The Crisis in Correctional Health Care: The Impact of the National Drug Control Strategy on Correctional Health Services

American College of Physicians, National Commission on Correctional Health Care, and American Correctional Health Services Association*

We therefore conclude that deliberate indifference to the serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain" . . . prescribed by the Eighth Amendment.

U.S. Supreme Court, 1976 (1)

The United States now incarcerates a greater percentage of its population than any other country: For every 100,000 persons, 426 are confined in prisons and jails (2). Most inmates are male, young, poor, and from minority groups. Most are substance abusers with substantial physical and mental health needs.

In the past decade, prison and jail populations doubled (3, 4), outpacing all attempts to increase the correctional system's ability to house and care for these inmates. From 1979 to 1988, direct governmental expenditures on corrections increased 216% (5). Despite this increase, at the end of 1990, prisons nationwide were estimated to be 18% to 29% over their capacities, while the federal system operated at 51% over capacity (3). Jails were operating at 104% of their rated capacity (4). The entire prison systems of 10 states, major institutions in another 30 states (5), and 30% of all large jail jurisdictions (4) are under court order to improve conditions.

These problems in our criminal justice system have been exacerbated by federal initiatives to reduce the use of illegal drugs. The most recent initiatives, known as the National Drug Control Strategy (NDCS), were first announced in September 1989 and have been updated yearly. The NDCS emphasizes mandatory minimums for many drug crimes. In 1989, the National Council on Crime and Delinquency predicted that "the current War on Drugs will overwhelm the nation's correctional systems over the next five years" (6). The 1991 NDCS notes, "As the recommendations of the criminal justice portion of the Strategy are implemented, prison overcrowding is likely to continue, posing difficult policy choices" (7).

Members of our organizations are devoted to health care and see firsthand the health effects of these difficult policy choices. Corrections in general and correctional health care in particular have suffered negative consequences: severe overcrowding, insufficient programs to treat substance abuse, and increasing prevalence of communicable diseases such as the acquired immunodeficiency syndrome (AIDS), tuberculosis, and hepatitis. The large increase in the number of substance abusers and sick and terminally ill inmates has rendered our nation's prisons and jails physically or financially unable to deal with their current populations, much less the explosive increases the future holds. It is the magnitude of inmate health problems that threatens to overwhelm the substantial gains made in correctional health care over the past two decades.

As measured by recognized standards of inmate health and health services, our correctional systems are in crisis. As a nation, we must respond to the problem of drug abuse with rational strategies that do not overwhelm the capacity of our criminal justice system to care for its inmates. (For a definition of terms used in this article, see Appendix.)

Background

The State of Correctional Health Care

Recent improvements in correctional health services are threatened by the nation's burgeoning prison and jail populations. Beginning in the 1970s, civil rights litigation and involvement by organized medicine resulted in the establishment of community standards in prison and jail health services where neglect had been the norm. Another positive step was the implementation of accreditation standards for correctional facilities by the National Commission on Correctional Health Care (NCCHC). The standards promote adequate health care systems through voluntary accreditation. To gain NCCHC accreditation, correctional facilities must meet standards for intake, assessment, and screening of incarcerated persons. In 1991, the NCCHC accredited 73 prisons (11%) and 230 jails (7%).

These standards have become increasingly difficult to meet and maintain during this period of population growth. Health services are a costly component of correctional facilities' operating budgets, taking up from 2.8% to 18.9% of state correctional department budgets (8). As more persons with greater health needs are incarcerated, this percentage is likely to increase. However, correctional health care budgets apparently are not increasing in proportion to the growing numbers of inmates with significant health problems (9).
No staffing formulas for health services in correctional institutions have been reported in the literature. The NCCHC standards specify one full-time equivalent physician for every 750 to 1000 inmates, but the Commission recognizes that no simple formula exists for determining appropriate staff size. The number and type of health care personnel required by an institution depends not only on its average daily population but also on the total number of inmates received during the year, their lengths of stay, and their particular health care needs (10). This lack of precise staffing formulas limits the ability of institutions to ensure appropriate expenditures for health care personnel as facilities are built or expanded. As this problem becomes more acute, expenditures for health services and medical supplies also may be jeopardized. The current situation encourages an unhealthy competition among security, housing-sustenance, and health care requirements for the same limited resources.

