

Challenges to Implementation of Medical and Mental Health Standards

- I. Background: State of health care behind bars
- A. Since the Supreme Court ruled in *Estelle v. Gamble* in 1976, written and unwritten standards have evolved, leading to improved policies and procedures for access to care and for reasonable quality of care. Actual systems of care and quality of care continue to vary widely across the nation. Some agencies do well and others fail to meet the “deliberate indifference to serious medical need” standards.
 - B. There is increasing professionalism. This leads to more consistent care and improved self-esteem for those who practice behind bars.
 - C. Professional staff is better qualified than in the past.
 - D. It is widely understood that timely access to appropriate medical and mental health care underpins the standard of care.
 - E. Agency oversight is generally better in state prison systems than in jails and juvenile facilities. There are widespread problems with accountability.
 - F. Broad-based challenges to improving correctional medical and mental health care remain:
 - 1. Correctional health professionals are disconnected from mainstream medicine.
 - 2. The sick call model that is used in most facilities is episodic in nature. It does not meet the primary care standard in the community.
 - 3. There is poor integration of care for patients with co-existing illness, for example chronic disease and mental illness and mental illness and addictive disorders. There are often parallel, but disconnected, systems for treating mental illness and addictions.
 - 4. Performance-measurement and quality management systems are crude and typically not constructive; they lag far behind community standards.
 - 5. There is poor transfer of medical information, behind the walls and poor transfer of medical information with community resources.

6. Often, there is poor communication between agency leadership and practitioners, in part due to command-control versus collaborative management styles. Custody staff has legitimate difficulty dealing with uncertainty. Health care professionals, on the other hand, are used to uncertainty, and often feel challenged by it.
7. Correctional agencies typically have undeveloped relationships with community providers.

II. Challenges specific to NPREC standards

- A. The majority of agencies are accreditation naïve. They are not comfortable with quantitative performance measurement. They are challenged by self-critical analysis, especially when it might become public.
- B. Behind bars, there is vast cultural and bureaucratic resistance to oversight, especially outsiders
- C. Preparation for certification or accreditation takes resources—time, training, record-keeping. These resources may not be allocated by legislatures.
- D. There are unknown consequences for failure to meet NPREC standards, e.g., potential civil rights litigation under §1983 and the Americans with Disabilities Act.
- E. There are legitimate concerns by health professionals regarding consequences of reporting episodes of sexual violence:
 1. There are tensions in the command-control environment, e.g., sex behind bars is against the rules, hence “it doesn’t occur here.”
 2. There is the risk of tension between custody staff and health care staff for reporting non-traumatic victimization (coercive sex for favors).
 3. With disclosure, prisoners could be punished (official or otherwise) for violating prison rules by having sexual activity.
 4. Intake assessment is often done by uniformed staff, not health professionals. It is a challenge for prisoners to disclose this kind of information to custody staff
 5. There is a potential ethical dilemma between maintaining the confidentiality of personal information, such as a recent or past sexual encounter, and the requirements of public safety, to protect patients and others from harm.
 6. Relationships with community providers who might be helpful with victims of sexual violence are often undeveloped.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this _____ day of November, 2007.

Robert B. Greifinger, M.D.