an evolving medical cost containment and data collection system. According to Health Care Service Division officials, the data help them to develop important management information such as average cost of medical service per inmate, average cost per medical procedure, in-house daily census per prison facility, and average length of stay. It is also used to make cost comparisons between in-house inpatient medical services and those provided by contract facilities, to monitor and evaluate high cost cases, to chart in-house utilization trends and other health care activities. The program is still in the process of using the data to make informed decisions which can be used to monitor, plan and evaluate how well contract facilities are performing.<sup>18</sup>

The Health Care Service Division (HCSD) is in the process of identifying performance measurements for its strategic management plan. The plan is to develop performance measures which can be compiled and evaluated with data that is currently being collected. Officials estimate that it will take two years to fully develop strategic goals, action plans and performance measurements.

### **Recruitment of Medical Personnel**

Recruitment of enough medical personnel to fully staff prison medical positions has been a chronic problem in the state prison system, especially in the rural and remote areas where most state prisons are located. The Department of Corrections has approximately 3,890 medical and health care staff positions budgeted for its 33 prison institutions and central office in Fiscal Year 1997-98. The vacancy rate for these positions has been steadily decreasing, from 25 percent several

years ago to 14 percent. However, the vacancy rate for psychiatric personnel remains at 24 percent. The Health Care Service Division actively manages recruitment efforts to assist the institutions with hiring staff. Recruitment efforts include networking with medical and psychiatric associations, medical and nursing schools and unions, and preparing and participating in national advertising recruitment campaigns, including the Internet.

According to medical professionals, it requires a nucleus of medical specialists at a health care facility to attract more professionals. Higher standards of care and acceptable institutional practices and quality assurances create an environment conducive to the practice of medicine. According to one Health Care Services Division official, "if you build a medical community, the professional will come."

Nonetheless, the location of many prisons is an impediment to recruiting psychiatrists, psychiatric social workers, physicians, pharmacists and laboratory technicians to work for the Department of Corrections. Prison medical facilities located in Vacaville, Folsom, or Marin, for example, attract medical professionals better than facilities in Coalinga, Corcoran or Chowchilla. In addition, some psychiatric personnel are offered pay bonuses as an incentive to practice prison medicine in the urban core areas mentioned above. This makes it very difficult for the remote prison medical facilities areas to compete.

Pay differentials between medical and correctional personnel who perform similar duties create additional disincentives. The Medical Technical Assistant (MTA) is a correctional officer class which is used extensively to perform duties in the prison health care system that could be performed by licensed nurses or other medical personnel. MTAs are paid 29 percent more than a licensed vocational nurse. The MTAs are in charge of sick call in inmate housing units and screen inmates at reception centers, correctional treatment centers, infirmaries, in the female skilled nursing facility, and at various contact points in prison acute care hospitals.

### **Medical Autonomy in Prisons**

The issue of medical autonomy in state prisons across the country and in California is of concern to health care professionals. The term medical autonomy means the acceptance and implementation of medical care directives as given by physicians, dentists, or psychiatrists.<sup>19</sup> Applied to prisons, medical autonomy means that if a doctor says that an inmate needs some form of inpatient care, then the prison warden or custodial staff must ensure access to that care. In 1993, concerns about medical autonomy in the California prison system were discussed in testimony before the Joint Legislative Committee on Prison Construction and Operations. A state prison doctor contended that prison medical decisions were overridden by prison wardens.<sup>20</sup> He also stated that the decentralized system led to variations in the distribution of resources and services in different prisons. If a prison warden felt strongly about hiring competent doctors and other medical personnel, then the care and medical resources at that prison were generally better than in prisons where the warden's commitment was not the same.<sup>21</sup>

Today, the relationship between custody and medical personnel is on a more equal footing compared to 1993. A clear set of procedures spell out what is to transpire when an inmate

requires medical care, both within the institution and outside the institution. This is especially true in medical decisions involving the transfer of an inmate to a community hospital for treatment. The medical benefit package described in the previous section establishes a clear scope of services which are provided to inmates, and clarifies which inpatient services an inmate may or may not receive at a community hospital. In addition, any operational problems involving inmate movement, either inside or outside the institutions, are now the responsibility of the Health Care Services Division, Health Care Population Management unit. This unit assists institutional staff and chief medical officers when inmates must be moved into health care beds and treatment settings, consistent with safety and security requirements. These changes have created a better working environment for health care practitioners, according to prison health care officials. According to Division officials, one of the major immediate benefits of the improved collaboration between custody and health care has been the use of Department of Correction buses to transfer inmates between institutions. Some 1,500 inmates requiring outpatient mental health or HIV treatment during the last 14 months, who would otherwise have required an escort by custody staff based on security classification, have been moved on Department of Corrections buses.