In addition to being ill-equipped for the population explosion, most correctional health services are not set up to meet the extensive needs of inmates. The typical delivery model is a reactive system of care on demand: sick call. Health services are requested rather than scheduled. Such a system does not lend itself to regular follow-up care, which is needed to manage chronic disease. Primary care and prevention models of health care delivery have not been emphasized in correctional systems. Even when health screening is done, systems may not be capable of following up on abnormal findings.

An ongoing problem in correctional health care is the lack of comprehensive data to define more accurately the population served and its health care needs. This problem has both public policy and medical professional components: Policymakers have not committed the resources to foster research in this setting or to develop academic programs that would train medical professionals in correctional health care. Medical professionals, for the most part, have not stressed the placement of correctional health care within the public health sector and have not forged extensive linkages with public health professionals. In general, public health professionals have avoided including correctional health in their sphere of concern.

We are aware of successful collaborative ventures among academic medical centers, public health departments, and correctional institutions. One such effort in 1990 resulted in an effective program for human immunodeficiency virus (HIV) counseling, screening, and treatment in prisoners in Rhode Island (Dixon PS, Flanagan TP, De Buono BA, Laurie JJ, Scott LD, Carpenter CCJ. "HIV infection in prisoners: meeting the health care challenge," Unpublished data). An HIV management team on site includes an attending physician from the Brown University faculty, a rotating infectious disease fellow, a full-time registered nurse, and two AIDS education specialists. This program was made possible with funding from the State Department of Health. Everyone wins in this collaborative arrangement: The prisoners receive ongoing, continuous care; the prison saves expensive, outside visits to specialists; the health department gains a way to reach a high-risk population with preventive education and early treatment of HIV infection; and the academic medical center benefits by providing a unique training site for its fellows.

Such cooperation is essential if correctional health care is to meet the challenges it now faces in providing the community standard of care to all incarcerated people—a challenge made more daunting by the increase in numbers of inmates and the problems they bring with them.

Correctional Populations and Demographics

On any day in the United States, more than 1.2 million Americans are behind bars. At last count, there were 771,243 men and women in state and federal prisons (3), 405,320 in jails (4), and an additional 56,123 in public juvenile facilities (11). In any year, an estimated 22 million admissions and discharges occur in correctional facilities in the United States: In 1989, admissions and discharges totalled 20 million in jails (4) and more than 1.2 million in public juvenile facilities (11); in that same year, prisons admitted 467,227 persons and released 386,228 (12).

In adult institutions in 1990, 94.3% of prison inmates and 91% of jail inmates were male. The proportion of women is growing in both jails and prisons. In the past decade, the number of women in prison tripled, and the overall prison population doubled (13).

The average age of inmates admitted to prisons in 1989 was 29.6 years (12). In 1989, 75% of jail inmates were between the ages of 18 and 34 years (14). However, the number of older inmates is growing. About 5% of those incarcerated in prisons in 1989 were 50 years of age or more (12).

Ethnic minorities are disproportionately represented in our correctional facilities. Blacks (12% of the U.S. population) now constitute 47% of the prison population (5) and 47% of the jail population (4). For Hispanics (7% of the U.S. population), the corresponding statistics are 9.6% (12) and 14% (4), respectively.

Growth in Correctional Populations

The population growth in the nation’s correctional facilities has been explosive and is predicted to continue. Much of the growth is attributable to society’s concern about drug abuse and attendant crime. Arrests for all offenses rose 27.7% in the last decade, but arrests for drug violations rose 125.9% (5). Many jurisdictions altered their sentencing guidelines and implemented mandatory sentences, which meant that more convicted persons received incarceration. A concomitant decrease occurred in the use of alternatives to incarceration, such as early release programs. Further, use of fixed sentences increased, which meant that more inmates were staying longer behind bars. At the same time, many jurisdictions de-emphasized or abolished early release programs, such as parole.

