THE NEWSLETTER OF THE SOCIETY OF CORRECTIONAL PHYSICIANS

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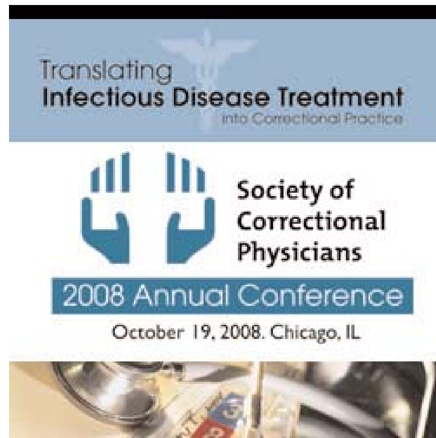
CorrDocs

Translating Infectious Disease Treatment into Correctional Practice

Dean Paul Rieger, MD, MPH, and Lynn F. Sander, MD, FACP, FSCP

On Sunday, October 19, the Society of Correctional Physicians held its Annual Conference and Membership Meeting. Once again the conference provided some of the most interesting and provocative continuing medical education available for correctional physicians. This article briefly describes the eight presentations; there will be more in-depth articles on some of the presentations in this and future issues of *CorrDocs*.

The conference opened with a breakfast presentation by Dr. Lester Wright, Chief Medical Officer for the New York State Department of Correctional Services, entitled HCV Management: Breaking Down Barriers to Care. The presentation addressed the challenge of continuing services for released patients who had hepatitis C evaluation and treatment started in the facility. Dr. Wright recognized that the treatment criteria requiring a predicted long length of confinement before therapy is begun need not exist as a barrier for those who would otherwise be candidates for such treatment. Using his contacts within the public health department in New York City (NYC) and with the HIV treatment community, he was able to create a treatment network providing continuity of care for those with HCV infection. Dr. Wright was able to obtain the funding by creating a coalition of providers including HIV and other treatment clinics located throughout New York State, NYC Health and Hospitals, NYS Department of Health, NYS Division of Parole, and pharmaceutical corporations with "access programs." Thus far, over a hundred inmates have been enrolled in the program.



Dr. Joseph Paris, DeKalb County Board of Health and Jail, followed with an interactive session on clinical dilemmas. Although Dr. Paris brought four very different cases for discussion, audience participation was so enthusiastic that only three could be addressed in the time provided. Details of this session are elaborated in a separate article on page 14.

Dr. Marc Stern, Health Services Director, Washington State DOC, followed up with a companion session dealing with administrative dilemmas, including that of a patient, who was not mentally ill, on a hunger strike. The Washington Supreme Court supported the DOC's authority to force feed the patient as necessary to preserve life. Initially, the discussion seemed to be uncontroversial; however, a member of the audience presented a similar case from his state in which the court decision not only permitted the patient to strike, but enjoined the correctional agency from force feeding, ultimately leading to the patient's death. Next, Dr. Stern presented a series of

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Letter From the Editor

It is hard to believe that another volume of *CorrDocs* has been completed. My thanks go out to everyone who contributed to its success.

As always, the Fall issue focuses on our annual conference. For those who couldn't attend, I hope that the brief recap and the more in-depth article on managing clinical dilemmas give you a taste of the meeting. Perhaps noting the date of October 18 for next year's conference in Orlando will allow you enough time to put it on your schedule. Most who attend find that networking with their colleagues is as useful as the actual sessions.

With the loss of Scott Savage's column, I have been recruiting authors for a regular ethics column. I am happy to announce that long-time SCP members Dean Rieger and Mike Puerini will be jointly filling that role,beginning with the next issue. Until then, there are several provocative articles in this issue that deal with ethical dilemmas including the ones on sexual victimization and managing clinical dilemmas.

I hope you find other information useful such as the newly approved position statement on restraints. This is SCP's first foray into independently voicing the physician perspective on matters that involve us. The legal column provides good advice on what constitutes a legal release of information. And the article on the revised NCCHC jail standard on receiving screening educates us on our role in that process.

Lastly, our humor column this month is an example of what we can do for our patients when we and outside agencies (including international) work together collaboratively.

Lynn Sander, MD
Editor

Article Submissions

CorrDocs' purpose is to communicate the thoughts and ideas of correctional physicians, as well as to report on news that impacts their practice. We welcome all submissions. Articles should be approximately 750 words in length and submitted electronically, preferably in Word.

Letters to the Editor

Did an article, opinion, or statement in *CorrDocs* inspire you, impact your work, sound too good to be true? Express your opinions in a letter to the editor. The editor relies on your feedback to continually improve the quality of information in *CorrDocs*.

Direct All Submissions to:

Lynn Sander, Editor
editor@corrdocs.org
fax: (773) 880-2424

Board Report July/August

Through the work of our Education Committee, SCP was able to get several grants to help support this year's annual conference. Since it is our largest meeting of the year, it is our largest expense and these grants are a welcome gift. One of these grants will come from Morehouse School of Medicine as part of its research plan to determine Quality Correctional Health Services: The Views, Attitudes and Beliefs of Correctional Health Care Providers. A survey will be distributed at our annual meeting in October.

In July, the board approved a position statement on the use of restraints (see page 3), developed by the Policy and Practice Steering Committee. We are looking at several mediums through which to publish it. The committee is now looking for new topics to tackle. If you have an issue you would like SCP to take a position on, let us know!

The Memorandum of Agreement between SCP and the National Commission on Correctional Health Care is nearly finalized. The MOA was developed to increase collaboration between SCP and NCCHC, including development of a certification program for physicians under the CCHP unbrella. The board strongly believes this relationship will strengthen both nationally-recognized organizations.