### **Medical Records Management**

As discussed previously, medical record management is a major cost concern for the Department of Corrections. Medical records often do not follow inmates in a timely manner when they transfer from county jails to the state prison system, when they leave on parole, nor, in many cases, when they return to incarceration after violating parole. Poor record management contributes to inconsistent medical treatment and to costly duplication of care. However, medical record transfer between prisons has improved dramatically. All inmates who transfer between or within facilities must carry their medical records and C file (custody file). Observation suggests that this practice is prevalent.

Medical records are compiled by hand and not computerized in a central database. A planned automated Correctional Management Information System (CMIS) in the new Health Care Services Division is delayed, as discussed above. A reliable electronic software transfer system that can manage medical records for 155,000 inmates and 103,000 parolees does not exist. Even so, Department of Corrections officials do not believe that an automated data system will solve the problem of medical duplication, particularly at state prison reception centers, because of the massive number of inmates who are entering the system.



## LEGISLATIVE AND ADMINISTRATIVE OPTIONS

While not necessarily recommendations of the author or the Bureau, the following are potential options for action. The bracketed number at the end of each option indicates a page in this report on which a relevant discussion appears.

### County Jails and State Prisons

More than 200,000 inmates will enter prison reception centers this year. During prison site visits we found that very little medical information is forwarded by county jails and regional state parole divisions with these inmates. This lack of continuity of care leads to costly duplication of services and, in some instances, to delayed inmate medical care [page 16]. County jails also appear to be passing on medical problems to the state prison system, such as inadequate tuberculosis and hepatitis screening [page 37].

- In order to improve the current situation, it might be cost effective for the state to fund medical screening at the county level. The purpose would be to immediately flag and attend to medical problems and ensure that medical records are forwarded when an inmate is transferred to a prison reception center. A \$20 million medical screening and records transfer model pilot could be established in Los Angeles County as a first step.
- One response might be to convene a state-county working group to develop options for improved medical coordination and the early provision of necessary medical services. Prevention and early detection are generally cheaper than later medical services, and certainly better for the inmate patient. The Office of Criminal Justice Planning or the Board of Corrections could serve as the conveyor or facilitator, forwarding recommendations to the Governor and the Legislature. It would make sense to include the Department of Health Services and county public health agencies in the discussion to ensure that a variety of resources are brought to bear on the problem in an effective, coordinated manner.
- Vertical integration of inmate medical records between county jails and the Department of Corrections health care systems could be required. One way to accomplish this might be to create a regional correctional medical treatment and processing center for state parolees and county offenders that would screen for infectious and communicable diseases. Medical information would be passed along with prisoners when they are transferred to state prison reception centers. One option might be to utilize county facilities or other public hospitals that have shut down over the past several years.
- The California Law Enforcement Telecommunications System (CLETS) is used to track criminals across jurisdictional lines and might be expanded to include transfer of medical record information. Currently, all 58 counties are connected by the CLETS system to the Departments of Justice and Corrections, allowing instant access to an inmate's "rap sheet". The system could be expanded to relay inmate medical information (especially about communicable diseases) from county medical personnel to state prison reception centers. This might require the state to

augment staff at the county level to input data, at an estimated cost of approximately \$1 to 2 million. This could prove to be a cost effective expenditure.

## **Hiring and Recruitment of Medical Personnel**

The state has a number of unaccredited and unlicensed prison infirmaries and correctional treatment centers that offer only sub acute levels of inmate health care services. Reasons for lack of licensing and/or accreditation include inadequate staffing levels of medical personnel and out of date facilities. Lack of licensing or accreditation complicates recruitment efforts to attract doctors and other medical specialists, as they prefer to practice their craft in licensed or accredited health care facilities [page 45].

