
ABA Standards for Criminal Justice
Third Edition

Treatment of Prisoners



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The commentary contained herein does not necessarily represent the official position of the ABA. Only the text of the black-letter standards has been formally approved by the ABA House of Delegates as official policy. The commentary, although unofficial, serves as a useful explanation of the black-letter standards.

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ABA Standards for Criminal Justice

Third Edition*

Treatment of Prisoners

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PART V: PERSONAL SECURITY	115
Standard 23-5.1	Personal security and protection from harm..... 115
Standard 23-5.2	Prevention and investigation of violence 117
Standard 23-5.3	Sexual abuse 120
Standard 23-5.4	Self-harm and suicide prevention 125
Standard 23-5.5	Protection of vulnerable prisoners 129
Standard 23-5.6	Use of force 132
Standard 23-5.7	Use of deadly force..... 137
Standard 23-5.8	Use of chemical agents, electronic weaponry, and canines 139
Standard 23-5.9	Use of restraint mechanisms and techniques 143
PART VI: HEALTH CARE	149
Standard 23-6.1	General principles governing health care 152
Standard 23-6.2	Response to prisoner health care needs 157
Standard 23-6.3	Control and distribution of prescription drugs 159
Standard 23-6.4	Qualified health care staff..... 160
Standard 23-6.5	Continuity of care 163
Standard 23-6.6	Adequate facilities, equipment, and resources 165
Standard 23-6.7	Quality improvement 167
Standard 23-6.8	Health care records and confidentiality 168
Standard 23-6.9	Pregnant prisoners and new mothers..... 173
Standard 23-6.10	Impairment-related aids 178
Standard 23-6.11	Services for prisoners with mental disabilities..... 179
Standard 23-6.12	Prisoners with chronic or communicable diseases 184
Standard 23-6.13	Prisoners with gender identity disorder 186
Standard 23-6.14	Voluntary and informed consent to treatment 189
Standard 23-6.15	Involuntary mental health treatment and transfer 194
PART VII: PERSONAL DIGNITY	201
Standard 23-7.1	Respect for prisoners 201
Standard 23-7.2	Prisoners with disabilities and other special needs..... 202
Standard 23-7.3	Religious freedom..... 206
Standard 23-7.4	Prisoner organizations 211
Standard 23-7.5	Communication and expression 213
Standard 23-7.6	Personal appearance 216
Standard 23-7.7	Records and confidentiality 217
Standard 23-7.8	Searches of facilities 220
Standard 23-7.9	Searches of prisoners' bodies 223

PART VI: HEALTH CARE

General Commentary

This Part deals with health care, encompassing medical (including vision) care, mental health care, and dental care. The components of the health care system that are involved in reception and intake—the immediate medical and mental health screening given prisoners on their arrival at an institution, and a first, comprehensive, medical assessment done within the first two weeks—are covered in Standards 23-2.1 and 2.5. And other specialized issues are covered elsewhere, in particular in Part V, on physical security, which covers health care issues related to sexual abuse (23-5.3), suicide prevention (23-5.4), uses of force (23-5.6 and 23-5.8), and restraints (23-5.9). But the general principles and core requirements are contained here.

Outside of prison, no constitutional right to health care exists.¹⁴⁵ But because prisoners are precluded by their confinement from the possibility of arranging for their own care, they have a constitutional claim for health care against the jurisdiction that imprisons them. (Prisoners are cut off from medical benefits such as Medicaid and Medicare.¹⁴⁶) At the same time, merely negligent provision of care does not, the Supreme Court has explained, breach the government's constitutional duty. The guiding principle of constitutional law, articulated in *Estelle v. Gamble*, 429 U.S. 97, 104 (1976), is that correctional officials or their designees are liable for failures to provide medical care, but only if those failures demonstrate "deliberate indifference" to a prisoner's "serious medical needs."¹⁴⁷ The deliberate indifference doctrine is designed to ensure

145. Cf. *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189 (1989) (Constitution does not impose upon the government a duty to protect or provide services).

146. 42 U.S.C. § 1396d(a)(25)(A).

147. A "serious medical need" exists when the failure to treat could result in further significant injury or the unnecessary and wanton infliction of pain. *Clement v. Gomez*, 298 F.3d 898, 904 (9th Cir. 2002).

that no person will be found constitutionally liable without a sufficient degree of culpability to render the harm “punishment” under the Eighth (or Fourteenth) Amendment.