On behalf of the Membership Committee, check your membership expiration date! All membership expire on December 31.

Rebecca Lubelczyk, MD
Secretary

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All advertising and other queries may be sent to:

Society of Correctional Physicians
1145 West Diversey Parkway
Chicago, IL 60614

www.corrdocs.org WEB
scp@corrdocs.org E-MAIL

773-883-5375 PHONE
773-880-2424 FAX

www.corrdocs.org

The field of correctional medicine continues to experience increasing professionalism and recognition of its specialization. Gone are the days when physicians practiced in correctional settings due to restricted or absent medical licenses. Today we practice in correctional settings as a choice: A choice that requires not only excellence in clinical skills, but the ability to navigate security requirements, political winds, and budgetary restrictions in providing the best care to our patients.

Our field requires specialized training that most of us received on the job or as a result of having some great mentors. As correctional medicine moves forward, more and more academic institutions are establishing correctional medicine fellowship programs to address this specialized need for training physicians. In the future, I expect that more of these fellowship programs will be established, and hope that residency programs with specialty recognition will soon follow. SCP is closely monitoring this trend and is pursuing the feasibility of specialty recognition.

For physicians currently practicing in the field, SCP continues to provide opportunities for professional development. We are the one organization whose mission is to specifically address the needs and concerns of correctional physicians. Our organization has continued to grow steadily, particularly over the past four years, to include new membership and an increase in renewals. Last year renewal membership retention increased from 73% to 82%. I encourage you to continue your own membership and to reach out to your colleagues and encourage them to join as well.

One of the major benefits of membership is the educational programming we provide at our annual conference, most recently held October 19 in Chicago. The focus was on infectious disease and included a host of expert presenters. The topics always included information relevant to a correctional practice. Details of the conference are presented in this and the next issue of *CorrDocs*. We plan to offer more educational programming that will benefit our membership at next year's annual conference in the Fall and at NCCHC's Updates conference in the Spring.

Other exciting SCP news includes an update to our Web site, which will be followed by a larger update project in January, as a result of our collaboration with NCCHC. Be sure to check out our Web site to see current and past issues of *CorrDocs*, search the membership directory, find upcoming meeting and events, and read SCP position statements.

Your membership is important to us. In addition to the ability to access CMEs specific to correctional medicine, there is no other setting that offers the opportunity for networking, mentoring and patient advocacy through policy and practice. I encourage you to continue to support your organization in its continued growth so that we will continue to ensure a strong voice for correctional medicine.

Michelle Staples-Horne, MD
President

Evaluation of Incarcerated People in Custody-Ordered Restraints

Adopted by the SCP Board of Directors, July 31, 2008

Introduction

Recognizing that restraints can be a necessary tool that custody staff sometimes must use to control the behavior of incarcerated individuals, the Society of Correctional Physicians adopts this position statement with a goal to enhance safety for both incarcerated individuals and staff.

Restraints are used by criminal justice agencies and in correctional facilities for a variety of purposes, including:

- the safe escort of incarcerated people within and between secure environments (e.g., wrist, waist and leg restraints);
- seclusion or restraint, as an emergency measure, by a physician's order for mental health or medical reasons to prevent imminent harm to the patient or other persons when other means of control are not effective or appropriate; and
- custody-ordered restraints to control an incarcerated person's problematic behavior by strictly limiting movement (e.g., four point restraints, restraint chair).

This position statement focuses solely on the last situation. Guidance on physician-ordered restraints and seclusion may be sought from other sources, such as the statement of a workgroup of the Council on Psychiatry and Law[1].

Groundbreaking work by Strumpf and Evans resulted in a marked change in restraint standards and decreased use of restraints for patients in nursing homes and hospitals[2]. When physical restraint is used as the measure of last resort, the result has generally been enhanced institutional, patient and staff safety. SCP endorses the extension of this key concept to correctional justice facilities.

Incarcerated people may have medical or mental conditions that bring about, or may be a result of, the use of custody-ordered restraints that strictly limit movement. Because custody personnel are not clinicians, they do not have the background or training to make clinical assessments; therefore, evaluation by qualified health care professionals[3] is

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required in most circumstances and should always be available and used. The availability of such services must be considered before security staff makes a decision to place an inmate into physical restraints for behavior control.

There is no use of physical restraint that is without risk. Physical restraint, for even brief periods of time, may be associated with a variety of harmful outcomes, including local trauma, myocardial infarction, asphyxia, aspiration, venous thrombosis, pulmonary embolism, rhabdomyolysis and death. Even with monitoring by qualified health care professionals (as defined in the NCCHC Standards Manuals), adverse outcomes may occur. Qualified health care professionals should provide adequate information to security staff to assist them in assessing the possible health risks as well as the possible benefits in the use of custody ordered restraints.

The National Commission on Correctional Health Care addresses the use of restraints in its *Standards for Health Services* (standards J-I-01, P-I-01 and Y-I-01). The compliance indicators for these standards require immediate notification of health services staff who must review the health record for contraindications or required accommodations and do health monitoring during restraint. Further, the NCCHC standards require notice to the physician and communication of concerns regarding improper use of restraints to appropriate custody staff. SCP supports and endorses the NCCHC standards and presents this position statement as an elaboration on them.