- The Department of Corrections and the Office of Statewide Health Planning and Development (OSHPD) could establish a “Correctional Health Professions Career Development” program to address medical personnel recruitment. This might include recruiting high school seniors to enroll in college health care professional programs that would qualify for entry-level medical positions in the Department of Corrections. The OSHPD has a similar program for college students who graduate and serve in medically underserved areas of California.
- The state could provide financial incentives for medical students in the form of grants or loans, which could be repaid by working a certain number of years in a prison medical setting. The state has a program similar in concept for teachers.
- The Department of Corrections could continue to explore ways to attract physicians from University of California medical schools to participate in intern residencies at the four Department of Corrections acute-care facilities or at correctional treatment centers. (The University of California requires a licensed facility for its interns.) This might require the Department and the University to create a joint task force to fully explore the logistic and financial obstacles.
- The Department of Corrections might examine the use and relative costs of Medical Technical Assistants (MTAs), registered nurses, and vocation nurses in its inmate health care system. This would include a review of the appropriate use and relative cost of these specialties relative to the kind of work performed [page 45].

## **Geriatric Care**

The number of state prison inmates 65 years and older is growing significantly. Growth models established at the beginning of the decade projected that this population would grow to 2,148 inmates by the year 2000. Since the model did not account for recent felony sentence enhancements or 3 strike felons, the prison geriatric population could grow even faster. The net result will be an increased demand for geriatric-related health care. There should be a better understanding of the potential costs and alternatives of caring for this inmate population.

- The Department of Corrections could develop new projection models for this age group and establish estimates as to the types of facilities and costs required to care for this population.

The Legislature could consider developing a broader range of correctional alternatives for this population. For example, under Title 2 of the Social Security Act, individuals are ineligible to receive Medicare benefits while incarcerated. The law is unclear, however, as to the rights of states to seek Medicare reimbursement for providing health care services for geriatric offenders. The Administration could seek reimbursement from the U.S. Department of Health and Human Services, Health Care Finance Administration (HCFA) for services rendered to geriatric offenders.

### **Privatizing Prison Health Care Service**

Community hospital and individual physician services are accessed under contract by the Department of Corrections. Improved contract management and utilization review have helped to stabilize rising correctional health care costs. The number of medical contracts (900) remains high. Specialized medical services and obstetric care for pregnant females, for example, remain outside the realm of institutional health care. Moreover, there are no licensed acute care services available within the state correctional system for women.

- The Department of Corrections could negotiate an exclusive single long-term contract with a single HMO or private correctional health care provider organization to manage female prison inmate health care. The contractor would be responsible for all medical issues, with the necessary security provided by the Department.
- The Department of Corrections could explore rationalizing its contracting-out system by forming a statewide Health Maintenance Organization among its hospitals, correctional treatment centers and infirmaries to provide a pre-determined level of inmate care at a given price. The Legislature might require inmates to pay a certain amount of the money they earn during incarceration as a co-payment instead of the current sick call co-payment.
- At least 12 California county jails have privatized health care services. However, the quality of care provided by these contractors has not been measured. Comparative public-private data on inmate health care quality and costs could be developed, perhaps as a precursor to standardizing state prison contracting-out practices.

### **Substance Abuse**

The Department of Corrections estimates that 85 percent of all parole violators are substance abusers and are likely candidates to again violate parole (test positive for drug use). However, the Department dedicates relatively few resources within prison reception centers and in the Parole Division to substance abuse treatment. The Department's few substance abuse programs are small and lack continuity [page 41]. In addition, some program eligibility requirements result in the selection of inmates whose primary problems are not substance abuse related [page 40].

- Security and safety are the primary goals of a prison system, so it is not unreasonable to assume that the Department of Corrections may not be the best provider of substance abuse services. As in the case of specialized medical care, it might make sense for the Legislature to place primary responsibility for the substance abuse treatment of state parolees with community drug and alcohol providers, perhaps in concert with the Department of Alcohol and Drug Abuse Programs.
- The Department could use the positive preliminary evaluation results of current substance abuse programs to advocate for continued or increased funding, especially in aftercare programming. The Department could also seek out available federal grant programs, including Byrne Memorial grants, to fund aftercare drug abuse programs for inmates who successfully complete prison residential programs.

The Department could re-examine its criteria for selecting inmates to participate in residential substance abuse treatment programs. In particular, inmates who have committed sexually-related crimes currently fill about 25 percent of the available residential treatment program slots. Since their primary offense is not drug-related, the treatment may not affect their primary problem, so they still may have a higher rate of recidivism [page 40].