Because of these policies, by 1989 one in three women and one in five men in local jails were being held on drug charges (15). Three quarters of them were black or Hispanic. In 1990, 54% of all federal prisoners were incarcerated for drug offenses (5). Focusing just
on state prisons, the National Council on Crime and Delinquency predicted the following:

1. Under existing policies, the states will increase their prison populations by over 68% by 1994, an annual average growth rate of about 13% per year.

2. The projected increase translates into an additional 460,000 prison inmates by 1994 for a total of 1,133,000 inmates. With average operating costs of $25,000 per inmate per year and a construction cost of $50,000 per cell, states will require at least an additional $35 billion to build and operate their prisons over the next 5 years.

3. The primary reason for the dramatic increase in prison populations is the "war on drugs," which is not only increasing the number of prison admissions but is also increasing the rate of parole violations.

4. The already disproportionate rate of blacks and Hispanics being sent to prison will increase considerably, principally because of the war on drugs (6).

Is the current war on drugs, with its emphasis on incarceration, an effective strategy for combating drug abuse in our society? The American Bar Association (ABA), in a recent report by its Ad Hoc Committee on Drugs, concluded that mandatory minimum sentences require expenditures "disproportionate to any deterrent effect or rehabilitative effect they might have" (16). The report stated the following:

Even though costly, incarcerating large numbers of drug offenders might have some benefits if stiffer prison sentences incrementally reduced criminal behavior. There is no proof that mandatory minimum sentences have that effect. Moreover, when increased numbers of offenders serve increased time in prison, correctional facilities must devote more of their resources to providing minimal "warehousing" services, rather than rehabilitative services for fewer inmates. Accordingly, drug offenders who might benefit from drug treatment programs (and education and job training programs) do not have access to such programs (16).

Health Status of Incarcerated Persons

Generally, American inmates come from lower socioeconomic strata. Thus, they generally have not had adequate health care on the outside and they tend to be at high risk for diseases such as AIDS, tuberculosis, hepatitis, heart disease, hypertension, and renal failure. In addition, many inmates are mentally ill or mentally retarded. Some of the more pressing health problems are noted below.

HIV Infection and AIDS

The incidence of AIDS is 14 times higher in state and federal correctional systems (202 cases per 100,000) than in the U.S. population (14.65 cases per 100,000) (17). The higher incidence in corrections is due to the over-representation of persons with histories of high-risk behavior, especially intravenous drug use.

The National Commission on AIDS, in a 1990 report, found that the policy of mandatory sentencing for drug offenders (who have high rates of HIV infection) had placed an enormous burden on an already weak prison health care system. The Commission noted the following:

Persons using injection drugs accounted for 28% of all adult and adolescent AIDS cases reported in the United States from 1983 through 1989. By choosing mass imprisonment as the federal and state governments' response to the use of drugs, we have created a de facto policy of incarcerating more individuals with HIV infection. Under the present policy, the percentage of drug offenders in the federal prison system will rise by 1995 from 47 percent to 70 percent. Clearly, we are thus converting the HIV disease problem in our prisons and must take immediate action to deal with it more effectively (18).

According to the National Institute of Justice, as of November 1989, a total of 5411 confirmed cases of AIDS were reported by state and federal correctional systems and 30 large jail systems (17). Although the distribution of cases of AIDS was uneven—14% of the systems contributed 84% of the cases in 1989—only 3 systems reported having no cases by 1989; 5 years earlier, 26 systems reported having no cases of AIDS.