Position Statement

The Society of Correctional Physicians endorses the following principles for the medical evaluation of incarcerated people placed in custody-ordered restraints to control problematic behavior by strictly limiting movement:

- Restraints are only used when less restrictive measures are, or would be, ineffective to protect the incarcerated person or others from harm.
- Potential risk to the incarcerated person from the use of restraints that strictly limit movement should be considered before such restraints are used to control behavior.
- Facilities should have and use policies and procedures regarding the use of custody-ordered restraints. The policies and procedures should include specific plans for the medical and mental health evaluation and monitoring of all incarcerated people who remain in custody-ordered restraints for behavior control for more than a few minutes. The medical director of the facility or system should have input into the development and periodic review of these policies and procedures.
- Qualified health care professionals evaluate incarcerated people as patients and do not give clearance, permission or consent to the use of custody-ordered restraints. These health care professionals are present for the benefit of their patients and to advise security regarding the medical best interests of the restrained individual.
- If further medical evaluation and treatment, including off-site care, is ordered by a qualified health care professional, timely arrangements should be made for such care. This requires a collaborative effort by health care and custody staff.
- Incarcerated people in custody-ordered restraints to control behavior need access to adequate hydration, food, hygiene, toileting and ongoing health monitoring by qualified health care professionals.
- While custody staff should frequently assess the need for continued restraints as a security procedure, health staff should frequently assess the potential health risks of continued restraints, as these may change over time. Any change in health risk must be communicated to the appropriate custody staff.
- All health services and custody staff should be trained regarding the safe evaluation of incarcerated people with problematic or dangerous behavior and the requirements for the care of restrained individuals before, during and after being physically restrained. Staff should also be trained to recognize possible injuries and adverse reactions that may be associated with the use of this form of physical control, and to recognize that negative outcomes may occur even with monitoring by qualified health care professionals.
- All health services and custody staff have a duty to report occasions of possible abuse and patient deterioration (physical or mental).

Endnotes

[1] Metzner, J.L., et. al., “The Use of Restraint and Seclusion in Correctional Mental Health Care”. Resource Document, Approved by the Joint Reference Committee, December 2006, American Psychiatric Association.

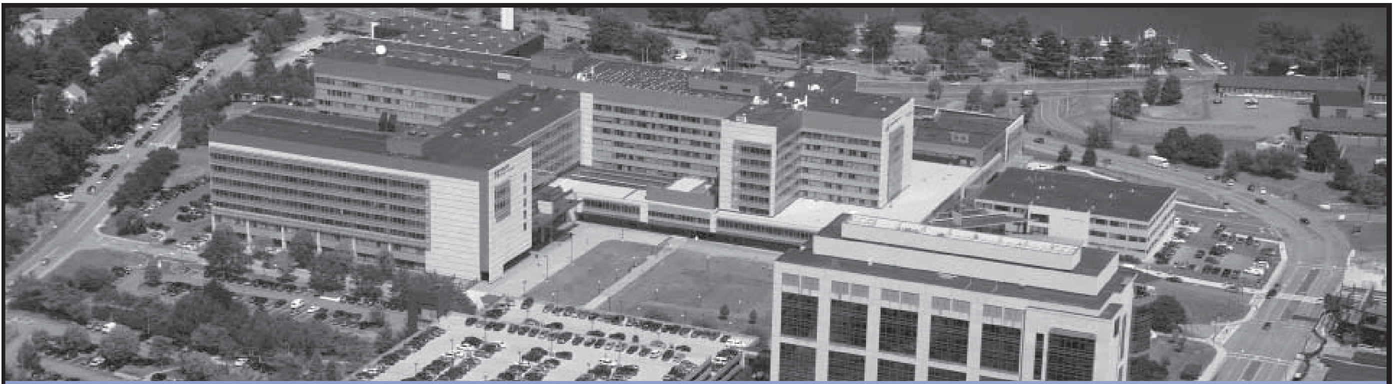
[2] Strumpf, N.E., Robinson, J., Wagner, J., & Evans, L. (1998). *Restraint Free Care: Individualized Approaches for Frail Elders*. New York: Springer Publishing Company.

[3] Qualified health care professionals include physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for patients.

[4] *Standards for Health Services in Jails*. (2008). Chicago, IL: National Commission on Correctional Health Care.

[5] *Standards for Health Services in Juvenile Detention and Confinement Facilities*. (2004). Chicago, IL: National Commission on Correctional Health Care.

[6] *Standards for Health Services in Prisons.* (2008). Chicago, IL: National Commission on Correctional Health Care.



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A Program of Commonwealth Medicine

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Jail Intake Screening: Understanding the Physician's Role

Joseph E. Paris, PhD, MD, FSCP

Implementing a sound intake screening process has always been a challenge for jail administrators, custody and medical staff. Most jail physicians are only peripherally involved in this activity, which is usually performed by custody or nursing staff. However, because of its significant impact on inmate health care at the facility, physicians should have a clear understanding of the issues involved. The recently published 2008 NCCHC *Standards for Health Services in Jails* include a revised essential standard, J-E-02 Receiving Screening, which must be met to be accredited. (Note: The concepts below represent the author's views. NCCHC accreditation staff should be contacted for official opinions on the issues.)

J-E-02 states that receiving screening is performed on all inmates at the intake facility to ensure that emergent and urgent health needs are met. This simple sentence is followed by 3½ pages describing compliance indicators, definitions, discussion and optional recommendations. Careful reading will reveal that compliance to J-E-02 entails the crafting of three distinct phases of the intake process:

1. medical clearance
2. booking performed by security staff
3. receiving screening performed as soon as possible by nursing staff or medically trained custody staff.

Medical clearance, a new concept not found in the 2003 *Standards*, may be performed by security or medical staff, and consists of a quick inspection of the new arrivals before they are "booked" or admitted to the facility. In some jails, medical clearance is referred to as prebooking screening. Only simple observation is mentioned specifically, because compliance with J-E-02 requires that immediate health needs (e.g., the need for life saving medications, insulin) are identified and addressed; however, a number of questions also will have to be asked. Additionally, potentially infectious individuals may need to be isolated and treated. Lastly, J-E-02 requires that medical clearance is documented in writing.