But while “merely” negligent care for prisoners is not unconstitutional, it remains tortious in many circumstances.¹⁴⁸ And in any event, for purposes of policy development and design, where the goal is to “shape the institutions of government in such fashion as to comply with the laws and the Constitution,” *Lewis v. Casey*, 518 U.S. 343, 349 (1996), the better approach is to focus less on blame and more on the appropriate standard of care. The medical, mental health, and dental care provided to prisoners is essential for public health, and such policies are essential in order to protect prisoners’ health and the health of the community at large. Accordingly, what is needed is not care that barely passes the “deliberate indifference” test, but rather a standard of care set by reference to the community. If medical science has determined the appropriate treatment for a given illness, that treatment is no less appropriate in prison. This approach is universally accepted within American corrections,¹⁴⁹ and is the key element of the Standards in this Part. International law, too, insists that prisoners receive care “of the same quality and standard as is afforded to those who are not imprisoned or detained.”¹⁵⁰

Over time, a large correctional facility will house prisoners with just about every health problem known in the community, from the common to the obscure. At the same time, prison and jail health care poses

148. See, e.g., *Moss v. Miller*, 625 N.E.2d 1044, 1052 (Ill. App. Ct. 1993); *Sloan v. Ohio Dep’t of Rehab. & Corr.*, 695 N.E.2d 298, 300 (Ohio Ct. App. 1997). Under the Federal Tort Claims Act, 28 U.S.C. § 2671 *et seq.*, the tort law of the state in which the relevant conduct occurred applies to federal employees who provide medical care to prisoners. See, e.g., *Berman v. United States*, 205 F. Supp. 2d 362 (M.D. Pa. 2002). Note, however, that federal contractors are not susceptible to suit under the FTCA, although state tort law may apply of its own force.

149. See, e.g., AM CORR. ASS’N, PUBLIC CORRECTIONAL POLICY ON CORRECTIONAL HEALTH CARE (ratified Aug. 6, 1987, and reviewed and amended Aug. 23, 1996) (mandating that health services within correctional facilities “be consistent with community health care standards”); NAT’L COMM’N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN PRISONS (2008). AM. PUB. HEALTH ASS’N, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS (3d ed. 2003).

150. Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 37/194, Annex, Principle 1, U.N. Doc A/37/51/Annex (18th Dec. 1982)

unique challenges, as well. The populations within them are sicker than those on the outside, and they are under enormous psychological stress. Communicable diseases (hepatitis C, HIV, tuberculosis, MRSA) are prevalent and dangerous not only to those who enter prison with the disease but to the closely confined population behind bars, staff and fellow prisoners alike. Asthma has proven particularly dangerous behind bars.¹⁵¹ Persons entering jail are frequently in need of alcohol and drug detoxification. What some call the “transcarceration” of people with serious mental illness, from mental health institutions to jails and prisons, has driven the proportion of such prisoners to new heights.¹⁵² And longer sentences have sharply increased the age of prison populations, with serious consequences for their health needs. (In 2008, 2.5% of state and federal prisoners, over 36,000 people, were 60 or older, and another 7.9%, or 122,000 were between 50 and 59.¹⁵³)

An additional challenge is created by the fact that some health care workers see a job in a correctional facility as undesirable, and by environmental pressures on correctional health care providers. As summarized in the leading textbook on correctional medicine:

Incarceration results in the transformation of a person into a prisoner. A prisoner is not always a patient, seeking and deserving of the professional’s skills and compassion. Correctional medical care for a prisoner can transform the attitudes and goals of the practitioner. The care and protection of the institution and its resources intrude on the primacy of the patient’s welfare. Prisoners may perceive their treating physician as remote, indifferent, or hostile. Physicians and other health workers in

151. See, e.g., Tim Reiterman, *Deadly Medical Lapses in Prison*, L.A. TIMES, Sept. 20, 2007, available at <http://articles.latimes.com/2007/sep/20/local/me-prisons20> (reporting interview with medical receiver Robert Sillen about preventable deaths in the California prison system: “The leading cause of [preventable] death being asthma is unconscionable, and it is evidence of systemic problems and problems with individual clinical judgments,” Sillen said in an interview. “Adults in 21st century California should not have asthma as a primary cause of death.”).

152. Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (Bureau of Justice Statistics, Sept. 2006), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf>. See commentary to Standard 23-6.8.

153. William J. Sabol *et al.*, *Prisoners in 2008* (Bureau of Justice Statistics, Dec. 2009), App’x tbl.13, available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/p08.pdf>.

prison may view their prisoner patients as manipulative and demanding. . . .

Compassion is not easily taught but may be effectively ground down by the daily experience of working in prison. Disrespect for prisoners may be easily learned. The doctor-patient relationship may often be fatally compromised by the transformation of the patient into a prisoner, with a consequent loss of sympathy and standing. It will not be possible to effectively apply the methods of quality assurance to correctional medicine unless health professionals working in prison identify the goal of quality solely as patient welfare.¹⁵⁴

It is evident, however, that these pressures can be resisted because so many correctional health providers do work effectively, competently, and with compassion to provide health care behind bars.

In short, health care behind bars is simultaneously challenging but vital, and appropriate care that meets the community standard of care is possible. The Standards that follow offer guidance.

Standard 23-6.1 General principles governing health care

- (a) Correctional authorities should ensure that:**
 - (i) a qualified health care professional is designated the responsible health authority for each facility, to oversee and direct the provision of health care in that facility;**
 - (ii) prisoners are provided necessary health care, including preventive, routine, urgent, and emergency care;**
 - (iii) such care is consistent with community health care standards, including standards relating to privacy except as otherwise specified in these Standards;**
 - (iv) special health care protocols are used, when appropriate, for female prisoners, prisoners who have physical or mental disabilities, and prisoners who are under the age of eighteen or geriatric; and**

154. Robert L. Cohen, *Health and Public Health Advocacy for Prisoners*, in *CLINICAL PRACTICE IN CORRECTIONAL MEDICINE* 28, 29, 38 (Michael Puisis ed., 2d ed. 2006).

- (v) health care that is necessary during the period of imprisonment is provided regardless of a prisoner's ability to pay, the size of the correctional facility, or the duration of the prisoner's incarceration.

(b) Prisoners should not be charged fees for necessary health care.

(c) Dental care should be provided to treat prisoners' dental pain, eliminate dental pathology, and preserve and restore prisoners' ability to chew. Consistent with Standard 23-2.5, routine preventive dental care and education about oral health care should be provided to those prisoners whose confinement may exceed one year.

(d) Prisoners should be provided timely access to appropriately trained and licensed health care staff in a safe and sanitary setting designed and equipped for diagnosis or treatment.

(e) Health care should be based on the clinical judgments of qualified health care professionals, not on non-medical considerations such as cost and convenience. Clinical decisions should be the sole province of the responsible health care professionals, and should not be countermanded by non-medical staff. Work assignments, housing placements, and diets for each prisoner should be consistent with any health care treatment plan developed for that prisoner.

(f) Prisoners should be provided basic educational materials relating to disease prevention, good health, hygiene, and proper usage of medication.

Cross References

ABA, TREATMENT OF PRISONER STANDARDS, 23-2.1 (intake screening), 23-2.5 (health care assessment), 23-2.8 (segregated housing and mental health), 23-6.2 to 6.15 (health care), 23-7.10 (cross-gender supervision), 23-7.11 (prisoners as subjects of behavioral or biomedical research), 23-8.2(b) (rehabilitative programs, substance abuse treatment), 23-8.8 (fees and financial obligations)

Related Standards and ABA Resolutions

ABA, LEGAL STATUS OF PRISONERS STANDARDS (2d. ed. superseded), Standard 23-2.5 (health care assessment), 23-5.1 (care to be provided), 23-5.2 (prompt medical treatment)

ABA, RESOLUTIONS, 101C (Aug. 1993) (correctional accreditation), 102B (Aug. 2002) (elderly prisoners)

ACA, JAIL STANDARDS, Performance Standard 4C (continuum of health care services), 4-ALDF-4C-02 (access to care), 4C-20 (dental care), 4C-21 (health education), 4-ALDF-4D-02 (provision of treatment)

ACA, PRISON STANDARDS, Performance Standards 4E-1A (continuum of health care services) and 4E-2A (staff training), 4-4345 (access to care), 4-4360 (dental care), 4-4381 (provision of treatment), 4-4398 (elective procedures)