The 1989 data revealed that for the first time, "the percent increase in cumulative total correctional cases in the United States (72%) exceeded the increases in cases in the U.S. population at large (50%)" (17). It is estimated that many more inmates are HIV seropositive. In states conducting blinded epidemiologic studies, rates of HIV seropositivity ranged from 0.6% (Oregon and Wisconsin) to as high as 17% (New York) (17). Clearly, all correctional systems will have to confront the problems of HIV infection and AIDS. Dealing with the problem of HIV infection and AIDS will have a tremendous effect on the costs of correctional health care and must be considered when calculating future budgets. The lifetime cost of caring for a single person with AIDS is estimated at over $85,000 ($32,000 annually) and the yearly cost of caring for an asymptomatic HIV-infected person is over $5000 (19).

Tuberculosis

Tuberculosis, a disease once thought to be well controlled in the United States, is on the rise. The increased incidence is attributable, in part, to the epidemic spread of HIV infection. The incidence of tuberculosis in persons with AIDS is almost 500 times that of the general population, and the risk for developing active tuberculosis among HIV-infected persons who have positive tuberculin skin tests is estimated to be 8% per year (20). The Centers for Disease Control (CDC) estimates that the incidence of tuberculosis among incarcerated persons in 1984 and 1985 was more than three times the rate in the general population. In 1987 in New Jersey, the rate (109.9 per 100,000) was 11 times higher than in the state's general population; in California, the rate (80.3 per 100,000) was six times higher. In New York prisons, cases of tuberculosis among inmates increased from 15.4 to 105.5 per 100,000 from 1976 to 1986, with 56% of cases occurring in HIV-positive inmates (21). The magnitude of future problems with tuberculosis in patients with HIV infec-
tion depends on the extent of overlap between these populations (20). Correctional facilities, with large numbers of intravenous drug abusers in crowded conditions, provides a dangerously good milieu for such overlap.

The CDC notes that transmission of tuberculosis in correctional facilities presents a health problem for both the institutions and the community into which inmates are released. In its guidelines for the prevention and control of tuberculosis, the CDC states the following:

Control of TB is essential in correctional health care. Each correctional institution should designate an appropriately trained official responsible for operating a TB prevention and control program in the institution. A multiinstitutional system should have a qualified official and unit to oversee TB-control activities throughout the system . . . the basic activities to be followed are surveillance, containment, and assessment (22).

Of particular concern are recent outbreaks of multidrug-resistant tuberculosis in prison systems. The New York State system reported an outbreak that has resulted in the deaths of 14 persons, including 13 inmates and one correctional officer, since December 1990. Because of this outbreak, New York just instituted mandatory, annual tuberculosis screening for all inmates and correctional staff (23).

Health Needs of Female Inmates

The number of women in state and federal prisons more than tripled between 1980 and 1990 to an all-time high of 43,845 (3). Sixty percent are non-white women. More than three fourths of these women have children (13). Some are pregnant when they enter prison or jail, although the precise percentage is unknown. These women often have high-risk pregnancies, despite their relatively young age (almost three fourths are between 18 and 34 years of age [13]). The lack of adequate prenatal care on the outside, coupled with extensive substance abuse and a higher incidence of chronic diseases (such as hypertension and diabetes) and communicable diseases (such as sexually transmitted diseases and AIDS), complicate their pregnancy management.

Women in correctional facilities have extensive health needs that few institutions are set up to meet. An estimated 41% of women in prison report previous sexual or physical abuse in their lives (13); these include 23% that report abuse occurring before 18 years of age. These women carry with them the emotional and physical scars of this abuse.

The National Commission on AIDS took note of the general neglect of women's health care in correctional facilities, as well as the specific lack of services for HIV-positive women. The Commission reported the following:

The lack of services for women and adolescents living with HIV disease is another area where the weaknesses in the correctional facilities parallel or exceed those in the general community. . . . In studies of the prison community, HIV seroprevalence rates among prison entrants are higher for women than for men. Clearly, this demands particular attention. Further, a significant number of women give birth to children shortly before they begin to serve prison sentences, or are pregnant and give birth during their incarceration. These women need prenatal services where confidential HIV testing is offered upon request. Special care to provide education and counseling is essential (10).