For those who work in facilities that admit patients from the street, the rationale for this early phase—medical clearance or prebooking screening—is obvious. The medical receiving screening proper can only proceed after an inmate is booked (fingerprinted, photographed and given a comprehensive evaluation of the security risk to determine what precautions should be taken by the staff). This may take 4 hours or more depending on the number of persons who present simultaneously at the facility. In some jails, the booking process may be prolonged if a judge requests that the inmate be brought to a courtroom for judicial proceedings prior to the booking. With the addition of medical clearance before booking, it is possible to rapidly screen out arrivals who may be inappropriate for admission to the facility or who have immediate health needs.

Since health care needs requiring follow up are identified during the intake process, and patients with significant needs may be lost to such follow up if the intake procedure is inadequate, jail physicians should understand the three phases of the intake receiving process at their facility. They should also be familiar with the level of personnel who are performing each phase of the screening, the information gathered, and the timeframe for each phase. Ideally, physicians would be involved in the development of the processes and training of staff. They also should participate in Continuous Quality Improvement activities regarding receiving screening, assessing whether the process in place adequately identifies all patients with medical needs. It is hoped that similar intake processes will be implemented in nonaccredited jails, as they may greatly contribute to the operation of a safe and humane receiving screening and subsequent incarceration for all inmates.

Dr. Paris is an SCP member and NCCHC surveyor. He is a busy correctional health care consultant, and part-time physician at the Dekalb County Jail in Atlanta, Georgia.

On the Hill

Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act

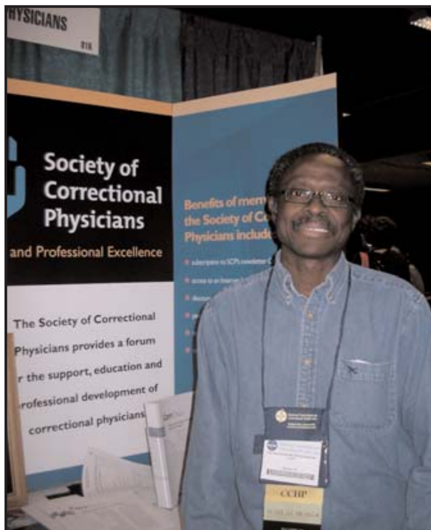
On October 14, the President signed into law S2304, the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act. S2304 reauthorizes the Mentally Ill Offender Treatment and Crime Reduction Act for an additional five years at $50 million per year. The bill also expands training for law enforcement to identify and respond appropriately to individuals with mental illnesses and supports the development of law enforcement receiving centers to assess individuals in custody for mental health and substance abuse treatment needs.

Stop AIDS in Prison Act

On September 25 the House passed HR1943, the Stop AIDS in Prison Act, and referred it to the Senate. The bill would require that inmates be tested for HIV once a year upon their request, and would call for confidential counseling for inmates before and after HIV testing. The bill would require that federal prison medical personnel provide "timely, comprehensive medical treatment" to HIV-positive prisoners. Inmates also would be tested before being released, unless they decline the testing and were not involved in an exposure incident. HIV-positive inmates scheduled for release would receive counseling, treatment referrals and a 30-day supply of any "medically necessary medications" they are already taking.

Continued from page 1

topics that had been solicited on the SCP listserver and prioritized by audience members. The first topic chosen was demands for special boots and bottom bunks. Although clinical indications for these are rare, the demand is greater than the legitimate need. It was pointed out that practitioners should determine in each case whether there is a true medical need versus something the patient wants, and practice accordingly, carefully documenting the decision process. It is also helpful to have guidelines for the use of these items delineated by protocols. The second topic chosen was the patient who repeatedly taxes the resources of health services with little apparent disease. There was consensus that regularly scheduled appointments are helpful in managing this group of patients. As the patient



Olugbenga Ogunsanwo stops by the SCP booth to greet conference attendees.

comes to trust that his medical needs will be met, the frequency of these appointments may decrease. Mental health personnel may also be helpful in identifying underlying etiology of the behavior. In these circumstances, documentation of a thorough evaluation is crucial as these inmates frequently file lawsuits. The final topic chosen was how to obtain medical information needed for continuity of care from a community hospital when the emergency department or other clinical areas do not provide it. Several solutions, which can be implemented simultaneously, were suggested:

- Speak with the HIPAA compliance officer as personnel may be concerned about violating these regulations. Occasionally, you will need to educate them on the differences in HIPAA rules for correctional institutions.
- Send a signed ROI with the patient; although not required, this may improve communication.
- Schedule routine meetings with hospital administration, creating a partnership to discuss all aspects of your relationship with them.
- If all else fails, withhold payment until the information is produced.

Dr. Robert Greifinger, Adjunct Professor, John Jay College of Criminal Justice, gave a presentation on MRSA. He stated that the two components necessary to decrease the spread of MRSA are the care of the individual patient and management of the environment, adding that MRSA is ubiquitous and surveillance is crucial. He noted that the prevalence of MRSA may be increased by overprescribing of antibiotics, and that treatment of MRSA does not always require them. When antibiotics are required, selection should be based upon the antibiotic resistance profile of your facility. Currently, there is no standardization of culture recommendations. Practice ranges from culturing whenever possible to limiting cultures to patients with serious infections, underlying diseases, infections that don't clear, recurrent infections, or with an unclear diagnosis. Whenever there is widespread MRSA infection in the facility, Dr. Griefinger noted it is likely related to inadequate laundering procedures. Water must be 140º-160º F with contact from 30 to 20 minutes. If these temperatures cannot be obtained continuously, use bleach at 200 ppm (or 2 tablespoons in a home washing machine) to kill bacteria without destroying clothing and linens. Other important points

Marc Stern leads the audience in a lively discussion of management dilemmas.

were:

- Avoid the cephalexin for skin infections as it is ineffective in treating MRSA.
- Make sure that bleach is available for disinfecting surfaces such as bathrooms and showers, and hospital grade disinfectants for other surfaces.
- Provide educational programs for personnel and inmates responsible for laundry and cleaning.