AM. ASS'N FOR CORR. PSYCHOL., STANDARDS, §§ 5 (professional autonomy), 15 (general ethical principle), 33 (treatment)

AM. NURSES ASS'N, CORRECTIONS STANDARDS, *passim*

AM. PSYCHIAT. ASS'N, PRINCIPLES, B (quality of care)

AM. PUB. HEALTH ASS'N, CORRECTIONS STANDARDS, I.B (access to care), I.C.A.1-2 (medical autonomy and ethics), II.C.7 (medical director), III.C (follow-up), III.E (urgent and emergency treatment), VI.J (palliative care and pain management), VI.K (hospice care), VII.A (health services for women), VII.B (children and adolescents), IX.C (health education and health promotion)

NCCHC, HEALTH SERVICES STANDARDS A-01 (Access to Care), A-02 (Responsible Health Authority), A-03 (Medical Autonomy), A-08 (Communication on Patients' Health Needs), A-09 (Privacy of Care), B-01 (Infection Control Program), B-02 (Patient Safety), B-03 (Staff Safety), C-01 (Credentialing), C-03 (Professional Development), C-09 (Orientation for Health Staff), D-03 (Clinic Space, Supplies, and Equipment), E-06 (Oral Care), E-07 (Nonemergency Health Care Requests and Services), E-08 (Emergency Services), F-01 (Healthy Lifestyle Promotion), F-02 (Medical Diets), G-01 (Chronic Disease Services), G-02 (Patients with Special Health Needs), G-04 (Basic Mental Health Services)

U.N. Standard Minimum Rules, arts. 22 to 26 (medical services)

Commentary

Subdivision (a): This subdivision introduces the topic of health care in jail and prison, making explicit certain key features of an acceptable system: autonomy for health care providers (subdivision (a)(i); see also subdivision (e)); coverage of all necessary health care, not just emergency care (subdivision (a)(ii)), without exception (subdivision (a)(v)); consistency with the community standard of care (subdivision (a)(iii)); see

introductory commentary to Part VI), and planned and knowledgeable consideration of the needs of special populations (subdivision (a)(iv)).

Subdivision (b): This subdivision disapproves the increasingly prevalent practice of charging prisoners fees for medical services.¹⁵⁵ (The federal government uses such fees,¹⁵⁶ as did at least 36 state prison systems in 2004.¹⁵⁷) Medical copays are not intended to recover a significant amount of money from prisoners; their purpose is rather to reduce prisoner use of medical services by discouraging malingering. But even seemingly small copays are daunting to prisoners; many are not offered paying jobs, and those who do work typically earn only a few dollars per day, or less.¹⁵⁸ The growing evidence that the result compromises health and safety¹⁵⁹ lies behind the American Public Health Association's stand against copayment policies. As that organization's Standards explain:

Copayment for medical service is a tool often used in the penal system to decrease requests for medical services. Rather than raise financial barriers that make prisoners with limited funds choose between health care and subsistence items such as cleaning supplies and postage, it is more appropriate to relieve clinics of administrative functions and nonmedical referrals. Therefore, copayment requirements are considered a barrier to health care and are punitive.¹⁶⁰

The Commission on Safety and Abuse in America's Prisons has similarly explained that "While co-payments seem reasonable on the surface,

155. Susan L. Clayton, *Inmate Health Care*, 29 CORRECTIONS COMPENDIUM 10 (2004).

156. Federal Prisoner Health Care Copayment Act of 2000, 18 U.S.C. § 4001 note.

157. See Clayton, *Inmate Health Care*, *supra* note 155, at 28-29 tbl.7 (36 of 44 responding prison systems use copays); see also National Institute of Corrections, *Fees Paid by Jail Inmates: Findings from the Nation's Largest Jails*, SPECIAL ISSUES IN CORRECTIONS (Feb. 1997), available at <http://www.nicic.org/pubs/1997/013599.pdf>.

158. See CAMILLE GRAHAM CAMP & GEORGE M. CAMP, CRIMINAL JUSTICE INST., THE CORRECTIONS YEARBOOK 2000: ADULT CORRECTIONS 111 (2000).