### **Medical and Vocational Training**

When inmates leave prison on parole they have few marketable job skills. Some analysts contend that this lack of job training leads to higher recidivism rates among parolees.

- Medical services is a fast-growing area of employment with high demand for nurses and other skilled personnel. Inmate medical personnel training programs could be created for inmates in all prison health facilities. The successful x-ray technician program at the California Men's Colony (whose graduates have the highest civilian job placement of all state prisons) could be a model [page 30]. This might entail some additional supervision, but could pay for itself over time in lower recidivism and personnel costs.
- The Legislature could require the Department of Corrections to analyze its vocational health programs for inmates, such as the x-ray technician program, as part of its mandated annual review to determine which programs are effective in reducing recidivism rates.

When inmates enter prison reception centers there is currently no process to determine whether they are suffering from mental retardation or some type of developmental disability.

- Rather than waiting for the results of pending or future lawsuits (*Clark vs. Wilson, 1997*), the Department of Corrections could select and apply an assessment tool to determine which inmates suffer from these disabilities [page 18].
- Inmates are given an education skills assessment test in state prison reception centers that is the equivalent of a general education diploma test. The Department could use this testing procedure as a way to determine if an inmate has a serious learning disability. In addition, the

Department could use this testing procedure as a tool to motivate qualified inmates to complete a high school equivalent education curriculum while in prison.

### **Programs for Inmate Mothers**

- The Department of Corrections does not collect data on what happens to the babies of inmate mothers who do not participate in the Department sponsored Inmate-Mother Program, so there is no information as to the caregiver placement or type of care which the infants receive [pages 23-26]. This lack of information inhibits notification to other service providers and coordination which could provide important services to the infant, the caretaker and the parents.
- A 1994 Orange County Probation study of criminal behavior indicated that eight percent of certain juvenile offenders commit a disproportionate amount of crime. The study suggested that many of these juvenile offenders come from homes where the parent or parents are or have been incarcerated.
- The Department of Corrections or the Department of Social Services could be required to establish a specific case management program for the children of inmate mothers to ensure that the mother does not place a child in living situations at risk of personal abuse, drug use, academic failure, or delinquency. Such a program could be coordinated with county social service departments, churches and interested volunteer community groups.

### **Female Inmate Medical Services**

Female inmates require more mental health services than male inmates, often due to depression over separation from their families [page 22]. They also have a high percentage (seventy percent) of substance abuse problems.

- The Legislature could require the Department of Corrections to develop a plan that insures adequate staffing levels of mental health personnel in the state prisons for women. Accreditation or licensing could establish recognized standards of care.
- Drug use is a relatively bigger problem for female inmates. Yet the Department offers only one residential drug treatment program for female inmates (Forever Free). The Legislature could require the Department of Corrections to develop more residential drug treatment programs for female inmates. Research suggests that mothers are highly motivated to return to their children, thus providing the needed incentive for successful program outcomes.
- The state should develop and keep data on the disposition and care of the children of incarcerated mothers. These children are at high risk and could benefit from the coordinated, concentrated provision of appropriate services. The Departments of Corrections and Social Services could form a working group to develop a tracking system. The California Judicial

Council might also be a useful participant since the courts could identify the children during sentencing.

## **HIV and Other Communicable Diseases**

Some prison medical officials believe that the written consent law (California Health and Safety Code, Section 199.22) protecting inmates from testing for HIV should be revised. One reason is that the presence of HIV infection is an important risk factor for developing active tuberculosis. Knowing an inmate's HIV antibody status can significantly alter treatment for tuberculosis. Other medical complications related to the HIV disease could severely impact the Department of Correction's ability to provide adequate and safe health care to the general inmate population [page 36].

- The Legislature could remove prison inmates from the current protection against mandatory testing for HIV, on the grounds that the restricted prison living situation is particularly dangerous for other inmates.
- To encourage voluntary inmate participation in the HIV testing program, the Department could restore work and earning privileges to HIV infected inmates and provide more attractive living options to them, rather than medical isolation. For example, the Department could re-examine its security classification policy for inmates who test positive for HIV. They might be re-located to HIV specific prisons regardless of their security status, where they could be medically monitored and treated if necessary.