Dr. Michael Lynch, a medical epidemiologist with the CDC, rounded out the morning's presentations with a discussion of foodborne outbreaks. After a review of their general characteristics, he presented a case from a prison in which there were three brief but identifiable outbreaks of *Campylobacter jejuni* culture proven to be the same strain. After an investigation, it was thought that the outbreaks were caused by water intermittently dripping from an uncapped extension of a pipe leading from the roof to the sewage system. Several months after the pipe was capped, however, there was a

Nicholas Scharff contributes to the conversation, adding perspectives from his personal experience.

fourth outbreak. There have been no outbreaks since the fourth episode, and the cause of the outbreaks is still uncertain. Other points made were:

- Saved trays are rarely if ever useful.
- Screening workers is useful only in selected circumstances.
- Pathogens on fresh vegetables are drawn into the plant tissue by water making removal difficult.

After a networking luncheon, Dr. William Wong, Medical Director of the Chicago Department of Public Health, related Cook County's experience with screening for sexually transmitted diseases. In Chicago, prevalence is high for both gonorrhea and chlamydia. Although jail-based screening identified large numbers of infected men and women, and their treatment resulted in a decreased prevalence in their community of residence, lack of funding has prevented the program from continuing. When the screening was suspended, the prevalence in the community rose, underscoring the relationship between provision of jail health treatment and community health.

2008 Start Award winner, Anne Spaulding, is congratulated by Rebecca Lubelczyk.

Save the Dates!

2009 Annual Conference
October 18
Orlando, Florida

2010 Annual Conference
October 10
Las Vegas, Nevada

Dr. Wong noted that patients were very accepting of urine-based testing, but it is crucial to treat patients as soon as test results are known.

The conference concluded with Dr. Anne Spaulding, Assistant Professor of Epidemiology at Emory University's Rollins School of Public Health, discussing pandemic influenza. She stated that the world is overdue for the "next pandemic flu outbreak," and that we should not become complacent as correctional institutions will be impacted. In the 1918 epidemic, there were three identifiable outbreaks at San Quentin prison in California.

A lesson learned from the 1918 epidemic was decreased morbidity associated with "social distancing" (e.g., closing of churches, movie theaters, schools and other places where people congregate). She suggested that limiting movement in prisons could reduce transmissibility and infection rates. Examples of this in a prison might include cessation of group activities, use of masks to reduce airborne secretions, and termination of visitation. Vaccination most likely will not be available because of production time needed, and current anti-influenza medications are not always effective. Other potential problems to be dealt with are staff shortages due to caring for ill family members or children if schools are closed, fear of contagion, and inadequate health resources (not only in our facilities, but also in the community). In closing, Dr. Spaulding stated that the pandemicflu.gov Web site is a resource on pandemic influenza planning and research.

The annual membership meeting concluded the day's events. The meeting was called to order by SCP President Michelle Staples-Horne. Anne Spaulding, chair of the education committee, reported that planing has already begun for next year's conference so as to be competitive in obtaining funding from government grants which must be submitted in January.

Michelle Staples-Horne consults with Buzz Keiper, and other attendees during a brief intermission.

Tom Lincoln, chair of the Web site committee, reported that SCP's Web site now has a functional online directory for members only, and that more services are to follow. Mike Puerini, chair of the policy and practice steering committee, announced that the position statement on use of restraints has been approved. Suggestions for other statements are now being sought. Paula Hancock, SCP's COO, reported that the organization's finances are improving and anticipates finishing the year in the black. She also reported that membership has increased and asked members to become active and fill out the Call for Volunteers form that was circulated. There will be an election for the SCP Board this year and a call for nominations will be forthcoming. There being no more business, the meeting was adjourned.

Lester Lewis patiently waits for his question to be answered. SCP attendees are a talkative crowd!

A Day in the Life: The Accidental Tourist

Kelly O'Brien, MD, FACP, CCHP

As the world is becoming more globally connected, so is medicine. Even those working in correctional institutions are part of this phenomenon.

A page from the psych nurse is rarely a good sign. "We've got a guy here, very psychotic. Not talking, bizarre behavior. We think he only speaks German."

Ah. A psychotic German. He wasn't causing problems, was eating okay, not getting in fights. Actually, it was surprising the psych nurse found him. Attempts to communicate through the language line were not successful. The frazzled German interpreter reported that Mr. Hansel wouldn't respond, which was obvious watching from this end. A German speaking sergeant came to help, "He won't speak, and when he does, it doesn't make any sense." The patient was sent from jail to the county hospital. Not the psych ward, the locked jail ward, while we tried to figure out what to do.

A passport in his property revealed he'd arrived through New York 4 months earlier. It was certainly reassuring to see the stamp of approval from Homeland Security. Now he was in Denver, in jail, mute, unkempt, unreachable and unknown. We began a multipronged attack on this problem.

The sergeant, distressed at the pathos of his countryman, called the "German police." Apparently there's one big force, and you don't waste time on details like cities or states. As it happens, an APB had been out for our patient. He'd wandered away from a group home leaving his fellow patients and psychiatrist with a hole in their midst. His father was located; medications were verified. The Tourist's father agreed to pay airfare for the patient and an escort. All we had to do was contact the German Counsel.