159. For example, the CDC found that copayments have contributed significantly to the spread of aggressive infections within correctional facilities, by discouraging prisoners from seeking treatment. See, e.g., Centers for Disease Control and Prevention, *Methicillin-Resistant Staphylococcus aureus Infections in Correctional Facilities—Georgia, California, and Texas, 2001-2003*, 52 MORBIDITY & MORTALITY WEEKLY REP. 992 (Oct. 17, 2003), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5241a4.htm>.

160. AM. PUB. HEALTH ASS'N, CORRECTIONS STANDARDS I.B.7.

they cost more in the long run by discouraging sick prisoners from seeking care early on, when treatment is less expensive and more effective and before disease spreads.”¹⁶¹ International law agrees. Principle 24 of the UN Body of Principles for the Protection of All Persons under any form of Detention or Imprisonment requires: “A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge.”¹⁶²

It should be noted, however, that both the ACA and the NCCHC standards allow assessment of medical copays against prisoners. The ACA Prison Standards require, “at a minimum,” that prisoners be informed on admission about the copayment requirement, that “[n]eeded offender health care is not denied due to lack of available funds,” and that “[c]opayment fees shall be waived when appointments or services, including follow-up appointments, are initiated by medical staff.”¹⁶³ The NCCHC approves of reasonable copayments by implication, including in a list of “examples of unreasonable barriers to care” “assessing *excessive* co-payments that prevent or deter inmates from seeking care for their serious health needs.”¹⁶⁴ This Standard disagrees with this regulatory approach; the flat ban in subdivision (b) reflects a judgment that it is inevitable, in the straitened economic setting of a jail or prison, for a copayment policy to “prevent or deter inmates from seeking care,” and that it is not only the prisoners who are deterred from seeking care but those with whom they come in contact, behind bars and later in the community, who suffer the public health consequences.

Subdivision (c): Dental treatment should not be limited to extractions; prisoners should receive services designed to save teeth where possible, and if their loss of teeth interferes with biting and chewing, they should receive dental prostheses.

161. COMMISSION ON SAFETY AND ABUSE IN AMERICA’S PRISONS, CONFRONTING CONFINEMENT 14 (2006), available at <http://prisoncommission.org>

162. G.A. Res. 43/173, Annex, principle 24, U.N. Doc. A/RES/43/173/Annex, available at http://www.unodc.org/pdf/compendium/compendium_2006_part_01_01.pdf.

163. ACA, PRISON STANDARDS 4-4345; see also ACA, JAIL STANDARDS 4-ALDF-4C-02 (same, except including only first and last restriction).

164. NCCHC, HEALTH SERVICES STANDARDS, A-01 (Access to Care) (emphasis added); see also NCCHC position statement, Charging Inmates a Fee for Health Care Services, available at <http://www.ncchc.org/resources/statements/healthfees.html>

Standard 23-6.2 Response to prisoner health care needs

(a) Correctional authorities should implement a system that allows each prisoner, regardless of security classification, to communicate health care needs in a timely and confidential manner to qualified health care professionals, who should evaluate the situation and assess its urgency. Provision should be made for prisoners who face literacy, language, or other communication barriers to be able to communicate their health needs. No correctional staff member should impede or unreasonably delay a prisoner's access to health care staff or treatment.

(b) A prisoner suffering from a serious or potentially life-threatening illness or injury, or from significant pain, should be referred immediately to a qualified medical professional in accordance with written guidelines. Complaints of dental pain should be referred to a qualified dental professional, and necessary treatment begun promptly.

(c) When appropriate, health care complaints should be evaluated and treated by specialists. A prisoner who requires care not available in the correctional facility should be transferred to a hospital or other appropriate place for care.

Cross References

ABA, TREATMENT OF PRISONER STANDARDS, 23-6.1 (general principles governing health care), 23-4.1 (rules of conduct and informational handbook), 23-7.2 (treatment of prisoners with disabilities and other special needs)

Related Standards

ABA, LEGAL STATUS OF PRISONERS STANDARDS (2d. ed. superseded), Standard 23-5.2 (prompt medical attention)

ACA, JAIL STANDARDS, 4-ALDF-4C-05 (referrals)

ACA, PRISON STANDARDS, 4-4346 (clinical services), 4-4348 (referrals), 4-4351 (emergency plan)

AM. PSYCHIAT. ASS'N, PRINCIPLES, B.2.b (staffing levels and access), E (confidentiality), F.4 (access to treatment), F.5 (modalities of treatment)