According to Health Care Services Division officials, 65 of the 96 new active tuberculosis cases identified at prison reception centers were newly arrived inmates from county jails. Forty-two of these cases were from Los Angeles County. This suggests that tuberculosis testing in county jails may be inadequate. Moreover, 49 of the 96 new active cases of tuberculosis involved HIV positive inmates.

- Based on the number of inmates with tuberculosis entering the Department of Corrections, the Legislature could require county jails to test all offenders who test positive for tuberculosis to also be tested for HIV. Perhaps some directed state funding would assist in broader county compliance.

## ENDNOTES

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<sup>1</sup> The right of a state prisoner to seek relief under *42 USC, Section 1983*, because of conditions relating to his or her confinement was recognized by the United State Supreme Court in 1964. *Cooper vs. Pate, 378 U.S. 546 (1964)*.

<sup>2</sup> Observations made by author of this report at North Kern State Prison and Donovan State Prison reception centers located in Kern and San Diego Counties respectively.

<sup>3</sup> Personal interviews.

<sup>4</sup> *RAND Research Brief*, "Criminal Justice Policies Toward the Mentally Retarded are Unjust and Waste Money," 1997.

<sup>5</sup> Personal Observation.

<sup>6</sup> Personal interview with prison reception center medical staff.

<sup>7</sup> Telephone interview with Paul Comesky, Prisoners Rights Union, Sacramento, California, 1996.

<sup>8</sup> Formula: 3 Correctional Officers' average annual salary of \$50,000 or \$26 an hour x 4 hours = \$312; One Correctional Medical Technician Assistant, average cost per hour = \$11 x 4 hours = \$44; Average ambulance service cost of Folsom State Prison, \$525; total cost of \$875).

<sup>9</sup> Ibid.

<sup>10</sup> The probable reason for the large discrepancy in the number of HIV positive inmates is based on estimates from the National Institute of Justice based on nationwide prison surveys, 1996.

<sup>11</sup> A 1992 legislative report about the deaths of HIV inmates, their poor living conditions, and other related health problems at the California Medical Facility at Vacaville focused attention on their plight. An Assembly Public Safety Committee Report, November 18, 1992.

<sup>12</sup> U.S. Department of Justice, Bureau of Justice Statistics, *Sourcebook*, 1996, p. 553.

<sup>13</sup> B. R. Bloom and C. J. Murray, "Tuberculosis: Commentary on a Re-emergent Killer," *Science*, 1992, Vol. 257, p. 1056.

<sup>14</sup> Centers for Disease Control and Prevention, *The Epidemiology of Viral Hepatitis in the United States, MMWR*, 1994, Vol. 2, pp. 437-455.

<sup>15</sup> California Department of Corrections, Health Care Service Division, Memo on Interferon Therapy, February 26, 1997.

<sup>16</sup> Michael L. Pendergast, Principal Investigator, "Evaluation of the Forever Free Program," California Institution for Women, Drug Abuse Researcher Center, University of California, Los Angeles, April 16, 1998.

<sup>17</sup> Ibid.

<sup>18</sup> The Department of Corrections has assigned 33 Staff Service Analyst to prison institutions to input health care data elements for fiscal purposes.

<sup>19</sup> Rebecca Craig, Consultant for California Medical Association.

<sup>20</sup> Testimony by Dr. Nabil Athanassious, before the Joint Committee On Prison Construction And Operations on October 29, 1993.

<sup>21</sup> Dr. Herman Masisonet, before University of California Policy Seminar on State Prisons, May 4, 1993.





## APPENDIX A



## **California Medical Association Accreditation Requirements for Prison Health Care Facilities**

- A designated health authority is responsible for health care services, pursuant to a written agreement.
- Matters involving medical, dental, and mental health care judgments are the sole province of the attending physician, dentist, or psychiatrist.
- Daily meetings occur between medical and security personnel.
- Pertinent health data is collected annually.
- Manuals of written policies cover all aspects of medical care, transportation and internal audits.

### ***Personnel***

- All medical personnel are licensed, with written job descriptions defining the specific duties.
- Staff development and training programs are in place, including those for correctional personnel.
- Policies clarify the medical assistance duties which inmates and volunteers can or cannot perform.

