SUNSETTED

CORRECTIONAL HEALTH CARE

Correctional Medicine

I. *Corrections and Public Health*: ACP supports maximizing the collaborative efforts of correctional entities with state, county and local health offices to best ensure the effective delivery of public health care. This should include direct involvement by health departments in the strategic planning, assessment, and the provision of clinical services when appropriate. The epidemiologic approach and management of infectious diseases, violence, and chronic diseases should be jointly addressed.

Efforts should be made to assure timely and accurate disease reporting for epidemiological purposes and to assure the continuity of care for these conditions upon an inmate's release from a correctional facility.

II. *Tuberculosis*: ACP supports the aggressive identification and assurance of treatment completion for actively identified tuberculosis (TB) cases and tuberculin reactors in correctional settings. CDC guidelines and collaboration with public health departments for testing and treatment are appropriate for this setting.

III. *Human Immunodeficiency Virus (HIV)*: ACP supports aggressive testing programs to identify all HIV-infected inmates to allow for early intervention, treatment, and education. Up-to-date therapy must be utilized. Experienced clinicians familiar with the treatment of HIV and its complications must oversee and direct patient care. Following discharge from the correctional setting, continuity of care should be maintained through appropriate community referrals.

IV. *Hepatitis C (HCV)*: ACP supports aggressive testing programs to identify HCV-infected inmates and ensure appropriate counseling concerning necessary lifestyle changes related to both disease progression and spread. Recognizing that clinical outcomes and predictors of response are still in the evaluation phase, and that local community standards may vary substantially, ACP supports the development of correctional policies that reflect the prevailing clinical approach and standards of the communities served.

V. *Qualifications of Practitioners in Correctional Settings*: ACP strongly opposes licensure provisions that enable physicians otherwise deemed unqualified to practice in the community for practice privileges in correctional settings. Prisoners by virtue of their incarceration do not forfeit their right to community standards of care that must be adhered to by those rendering care to this population.

VI. *Medical Schools Involvement in Prisons, Prisoners as Experimental Subjects, and Health Services Research*: ACP supports medical and academic institutional involvement in the delivery of correctional health services. The quality and level of care should be consistent with that provided to other segments of the populations served by these providers. All consideration for access to experimental treatments and involvement in medical research must be reviewed and controlled by Institutional Review Board oversight. Informed consent and right of refusal must be rigorously respected and assured. No laxity of standards applied to research projects with prison subjects is acceptable. Ethics committees must provide input and oversight to ensure appropriate protocol implementation.

ACP strongly supports health services research in the field of correctional health care. The same scientific rigor applied in academic centers, HMOs, and community-based clinics must be utilized in the prison populations. Opportunities for health interventions and priorities for health expenditures must be based upon sound scientific knowledge and evidence-based medicine.

VII. *Private Prisons and Private Medical Vendors*: ACP advocates that all aspects of medical care, inclusive of level and quality, provided by private, for-profit prisons or by private medical vendors, must be at least equivalent to that provided in public facilities. States contracting for these services must provide the necessary oversight and maintain the technical ability to ensure the appropriate delivery of services in terms of type and quality.

VIII. *Special Prison Populations: Women, the Elderly, Special Needs, and the Terminally Ill*: ACP advocates that corrections systems address the specific needs of the special populations they incarcerate. Screening and prevention guidelines should follow nationally accepted parameters. Provision of special services to inmates should be determined by medical necessity. Hospice programs should be provided in the correctional setting within the security constraints of the environment.

X. *Substance Abuse and Mental Illness*: ACP supports identification and voluntary treatment of inmates with substance abuse problems. Specifically, prisons should identify and offer services to addicted inmates at a minimum of six months prior to their discharge into the community. Continuity of such treatment begun in prison should occur upon discharge. Mentally ill inmates must receive care consistent with the community standard of care and protection including specialized units as needed within the prison environment.

XI. *Accreditation of Correctional Health Care*: ACP supports the accreditation of medical care provided in correctional settings. Specifically, the College encourages acceptance of medical care consistent with community standards. Accreditation entities uniquely focused on corrections, such as the National Commission on Correctional Health Care (NCCHC), are best qualified to ensure these standards (23). The standards for accreditation should reflect those of the community, and use evidence-based medicine as the standard against which to measure outcomes assessment. (BoR 07, reaffirmed 11)

XI. *Opiate Replacement Therapy*: ACP endorses the medical treatment model of employing Opiate Replacement Therapy (ORT) in conjunction with the provision of appropriate medical services and counseling as effective therapy in treating incarcerated opiate addicted persons. (BoR 01-07)