AM. PUB. HEALTH ASS'N, CORRECTIONS STANDARDS, I.B (access to care), III.B (prisoner-initiated care), III.D (specialty consultative services)

NCCHC, HEALTH SERVICES STANDARDS A-01 (Access to Care), A-07 (Emergency Response Plan), E-06 (Oral Care), D-05 (Hospital and Specialty Care), E-05 (Mental Health Screening and Evaluation), E-07 (Nonemergency Health Care Requests and Services), E-08 (Emergency Services), E-12 (Continuity of Care During Incarceration)

U.N. Standard Minimum Rules, arts. 22(2) (hospital and specialized care), 25 (care for prisoners)

Commentary

There are three keys to appropriate health care access systems for prisoners, the topic of this Standard. First, in subdivision (a), prisoners must have a way to communicate their health care needs in a timely way—professional standards agree that prisoners need daily opportunities to make health care requests.¹⁶⁵ Second, in subdivisions (a) and (b), those needs must be relayed promptly, and without impediment, to health care staff; staff should avoid any obstacles for such communication.¹⁶⁶ The American Public Health Association notes that health care request should be

submit[ted] . . . to health care staff whether the request is made in writing or verbally or whether the request is made by the prisoner or through other prisoners, correctional staff, cellmates, family members, or other workers in the facility. Even requests that do not arrive in the standard format must be reviewed and addressed.¹⁶⁷

In addition, emergency needs need to be relayed immediately—and subdivision (b)'s provisions are written to ensure that it is qualified health care staff evaluate whether a reported need is an emergency. And third, in subdivisions (b) and (c), the health care staff that evaluate requests and provide treatment should be professionally qualified, even if that requires a specialist consultation or referral or a transfer to a hospital. Especially in isolated locations, telemedicine can be a helpful way to provide prompt consults by specialists.

165. See AM. PUB. HEALTH ASS'N, CORRECTIONS STANDARDS I.B.4; NCCHC Correctional Standards E-07; ACA, PRISON STANDARDS 4-4346; ACA, JAIL STANDARDS 4-ALDF-4C-26.

166. The language in subdivision (a) barring impediments to access to health care also means that correctional authorities should not interfere with furloughed prisoners who may wish to consult their own doctors.

167. AM. PUB. HEALTH ASS'N, CORRECTIONS STANDARDS I.B.4.

Standard 23-6.3 Control and distribution of prescription drugs

A correctional facility should store all prescription drugs safely and under the control and supervision of the physician in charge of the facility's health care program. Prescription drugs should be distributed in a timely and confidential manner. Ordinarily, only health care staff should administer prescription drugs, except that health care staff should be permitted to authorize prisoners to hold and administer their own asthma inhalers, and to implement other reasonable "keep on person" drug policies. In an emergency, or when necessary in a facility in which health care staff are available only part-time, medically trained correctional staff should be permitted to administer prescription drugs at the direction of qualified health care professionals. In no instance should a prisoner administer prescription drugs to another prisoner.

Cross References

ABA, TREATMENT OF PRISONER STANDARDS, 23-5.2(a)(v) & (vi) (prevention and investigation of violence (drugs, and prisoners' authority), 23-6.1 (general principles governing health care), 23-6.8 (health care records and confidentiality), 23-10.3 (training)

Related Standards

ABA, LEGAL STATUS OF PRISONERS STANDARDS (2d. ed. superseded), Standard 23-5.6 (control of drugs)

ACA, JAIL STANDARDS, 4-ALDF-4C-38 (pharmaceuticals)

ACA, PRISON STANDARDS, 4-4378 (pharmaceuticals), 4-4379 (nonprescription medication)

NCCHC, HEALTH SERVICES STANDARDS, C-05 (Medication Administration Training), C-06 (Inmate Workers), D-01 (Pharmaceutical Operations), D-02 (Medication Services)

AM. PUB. HEALTH ASS'N, CORRECTIONS STANDARDS, II.E.1.b (drugs and biologicals)

Commentary

Professional standards, cited above, are far more detailed in their regulation of pharmaceutical operations; this Standard signals the importance of the topic.

Allowing prisoners with asthma to have their own inhalers can be useful for their safety; a sufficiently speedy response to an asthma attack is otherwise very difficult. The Standard makes clear that such a policy and other reasonable “keep on person” policies are not foreclosed if a correctional facility’s decision-makers so choose.