Mental Disorders

Studies estimate that between 6% and 14% of the correctional population may have major psychiatric disorders (24). More than 13% of jail inmates in 1989 said that they had taken prescribed medication for an emotional or mental problem, and 8% indicated they had previously been sent to a mental hospital or treatment program by a court (14). Mentally ill inmates are considered special-needs offenders and often require specialized housing and security in addition to such mental health services as psychological screening, counseling, psychotherapy, and medication (24).

In a 1991 study, the General Accounting Office (GAO) found that 5.5% of all federal inmates had diagnosed Axis I mental disorders—not including those inmates whose disorder mainly involved use of drugs or alcohol (25). Only two thirds of these inmates were involved in the facilities' psychology or mental health programs. In addition, two thirds of all Bureau of Prisons facilities reported having inmates with undiagnosed Axis I disorders, having inmates with diagnosed Axis I disorders who were not enrolled in treatment programs, or having inmates who were not receiving needed inpatient psychiatric care. More than half of all facilities reported that some mentally ill inmates went untreated because of insufficient resources (staff, programs, or facilities) (25). A 1990 advisory group put together to identify mental health care issues proposed extensive recommendations to improve the Bureau's identification management and delivery of such care, and some of these recommendations have been implemented.

Acute and chronic mental disorders in correctional settings can have dire consequences, including suicide, which is especially a problem in jails and detention centers. In 1990, suicide accounted for 30% of all inmate deaths in larger (more than 100 inmates) jails (4). In a 1986 study, researchers identified 401 suicides in holding and detention centers and estimated that the suicide rate in detention facilities is approximately nine times greater than in the general population (26).

Additionally, a smaller percentage of inmates is classified as mentally retarded or developmentally disabled, and these inmates require support services from the mental health program. A survey of state and federal correctional systems by McCarthy (27) showed that about 2.5% of the total inmate population was classified as mentally retarded, but other studies suggest that 10% may be a more accurate figure (28).

Substance Abuse

According to a 1991 study by the GAO, nearly three quarters of all state inmates (29) and two thirds of all federal inmates (30) have substance abuse problems requiring treatment. In a recent Bureau of Justice Statistics survey, 58% of all jail inmates in 1989 reported regular drug use (15).
Few offenders receive any treatment or services for substance abuse while incarcerated. The Bureau of Justice Statistics noted that about 5% of jail inmates were receiving treatment for drug abuse at the time of the survey. In a 1989–1990 American Jail Association survey, fewer than 20% of jails reported drug treatment programs involving paid staff (American Jail Association. Personal communication). Three quarters of all jails did not provide group therapy, drug education, transition planning, and referral to community drug treatment agencies.

In state prisons, the GAO found that fewer than 20% of inmates with substance abuse problems were receiving any type of drug treatment (29). The GAO noted the challenges that states face in expanding treatment programs; these include 1) limited funding for providing treatment services; 2) security considerations; and 3) difficulties in assuring the availability of aftercare.

The GAO stated that only about 1% of the estimated 27,000 inmates in federal prisons who have moderate-to-severe substance abuse problems were receiving intensive treatment. Although the Bureau of Prisons has an ambitious plan to ensure drug treatment for all federal inmates in need, the GAO found that “implementation falls far short of meeting the needs of federal inmates” (30).

The extent of substance abuse among incarcerated persons and the need for treatment in this population have major budgetary implications for correctional institutions. The Bureau of Prisons estimates that the average cost of treatment in intensive programs is about $5000 yearly per federal inmate (30). This is in addition to the $18,000 average annual cost of incarceration in federal prisons in 1990 (30).

Resource Needs

Although it is possible to discuss the average cost of treating specific conditions that are prevalent in the inmate population, it is impossible to estimate, with precision, the total amount of funds needed to provide adequate health care in each institution. The costs of health care vary with the services supplied, the numbers and kinds of health care personnel, and with the nature of the delivery system. In the absence of this level of detailed information, we will need to look at broad numbers and use some proxy measures to determine the adequacy of correctional health care budgets.