### ***Care and Treatment Standards***

- Written policies exist for emergency services, health screening, and inmate detoxification.
- Access to treatment is ensured, including daily nursing triage of inmate complaints and clinical care.
- Written policies have been developed for health appraisals, communicable diseases, hospital care, drug addiction treatment plans, standardized nursing procedures, health promotion, chemical dependent inmates, pregnant and lactating inmates, dental care, and personal hygiene.

### ***Pharmaceutical Standards***

- Compliance with all state and federal laws governing the prescribing, dispensing, and administering of drugs is required.

### ***Health Record Standards***

- Physicians maintain individually completed and dated health records. Record forms include screening, appraisals, diagnostic treatments, medication, x-rays, consent and refusal, release, date and time of health encounter, summary of hospitalization, treatment plans, psychiatric care, confidentiality, transfers, and other pertinent information.

### ***Medical/Legal Issues***

- Outpatient care is required for the detention, diagnosis and treatment of mental illness.
- Written policies must define procedures for suicide prevention, collection of forensic evidence, informed consent, and medical research.

### **The Accreditation Process**

Any jail, prison, or correctional facility which wants to ensure that its facility meets national health care standards can request assistance from several accreditation organizations. In California, the California Medical Association, the National Commission on Correctional Health Care, and the Joint Commission on Accreditation of Healthcare Organizations all offer accreditation services. Once the appropriate medical policies and procedures are established, the correctional institution can request that a accreditation body inspect and evaluate the program. The California Medical Association, for example, will field an accreditation team composed of physicians, nurses, and administrators. The CMA charges the correctional facility a fee which varies with the number of inmates. CMA accreditation fees range from \$1,500 for jails and prisons with up to 500 inmates to \$3,500 for facilities with over 3,000 inmates. The California Medical Association has concentrated its accreditation efforts on county jails. The CMA contends that high prisoner turnover in jails requires sufficient standards of care in order to control the spread of infectious and communicable diseases in both the jail and general populations. The National Commission On Correctional Health Care has also accredited several Bay Area county jails and detention centers.

## APPENDIX B



## **Health Care Service Division Organizational Structure**

As the medical management model continues to evolve within the California Department of Corrections, new strategies and goals have developed. Today, the Health Care Service Division is guided by the following series of strategic management principals which must provide:

- *Program Standardization* to consistently ensure medically necessary health care services in all prisons;
- *Development of Support Services Systems* which are necessary to operate a comprehensive health care organization in a correctional environments;
- *Resource Management* to ensure that a competent and qualified workforce delivers health care services; and
- *Inter-organizational Operations* that are promoted at all levels of the Department of Corrections by top management.

Health care delivery in the Department of Corrections includes four lines of business: Medical/Surgical, Mental Health, Public Health and Dental. The organizational structure of the Health Care Service Division includes four major systems and programs.

### ***Health Care Operations***

- Manages the day-to-day prison medical activities;
- Responsible for medical, dental, and psychiatric services;
- Ensures compliance with health care regulations, standards, and licensing requirements; and
- Population Management.

### ***Program Support and Evaluation***

- Program evaluations;
- Training and recruiting medical personnel;
- Medical management information system;
- Health care costs and utilization program; and
- Contract Medical Services.

### ***Planning and Program Coordination***

- Planning for older inmates and female health issues; and
- Program coordination of privatization and system-wide contracting.

### ***Health Care Policy***

- Litigation and implementation of court orders including a risk management program;
- Public health issues and pharmacy services; and
- Utilization management and performance review.





## APPENDIX C



## Chronic Viral Hepatitis Guidelines

### I. Policy

- A. Each institution shall provide health care services for patients with chronic viral hepatitis caused by hepatitis B Virus (HBV) and hepatitis C Virus (HCV).
- B. Patients with infectious liver disease shall receive timely, efficient, and appropriate medical therapy.
- C. These services shall utilize these HCSD guidelines regarding the evaluation and treatment for HBV and HCB, and for the use of alpha-Interferon.
- D. The attached materials are specifically intended as guidelines in the treatment of chronic viral hepatitis caused by the HCV since it is the most prevalent causative agent of this entity in the correctional setting.
- E. These guidelines also generally apply to HBV-induced chronic liver disease, but there are some important differences.
- F. Dosage and duration of therapy of alpha-Interferon are included in the package inserts or are referenced in the attachments to this policy.
- G. Note: Choosing treatment options for patients with chronic viral hepatitis can be a complicated task, since information gained from the studies do not correlate well with the histopathology. In addition, this field of medical practice is new and is rapidly changing, as new techniques and therapies are developed. They will continue to be periodically updated, consistent with the principles of medical practice.
- H. These guidelines are intended to assist the practitioner in the treatment of hepatitis caused by HBV or HCV, but as always, guidelines are not a substitute for exercising good clinical skill and judgment.