The German Counsel in Denver consists of a lone man with a briefcase. He referred us to the embassy in Los Angeles. Our contact there, in his first week of employment, now had his first big case. He was enthusiastic and hopeful, traits not often seen in those of us who work with homeless psychotic guys in jail.

I jokingly suggested I'd be happy to escort him home. For future reference, German embassy officials have no sense of humor. "Fine. Can you be ready this Friday?" Not one to turn down a free transatlantic flight, I quickly agreed. The hospital, however, said something to the effect of No Way On Earth, citing details like liability, time off work, etc. The sergeant was willing to go but the Sheriff's Department had the same reaction. Word got out, leading to interesting voice mails: "Dr. O'Brien, this is Joel on 9th floor. I speak some Polish, and I can get this weekend off. Let me know if you need me."

One of the Important Staff Physicians recommended the Complex Discharge Committee as a resource. An appropriate multitude of calls were made to get him on their agenda, ahead of the other homeless psychotic guys found at county hospitals. Five days later, they met, deliberated and delivered with pride the enthusiastic recommendation that I contact the Germany embassy.

Then the Important Staff Physician commented, "You don't want to spend 12 hours next to some psychotic guy on a plane," showing how little he knows about my life. This patient is almost mute. I live with a 15-year-old daughter who speaks English well and constantly. Her life is a psychodrama. Twelve hours with the Accidental Tourist sounded like a vacation. No matter, I was not to go. The sergeant and I sadly informed the embassy that neither of us could travel. The Tourist's father was too frail to come alone, and he had no other family. The embassy official began the task of finding an employee who wanted a really quick trip back to Germany.

Fortunately, Denver has an innovative court-to-community program, and in stepped our Angel Advocate. She could arrange his release from custody on the day of his flight to Germany. All we needed was someone to get him from jail to the airport while not letting him know that technically he wasn't in custody anymore.

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Legal and Legislative Updates

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form. You would not be permitted to discuss the care and treatment with the requestor.

Again, the safest course is to require a specific release for the interview requested. If parole officer John Doe wants to interview Dr. X and mental health caseworker Y, then the patient's release needs to state: "I authorize Dr. X and mental health caseworker Y to meet with parole officer John Doe and discuss my protected health information, including but not limited to my mental health conditions, diagnoses and treatment." With this specific patient release, you can be confident that the patient understands and authorizes the meetings.

While this may seem cumbersome for the requestor, your obligation is not to the requestor, but to the patient. The natural desire to assist and provide information cannot get in the way of necessary legal protections, designed not just to protect the patient, but to protect the health care provider as well.

So, when does a patient release actually protect you? Not until it specifies the entity or provider authorized to release the information, the exact type of protected health information to be released, whether it applies to written records, oral discussions of protected health information or both and when it contains reasonable time parameters.

Ms. Johnson is an attorney with Insley and Race, LLC, in Atlanta, Georgia. Readers may contact her at djohnson@insleyrace.com.

When Does A Patient Release Protect You?

Deana Johnson, JD

It happens weekly: a client calls, reports that someone is requesting records, mentions there is a patient release, and seeks approval for the release of the requested information. The lawyer's response is always the same.... We need to review the release.

Although the caller may be too polite to say it, the natural question is "why?" The answer, and purpose of this article, is that certain categories of information require very specific releases, and what is given by the requestor very rarely complies. Therefore, if the provider releases the requested information, he can be liable for violations of federal and/or state law, many of which contain strict penalty provisions.

There has been much written and even more complaining about HIPAA, a federal law governing confidentiality of patient records. The reality, however, is that most states had laws protecting this same information long before HIPAA was first debated by the legislature. Specifically, information about mental health treatment and infectious diseases has long been recognized as highly sensitive, requiring more than the garden variety release from the patient. HIPAA did not change those preexisting state laws; instead, it supplemented them. Thus, both before and after HIPAA, release of mental health or infectious disease information mandates a specific, knowing and timely release by the patient.

A True Story

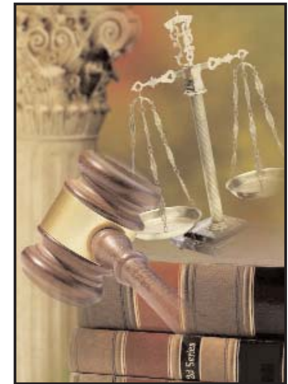
An investigator from a parole board wanted to review mental health treatment records of a parolee to determine if he was meeting the conditions of his parole. The investigator sent a release to the treating facility and repeatedly called, asking to expedite the request. A call such as the one described in the first paragraph was placed to our law office. Upon a quick review, it was apparent that the release signed by the patient (almost a year prior) applied to telephone service providers, not health care providers. If the institution had relied on that release and provided confidential mental health information about the patient, both HIPAA and state law would have been violated.

Did the investigator knowingly provide the wrong type of release? Probably not. Releases have become so common, people are asked to sign very general forms well before information is actually needed. These contain no expiration date and no parameters on the type of information being released. Do not let a requestor bully you into believing such a general release protects you.

Instead, the first question always to ask is what specific information is being requested. The only way to answer that and protect yourself is to require the request be made in writing. Even an informal email suffices to put necessary parameters on the request.

The second question examines whether the patient release specifically covers the type of information requested. In order to answer this second question, you must see the release. Who is it addressed to? When was it dated? What information does it cover? A phrase such as "all medical information" or "all information in your possession" is insufficient to allow release of mental health or infectious disease information.

> Releases that protect you MUST specify:
> ✓the entity or provider authorized to release the information,
> ✓the exact type of protected health information to be released,
> ✓the type of records that it applies to, i.e. written, oral or both, and
> ✓reasonable time parameters.