The Cost of Correctional Health Care

The cost of providing health services to inmates is influenced by factors within the criminal justice system and within medicine as a whole. In general, the cost of health services in the United States has escalated dramatically in recent years. According to the Health Care Financing Administration (HCFA), U.S. health care spending totalled $604 billion in 1989, an 11% increase in 1 year. The HCFA estimates that the factors leading to the increase in personal health care expenditures include general inflation (44% of the increase), industry-specific inflation (21%), and population changes (9%). The remaining increase is accounted for by other factors, including changes in technology, medical practice, and service intensity (31).

The costs of correctional health care have escalated for many of the same reasons. In addition, litigation has resulted in court-ordered standards of care in many correctional systems, which forced those systems to increase health care spending to meet community standards of care.

In 1990, the National Commission on Correctional Health Care (NCCHC) surveyed the 50 state correctional systems and the Federal Bureau of Prisons to determine how much each was spending on health services (8). The results showed not only an increase in the total dollars expended for health care, which one would expect from the population explosion, but also dramatic increases in the average cost per inmate.

On an average basis, state correctional systems increased their per inmate annual health expenditure 104% in seven years. They spent $906 per inmate for health care in 1982, $1394 in 1985, and $1848 in 1989 (8). If we estimate that half of these inmates have drug problems requiring intensive treatment, at an average annual cost of $5000 (by Bureau of Prisons estimates), we find that states should be spending $2500 per inmate on drug treatment alone. Although these cost estimates should be used with caution, it is clear that the magnitude of inmate health problems—including not only the target conditions we mention here but also the acute and chronic illness to which we are all susceptible—far exceeds current budgetary outlays for prison health care.

Problems and Costs in the National Drug Control Strategy Budget

By its own report, the NDCS devotes 70% of the federal resources in combating drug abuse to law enforcement ("supply reduction") and 30% to prevention and treatment initiatives ("demand reduction") (7). Although the NDCS emphasizes incarceration, its budget does not reflect appropriate increases in operating costs such as health care. Its goal, through construction of new prison beds, is to reduce the federal prison system's overcrowding rate to 139% of rated capacity by 1995. This goal would be reached after construction of more than 50,000 beds at a total cost of more than $2.1 billion in the 1990 to 1992 period (7). In comparison, the 3-year total amount dedicated to drug treatment resources in federal prisons is $39 million. No mention is made of other resources for health care.

The NDCS notes that 92% of all incarcerated persons are confined in state and local prisons and jails and that these localities are principally responsible for handling most of the population expansion. Other than a challenge to state and local governments to explore ways to reduce operating costs and to provide drug treatment, the NDCS offers few solutions to the fiscal burdens imposed on localities by a policy of putting more drug offenders behind bars. As the ABA states, "Given the current state of the nation's correctional system, sentencing policies that are not based on realistic estimates of prison capacity or accompanied by additional resources to meet the demands are fiscally irresponsible."
(15). We believe these budgetary problems threaten to overwhelm correctional systems and may doom inmates to unacceptable, substandard care.

The courts have affirmed that lack of resources can not excuse systemic medical deficiencies, including shortages of qualified medical personnel, equipment or supplies (32). “Thus, lack of funds . . . does not justify operating a prison in an unconstitutional manner” (33). Incarcerated persons must receive health care that meets the currently accepted standard of care in the community, and adequate resources must be dedicated to providing that care. No less can be tolerated—ethically or legally.