### II. Purpose:

To ensure that inmates with chronic viral hepatitis infections shall receive health care services that are medically necessary.

### III. Procedure

- A. Each patient who has or is being evaluated for chronic viral hepatitis shall be enrolled in the Chronic Care Clinic program.
- B. Patients shall be seen and followed up by a physician at least every 90 days.
- C. The treating physician shall use sound clinical judgment to individualize the therapy as medically indicated.
- D. The physician shall monitor the patients from diagnosis through the conclusion of therapy.
- E. Each patient who is enrolled in the treatment program shall complete the form "Inmate Consent for Special Therapeutic Treatment"
- F. An information chrono, CDC 128-C, shall be completed and health care staff notified, when an inmate is found to be in possession of alcohol, drugs, drug or tattoo paraphernalia prior to, or during the alpha-Interferon therapy.

- G. Patients being evaluated for treatment with alpha-Interferon shall be requested to take a Human Immunodeficiency Virus Test, and participate in random drug and alcohol testing.
- H. Possession or use of alcohol or non-prescribed drugs, or fresh tattoos or equipment will result in termination of the alpha-Interferon therapy.
- I. When a patient is being considered for alpha-Interferon therapy and has a major mental illness, the patient shall have an evaluation and recommendation by a psychiatrist.
- J. The treating physician shall record each patient encounter in the unit health care record.

#### **IV. Qualifying Factors for Treatment**

- A. The absence of any one of the inclusion criteria for treatment or the presence of any one of the exclusion criteria precludes treatment with alpha-Interferon.
- B. The case may, upon request by the inmate or physician, be reviewed by the institution's Medical Authorization Committee and if all members agree, treatment is approved.
- C. If there is dissent, the case may be referred to the Central Office Health Care Committee.

#### **V. Evaluation**

- A. When a patient does not meet the criteria for alpha Interferon treatment, the treating physician shall consider other diagnostic entities, evaluations and treatments, including referral to a gastroenterologist or other specialist consultant.
- B. The diagnosis of chronic liver disease caused by HBV and HCV shall be made using examination, evaluation and the HCSD guidelines.
- C. Other Differential Diagnosis (examples; these are not meant to be all-inclusive):
  - 1. Hepatitis B and D, F, and G viruses
  - 2. Epstein-Barr virus infection
  - 3. Cytomegalic virus
  - 4. Alcohol and/or drug related hepatitis
  - 5. Cholestatic liver disease
  - 6. Steatohepatitis
  - 7. Autoimmune disease
  - 8. Alpha-one antitrypsin deficiency
  - 9. Wilson's disease

## **VI. Reporting**

- A. Each institution's health care staff are legally required by Title 17, California Code of Regulations (CCR), Section 2500, to report infectious hepatitis to their local County Health Department. It is also necessary to report these cases to the Public Health Section (PHS) to enable compliance with the Legislative Supplemental Report of the 1996 Budget Act.
- B. Funding for hepatitis treatment depends upon the accuracy and completeness of information reported. Several documents are used to report hepatitis cases to the PHS.
  - 1. Confidential Morbidity Report (CMR)
    - a.) Sent to the Local County health Department
    - b.) Sent to the Public Health Section/Inmate Medical Records
  - 2. Monthly Report of Inmate Hepatitis Cases, due by the 10th of the following month. It is to include:
    - a.) The total number of active and chronic cases of HBV and HCV
    - b.) The number of liver biopsies done for the diagnosis of viral hepatitis
    - c.) The names of CDC inmate patients on interferon treatment
    - d.) The names of inmates and patients whose alpha-Interferon treatment
    - e.) The names of inmates and patients whose alpha-Interferon treatment has been stopped
    - f.) Those inmate patients whose diagnosis was made as a result of a "gassing" or blood borne pathogen exposure.
  - 3. Distributed Data Processing System (DDPS)
    - a.) Provides codes for types of hepatitis cases
    - b.) Allows for entry of data directly into the system

## **VII. Treatment**

- A. Eligibility criteria for alpha-Interferon therapy in patients diagnosed with HBV and HCV, treatment guidelines, and monitoring recommendations are outlined in Criteria for Hepatitis C, found on page 69.
- B. Inmate patient laboratory monitoring of alpha-Interferon therapy shall occur at least at 4, 12, and 26 weeks.
- C. In the event the HCV quantitative virus level is still detectable after the third month of therapy, the treating physician will consider alternative therapy or discontinuation of therapy.