For discussion of the general requirement that no prisoner administer prescription drugs to another prisoner, see the commentary on Standard 23-6.4(c).

Standard 23-6.4 Qualified health care staff

(a) Each correctional agency should employ or contract with a sufficient number of qualified medical, dental, and mental health professionals at each correctional facility to render preventive, routine, urgent, and emergency health care in a timely manner consistent with accepted health care practice and standards.

(b) Health care providers in a non-federal correctional facility should be fully licensed in the state in which the facility is located; health care providers in a federal correctional facility should be fully licensed in the United States. No health care provider should be permitted to practice in a correctional facility beyond the scope permissible for that individual provider outside of a correctional facility, given the provider’s particular qualifications and licensing.

(c) Regardless of any training a prisoner may have had, no prisoner should be allowed to provide health care evaluation or treatment to any other prisoner.

Cross References

ABA, TREATMENT OF PRISONER STANDARDS, 1.1(k) (general principles governing imprisonment, private contractors), 23-5.2(a)(v) & (vi) (prevention and investigation of violence, drugs, and prisoners’ authority), 23-5.9 (use of restraint mechanisms and techniques), 23-6.1 (general principles governing health care), 23-6.8 (health care records)

and confidentiality), 23-6.13 (prisoners with gender identity disorder), 23-10.2 (personnel policy and practice), 23-10.3 (training)

Related Standards

ABA, LEGAL STATUS OF PRISONERS STANDARDS (2d. ed. superseded), Standard 23-5.1 (care to be provided)

ACA, JAIL STANDARDS, Performance Standard 4D (health services staff), 4-ALDF-4D-03 (personnel qualifications), 4D-05 (credentials), 4D-11 (inmate assistants)

ACA, PRISON STANDARDS, 4-4382 and 4-4383 (personnel qualifications), 4-4384 (credentials), 4-4393 (offender assistants)

AM. ASS'N FOR CORR. PSYCHOL., STANDARDS, § 2 (licensure), 12-13 (staffing requirements)

AM. PSYCHIAT. ASS'N, PRINCIPLES, B.2.b (staffing levels and access)

AM. PUB. HEALTH ASS'N, CORRECTIONS STANDARDS, II.C (staffing and organization)

NCCHC, HEALTH SERVICES STANDARDS, C-01 (Credentialing), C-06 (Inmate Workers), C-07 (Staffing)

NCCHC position statement, Licensed Health Care Providers in Correctional Institutions <http://ncchc.org/resources/statements/lhcp2005.html>

U.N. Standard Minimum Rules, arts. 22 (medical staff), 52 (medical officer)

Commentary

Subdivision (a): Prisons and jails cannot provide adequate care if they do not employ or contract with enough health care providers, covering all the necessary disciplines, specialties, and licensing levels.

Subdivision (b): This subdivision applies the general parity principle articulated in Standard 23-6.1(a), that correctional health care should satisfy the community standard of care. See introductory commentary to Part VI. Prisons and jails should not be dumping grounds for the dregs of the profession (e.g., doctors or nurses with suspended licenses or ethics complaints). Like this subdivision, NCCHC standards forbid correctional facilities to employ health care personnel whose license restricts their practice to correctional institutions. The NCCHC elaborates in a position statement:

[S]uch practice imparts a sense that patients in a correctional environment are undeserving of qualified care that is similar to care available in the community. This concept is anathema to the important medical canons of ethics and disregards the important public health role correctional health care can play.

Further, correctional systems should not employ licensed health care professionals whose licenses are restricted to government institutions, including corrections. It conveys a substandard image of correctional health care that can inhibit patients from seeking necessary care; adversely affects recruitment of other health professionals; and potentially leads to unwelcome public reaction when there is a negative patient outcome.¹⁶⁸

Subdivision (c): Allowing a prisoner to provide health care to another discloses confidential information and puts the former prisoner in a position to have coercive authority over the latter, which is forbidden under Standard 23-5.6(a)(vi). Subdivision (c)'s particular ban on prisoner provision of health care is clear in the case law.¹⁶⁹ Of course in a situation in which health care personnel are unable to reach a prisoner in need of emergency care—for example, when a prisoner is wounded during a riot—this subdivision does not mean that authorities should prevent prisoners from assisting each other.