In order to comply with HIPAA and many state laws, a release for mental health or infectious disease information must specifically state that is the type of information being released. In addition, the release must contain reasonable time parameters. While the specifics of these items vary depending upon state law, a general rule to follow is that the release be limited to one year from date of execution and include separate lines for release of mental health or infectious disease information that are separately initialed by the patient. That way, the patient is clearly aware he or she is releasing this very specific type of information.

If you are uncomfortable with the release provided, insist that the requestor use your institution's form. Most hospitals and correctional facilities have form releases that the legal staff has reviewed and approved.

One final area to address is when the requestor does not seek copies of records, but instead or in addition, wishes to interview the providers. Such requests arise in the context of lawsuits, challenges to sentences, parole hearings, etc. Most of the time, the requestor sends the same release that he would use if seeking records. If you go back to the second question above—the type of information requested, you can find the answer to whether an interview is permissible. If the release is for mental health records, for instance, the patient has not permitted you to release protected health information other than in record

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In the meantime, the Tourist went to court. He was clearly incompetent, but if released he'd be out the door and lost some where in the United States again. The judge agreed not to address the competence issue at this time.

Multiple e-mails flew from hospital to court services to jail to the sergeant's house to the German embassy, the German police and the German psychiatrist.

The patient improved enough to return to jail. Medications were continued, e-mails were continued, and court was continued while we stalled until we heard back from the embassy. The sergeant kept up his persistent phone calls, the embassy official kept scouring viable employee travel options, and the Angel Advocate kept standing by, unsigned release form in hand. The Important Staff Physician and the Complex Discharge Committee kept meeting, though the patient was now at jail and technically out of the hospital; thus their work here was finished.

On Tuesday we heard; the embassy had an escort and two tickets for Thursday. The sergeant e-mailed the hospital, who e-mailed the Advocate, who e-mailed back, and we all e-mailed the embassy and the jail. Then, in an unexpected move, the jail psychiatrist wasn't sure she could "clear him to travel." Fearing violence against the psychiatrist from everyone except maybe the patient, I suggested she reconsider. Lo and behold! He was cleared to fly, but only with a nonmedical German civilian.

Thursday morning, we were sending him out without pills or prescription. The nonmedical German escort couldn't give him medication anyway, and he couldn't fill our script in Germany. We settled on giving him his evening dose early and hoped for no weather delays. The Angel Advocate came with the release as promised. The sergeant showed up at jail and drove him to the airport.

Through the day, as the plan appeared to be working, the Accidental Tourist became more open. He stepped out of jail into the warm July air and told of his adventures riding the bus across the country, visiting his (delusional) family in Minnesota, and coming to stay in the Denver parks. The nonmedical German escort came off the L.A. plane to pick up our patient for the next leg of the trip. As the Accidental Tourist boarded, he warmly shook the sergeant's hand and asked that everyone be thanked for their kindness. Turning back on the tarmac, he shouted with sincerity, "Auf Wiedersehen—I'll be back for Christmas!"

Dr. O'Brien is an SCP member and physician with Denver Health and Hospital. Readers may contact her at kelly.obrien@dhha.org.

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Prison Sexual Victimization: Exploring Frequency and Recommended Help-Seeking Behaviors Among Inmates

Ashley G. Blackburn, PhD, Shannon K. Fowler, PhD, Janet L. Mullings, PhD, and James W. Marquart, PhD

Thanks largely to the Prison Rape Elimination Act of 2003, corrections officials and health care professionals are now researching the understudied help-seeking practices related to prison sexual violence. Described here are findings from a self-report study of more than 900 male (n=485) and female (n=427) inmates in a large Southern prison system. Self-administered surveys were used to measure the frequency of in-prison sexual victimization as well as perceptions on help-seeking behaviors.

When asked whether they had experienced lifetime sexual victimization, 68.9% of female inmates and 27.4% of male inmates responded positively, indicating that 46.8% of our entire sample had been sexually victimized at some point during their lifetime. When asked whether they had been sexually victimized while in prison, 14.8% of our sample responded positively (17.3% females; 12.6% males). Of those inmates reporting in-prison sexual victimization, 40 reported a completed sexual assault, 20 reported an attempted sexual assault, 62 reported unwanted touching, 11 reported sexual abuse and 6 did not indicate how they were victimized.

Our research also explored perceptions of help-seeking behaviors among inmates. Six scenarios were provided (three for the men; three for the women), and the inmates were asked to respond to a series of questions after having read each scenario. All three male scenarios described incidents occurring between two inmates, whereas one female scenario described an incident where the perpetrator was a correctional officer.

The first male scenario described an inmate in debt who was threatened with violence and forced to have oral sex with the inmate from which he had borrowed items. For this scenario, 81.2% of the male inmates suggested the victim should be treated for injuries, 90.2% suggested the victim should be tested for sexual transmitted diseases (STDs), and 80.6% suggested the victim speak with a counselor or chaplain. The second male scenario portrayed a physical assault followed by forced oral sex. For this scenario, 88.4% recommended the victim be treated for injuries, 90.0% recommended the victim be tested for STDs, and 81.0% recommended the victim speak with a counselor or chaplain. The last male scenario depicted a debt induced physical assault and forced anal sex. After reading this scenario, 88.8% suggested the victim be treated for injuries, 90.0% suggested he be treated for STDs, and 78.4% suggested the victim speak with a counselor or chaplain.