Summary and Conclusions

Clearly, mandatory sentencing practices and the NDCS have overwhelmed correctional facilities to the point of crisis, without substantially alleviating the national problem of drug abuse or drug-related crime. As health professionals, we are seeing the human cost of putting more and more people behind bars. Funding for correctional health care has lagged far behind the explosive population growth. These policies have resulted in severe overcrowding, insufficient treatment programs for substance abusers, and increased prevalence of communicable diseases, particularly those associated with intravenous drug use. This is a national public health problem: Inadequate health services mean that inmates—nearly 10 million of whom are released each year from prisons and jails—may be returned to the community with diseases that threaten the health of the community. In other words, this affects us all.

In light of the above, we conclude the following:

1. Given its enormous human and financial cost, the NDCS, with its emphasis on incarceration, must be reconsidered. Its effectiveness in managing and preventing drug abuse must be evaluated, and alternative approaches that put less emphasis on criminal sanctions and more on prevention and treatment must be considered.

2. Correctional health care budgets must reflect the growing mental and physical health needs of the inmate population. Federal, state, and local officials must increase funding to provide comprehensive, integrated services to treat substance abuse, as well as conditions linked to intravenous drug use—such as HIV infection and AIDS and hepatitis B infection. Systemic deficiencies in meeting the health needs of female inmates and of mentally ill inmates must be corrected.

3. Correctional health care must be recognized as an integral part of the public health sector. State and local health departments must join with correctional health professionals to control the spread of infection within corrections and to the public. This will necessitate additional resources for most health departments and/or coordinating agencies, which are already reeling from the effects of AIDS and the resurgence of communicable diseases such as tuberculosis.

4. All correctional facilities must implement and maintain standards, such as those for NCCHC accreditation, as one way to ensure minimally adequate health care delivery systems.

5. To respond to new and increasing demands, correctional care must evolve from its present reactive “sick call” model into a proactive system that emphasizes screening, early disease detection and treatment, health promotion, and disease prevention. We call for increased cooperation among academic institutions, state and local health departments, and departments of corrections to foster this evolution. This approach must be accompanied by resources for research that more accurately defines inmate health needs and explores how systems can more adequately meet these needs.

Appendix

Organizations

1. American College of Physicians (ACP): a professional association formed in 1915 that represents over 75,000 physicians whose specialty is internal medicine. The ACP was founded in 1915 to uphold high standards in medical ethics, education, research, and practice, with the overarching goal of ensuring the quality of patient care.

2. American Correctional Health Services Association (ACHSA): a professional association formed in 1975 that represents about 1500 correctional health professionals from various disciplines (for example, medicine, nursing, pharmacy).

3. National Commission on Correctional Health Care (NCCHC): a not-for-profit 501(c)(3) organization formed in 1983 whose board of directors comprises individuals named by 32 professional associations, including the American Medical Association, the American Bar Association, the American Nurses Association, ACP, and ACHSA. The NCCHC serves as the primary accrediting body for correctional health systems in the United States.

Terms

1. Jail: a facility operated by a local government (city or county) to detain persons before trial or to hold persons convicted of a misdemeanor who generally have a sentence of less than 1 year. Jails are also currently used to hold convicted felons awaiting transfer to a prison.

2. Prison: a facility operated by the state or federal government to confine convicted felons who generally have been sentenced to 1 year or more.

3. Correctional facilities: in this article, a term referring inclusively to both prisons and jails.

4. Juvenile institutions: a facility for holding detained or adjudicated youth who generally are less than 18 years of age.

5. Mandatory sentence: refers to a sentence in which incarceration is mandated by law.

6. Fixed sentences: refers to a sentence in which the length of time in a correctional facility is estab-
lished by law. Many drug offenses carry both mandatory and fixed sentences as their penalty.

Acknowledgments: The authors thank the three organizations that developed this paper for their extraordinary cooperation, especially Kim Thorburn, MD, President of the American Correctional Health Services Association; Robert Darnais, PhD, President of the National Commission on Correctional Health Care; and Ellen Marshall, Policy Coordinator of the American College of Physicians.

Requests for Reprints: Linda Johnson White, Director, Department of Scientific Policy, American College of Physicians, Independence Mall West, Sixth Street at Race, Philadelphia, PA 19106-1577.


References