## **Patient Eligibility For Alpha-Interferon Treatment Hepatitis B**

### **Inclusion Criteria**

*Absence* of any one of the Inclusion Criteria excludes inmate from the program. However, the case may be reviewed by the local Medical Authorization Review (MAR) Committee then by headquarters Health Care Review Committee if necessary.

- A. Age > 18 - < 65 years
- B. Serum Hepatitis B(HB)e Antigen (HBeAg) positive
- C. Serum HB surface Antigen HBsAg) positive > six months
- D. HB Virus (HBV) quantitative viral load assay positive (any method)
- E. Consent signed for random drug and alcohol screening during treatment
- F. Consent signed for special therapeutic procedures

### **Exclusion Criteria**

*Presence* of any Exclusion Criteria excludes inmate from the program. However, the case may be reviewed by the local MAR Committee. If there is dissent concerning treatment, then the Central Office Health Care Committee should be consulted.

- A. History or documented use of injection drugs or alcohol within preceding three (3) months or during treatment process
- B. Poor control of a major medical illness (e.g., diabetes, mellitus, hypertension, chronic obstructive pulmonary disease [COPD], left ventricular failure)
- C. Poor control of a major psychiatric illness
- D. Inability to complete follow-up and treatment process
- E. Organ transplant recipients
- F. Duration of infection > 20 years
- G. Clinical signs or symptoms of liver disease (ascites, encephalopathy, history of variceal bleeding)
- H. Human Immunodeficiency Virus Antibody (HIV-AB) positive *and* T-cell helper lymphocytes (CD4) < 500
- I. Hepatitis Delta Virus (HDV)-AB positive
- J. Platelet count < 100,000
- K. Liver biopsy: presence of bridging necrosis and/or cirrhosis
- L. Antinuclear Antibody (ANA) > 1:640

## **Patient Eligibility For Alpha-Interferon Treatment Hepatitis C**

### **Inclusion Criteria**

*Absence* of any one of the Inclusion Criteria excludes inmate from the program. However, the case may be reviewed by the local Medical Authorization Review (MAR) Committee. If there is dissent concerning treatment, then the Central Office Health Care Committee should be consulted.

- A. Age > 18 - < 65 years
- B. Hematocrit (Hct) > 30%, Albumen (Alb) > 3.5 gm/dl, Creatinine (Cr) < 1.5mg/dl, International Normalized Ratio (INR) < 1.2
- C. Viral RNA positive, Polymerase Chain Reaction (PCR) process if available
- D. Consent signed for random drug and alcohol screening during treatment
- E. Consent signed for special therapeutic procedures including liver biopsy
- F. Liver biopsy: presence of inflammation
- G. Elevated ALT (SGOT, transaminase) > 45 u/ml

### **Exclusion Criteria**

*Presence* of any Exclusion Criteria excludes inmate from the program. However, the case may be reviewed by the local MAR Committee. If there is dissent concerning treatment, then the Central Office Health Care Committee should be consulted.

- A. History or documented use of injection drugs or alcohol within proceeding three (3) months or during treatment process.
- B. Poor control of a major medical illness (e.g., diabetes, mellitus, hypertension, chronic obstructive pulmonary disease, left ventricular failure)
- C. Poor control of a major psychiatric illness
- D. Inability to complete follow-up and treatment process
- E. Organ transplant recipients
- F. Clinical signs or symptoms of liver disease (ascites, encephalopathy, history of variceal bleeding)
- G. Human Immunodeficiency Virus – Antibody (HIV-Ab) positive *and* T-cell helper lymphocytes (CD4) < 500
- H. Platelet count < 100,000
- I. Liver biopsy: presence of bridging necrosis and/or severe cirrhosis
- J. Globulin > 5.0 gm/dl
- K. Antinuclear Antibody (ANA) > 1:640