The first female scenario described a situation in which the victim was coerced and verbally threatened to stay in a sexual relationship with another inmate. For this scenario, 54.1% suggested the victim get treated for injuries, 82.3% suggested the victim be treated for STDs, and 75.9% suggested the victim speak with a unit counselor or chaplain. The second female scenario portrayed a violent physical and sexual assault between two cellmates. For this scenario, 89.2% recommended the victim get treated for injuries, 89.2% recommended the victim be tested for STDs, and 87.4% recommended the victim speak with a counselor or chaplain. Finally, the last female scenario depicted a forced sexual encounter between a male correctional officer and a female inmate who had once had a consensual sexual relationship. Responding to this scenario, 79.8% suggested the victim be treated for injuries, 86.2% suggested the victim be tested for STDs and pregnancy, and 78.0% suggested the victim speak with a counselor or chaplain.

Some limitations to our research should be noted. First, this was a self-report study on a sensitive topic using an inmate sample. Further, because our sample was not randomly selected, we can only generalize our findings back to inmate population from which our sample was drawn.

Even with these limitations, our findings have a few implications for correctional personnel. First, it was found that almost half of our sample reported lifetime sexual victimization, the repercussions of which, both physical and psychological, correctional authorities and health care professionals will be forced to respond. Additionally, inmates' scenario responses were encouraging in that the majority of respondents recommended help-seeking behaviors for victims. It is interesting, however, that this was less so when respondents perceived the victim carried some responsibility for their victimization (by getting into debt or having a consensual relationship) despite increased violence.

Increased correctional education on and promotion of reporting and help-seeking behaviors is imperative to lessen the stigma associated with such behaviors. As increased attention is paid to correctional facilities across the nation, particularly as relates to in-prison sexual victimization, it will be important for correctional authorities to be aware of the health-related consequences of such victimization so that those consequences are not exacerbated as a victim moves through the correctional system.

Dr. Blackburn is an Assistant Professor, Department of Criminal Justice at the University of North Texas in Denton, Texas. Dr. Fowler is with the University of Texas at Arlington, Dr. Mullings is with Sam Houston State University, and Dr. Marquart is with the University of Texas at Dallas.

Managing Clinical Dilemmas in Correctional Health Care

Lynn F. Sander, MD, FACP, FSCP

Back by popular demand, Joseph Paris, MD, moderated an interactive session on complicated clinical situations at the SCP annual conference on October 19. Dr. Paris pointed out that working in the correctional setting is inherently challenging for several reasons, including practicing medicine in a nonmedical environment. Frequently our patients are not medically sophisticated and are poor historians. This is compounded by the lack of current medical records. This population has a high incidence of mental illness and substance abuse, many have a risk-taking lifestyle, and most come from a medically underserved population with a lack of previous health care. This combination of factors leads to situations usually not found in community medicine.

Several cases were presented and then the audience was asked for suggestions on how to manage the situation. In most cases, there is no right or wrong answer, but information from experienced colleagues regarding how similar cases were handled is often helpful to those new to the field. It is hoped that a recap of the discussions will prove interesting and useful to our readers.

Case 1

As the prison's medical director, you are called down to the maximum security area. Upon arrival, you see five officers holding down a long-term inmate with a history of explosive and vicious behavior. The lieutenant in charge says, "Doc, give him a shot to make it easier to place him in the restraint chair so no one is hurt." What do you do?

Discussion

First, one must talk to the patient to determine if he is psychotic or if this is behavioral. Treatment should be based upon this determination. Include in your differential agitated delirium, which requires immediate medical treatment. You also should inquire why the officers want to restrain the patient, and if it is a punitive action. It is important to know your state's laws. Although most states do not allow involuntary medication except if the patient is an imminent danger to himself or others, some states do allow involuntary medical for behavioral control. One must remember that the restraint chair can be dangerous and may lead to patient morbidity and mortality. Anytime you are forced to use physical restraint, you are in a risk situation. Other suggestions given were: try to talk the patient down, increase the number of officers present and a small number present would give the shot to allow for transport. Lastly, it is crucial that your facility develop policies and procedures for this situation.

Case 2

As the jail's medical director, you receive a call from the night nurse at 2:00 AM about a new intake in the "drunk tank" (used for observing intakes with mild intoxication/withdrawal prior to placement). She states that she has a bad feeling about a slightly drowsy new intake in the tank. She continues, "This inmate was sutured at the ER just prior to intake, and the ER gets mad if we send back an inmate that they already evaluated" What would you do next?

Discussion

Simultaneously, most of the audience shouted, "Send him back!" It was then pointed out that you should get more information from the nurse regarding objective findings such as vital signs, mental status, and the injury that was sutured. Even if this did not reveal significant findings, your decision would most likely be the same. If the nurse is experienced and one who you trust, you will go with her sense of the patient. If you were less comfortable with the nurse, you would want to have further evaluation. Dr. Paris asked if you would go in to see the patient, but it was pointed out the time to get to the facility might be problematic if the patient needed more urgent intervention. And if further diagnostic testing were required, you would not be able to accomplish this at the jail. Dr. Paris also asked what you would do if security balked at transporting the patient back; however, both patient safety and NCCHC standards require that corrections must be convinced that the transport is necessary.

Case 3

You are the prison medical director. A 60-year-old, male smoker with whom you are familiar is readmitted to the prison. During his previous 2-year incarceration, he developed an abnormal chest x-ray and shortness of breath. He signed a refusal for bronchoscopy and biopsy, saying that "it was a done deal." And so he was released without evaluation or treatment. You note he is short of breath at rest, and has abnormal liver function tests and anemia. What would you do next?

Discussion

The general consensus was that you approach the patient again about evaluation. If he refuses, you must take measures to assure that other inmates and staff are safe in case he has an infectious disease such as tuberculosis. It was also suggested to find a provider with whom the patient can develop a trusting therapeutic relationship. Also mentioned was bringing up the issue of compassionate release, in case this might motivate him to have a diagnosis.

If these discussions sound interesting to you, save October 18, 2009, for SCP's annual conference in Orlando, FL.

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