The existence of this ban also does not mean that prisoners cannot serve as health care attendants or in other health-related roles, if no medical treatment is provided. The NCCHC, which has a similar rule in its standards, explains that if care is taken, some health-related activities are acceptable.

168. NCCHC, CORRECTIONAL STANDARDS, C-01 (essential); see also NCCHC and Society of Correctional Physicians, Position Statement: Licensed Health Care Providers in Correctional Institutions, (NCCHC, Oct. 9 2005) available at <http://ncchc.org/resources/statements/lhcp2005.html>.

169. See, e.g., *Newman v. Alabama*, 503 F.2d 1320, 1323 (5th Cir. 1974); *Williams v. Edwards*, 547 F.2d 1206, 1215 (5th Cir. 1977); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1326 (S.D. Tex. 1980), aff'd in part and vacated in part, 679 F.2d 1115, amended in part, 688 F.2d 266 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983).

The use of inmates in appropriate peer health-related programs is permitted. For example, inmates may assist other inmates in activities of daily living (ADL) [defined elsewhere as “generally refer[ing] to ambulation, bathing, dressing, feeding, and toileting”] in regular housing units. Inmates also may participate in support groups that assist other inmates with health problems (e.g., a buddy system for potentially suicidal inmates) and hospice programs. Inmates are not substitutes for regular program or health staff.¹⁷⁰

As the NCCHC explains, “An intent of this standard is that the health services program is not used as a vehicle that places inmates in a position of power over their peers.”¹⁷¹

In addition, when prisoner workers are assigned to assist health services, care should be taken to safeguard confidentiality, security, and both worker and patient health. See NCCHC, HEALTH SERVICES STANDARDS, C-06 (Inmate Workers).

Standard 23-6.5 Continuity of care

(a) A correctional agency should ensure each prisoner’s continuity of care, including with respect to medication, upon entry into the correctional system, during confinement and transportation, during and after transfer between facilities, and upon release. A prisoner’s health care records and medication should travel with the prisoner in the event of a transfer between facilities, including facilities operated by different agencies.

(b) Prisoners who are determined to be lawfully taking prescription drugs or receiving health care treatment when they enter a correctional facility directly from the community, or when they are transferred between correctional facilities—including facilities operated by different agencies—should be maintained on that course of medication or treatment or its equivalent until a qualified health care professional directs otherwise upon individualized consideration.

170. NCCHC, HEALTH SERVICES STANDARDS, C-06 (Inmate Workers).

171. *Id.*

Cross References

ABA, TREATMENT OF PRISONER STANDARDS, 23-2.5 (health care assessment), 23-6.11 (services for prisoners with mental disabilities), 23-6.13 (prisoners with gender identity disorder), 23-8.9 (transition to the community)

Related Standards

ABA, LEGAL STATUS OF PRISONERS STANDARDS (2d. ed. superseded), Standard 23-5.2(b) & (c) (prompt medical treatment)

ACA, JAIL STANDARDS, 4-ALDF-4C-04 (continuity of care)

ACA, PRISON STANDARDS, 4-4347 (continuity of care)

AM. ASS'N FOR CORR. PSYCHOL., STANDARDS, § 61 (transfer of records)

AM. PUB. HEALTH ASS'N, CORRECTIONS STANDARDS, II.F.2 (transfer of records), III.H (transfer and discharge)

NCCHC, HEALTH SERVICES STANDARDS, D-02 (Medication Services), E-02 (Receiving Screening), E-03 (Transfer Screening), E-10 (Patient Escort), E-13 (Discharge Planning), H-04 (Management of Health Records)

Commentary

Times of transition—whether at the start of incarceration (especially when it is unexpected), or at the time of transfer or release—can be medically dangerous for prisoners with serious medical needs, if their health records are delayed or their medications disallowed or lost.

Subdivision (b): This subdivision is modeled on an NCCHC subdivision, Standard D-02. When a prisoner arrives at a correctional facility from the community or from another facility, substitution of a close-to-equivalent treatment—for example a generic form of the prescribed medication—is acceptable. But it is inappropriate to simply discontinue or suspend that prisoners' treatment, whether or not the prisoner brings prescribed medication to the facility. Instead, previously prescribed treatment should continue until a qualified health professional, with appropriate credentials to authorize prescription of drugs, individually assesses the prisoner and the pre-existing treatment, and decide upon a treatment plan going forward.