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Assessment of County Jail Health Care Services and Inmate Health Status

North Central Georgia Health Systems Agency, Inc., Atlanta

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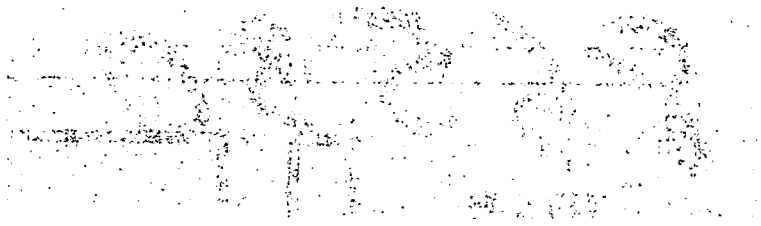

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An assessment of the health care delivery systems used and the health status of inmates incarcerated in Area III county jails demonstrates the need for various community agencies to take an active leadership role toward improving the level of health care delivered in the jails. Standards for Accreditation of Medical Care Health Services in Jails (1978) and previous research of B. Jaye Anno were used to design the survey instruments. The three questionnaires distributed provided data on jail health needs and services. To be accredited by the American Medical Association, a jail must meet 10 essential standards. Only one was met by all 23 jails surveyed--provision of 24-hour medical and dental care. Recommendations for upgrading the present system assign various responsibilities to jails, the Medical Association of Georgia, and the North Central Georgia Health Systems Agency. The survey instrument is appended.

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JAIL HEALTH

ABSTRACT

The North Central Georgia Health Systems Agency coordinated with the Medical Association of Georgia's Program to Improve Health Care in Jails to develop a study that would assess the health care delivery systems used in Area III county jails and the health status of inmates incarcerated in these jails. Survey questionnaires were designed based on American Medical Association Standards for the Accreditation of Medical Care and Health Services in Jails (1978) and previous research of B. Jaye Anno.

Jails in Area III ranged in age from three years to 118 years old (mean of 34 years). The average daily population of the 23 county jails participating in the study ranged from four to 776 and the average daily intake ranged from one to 60.

To be accredited by the AMA, a jail must meet ten essential standards and 85% of the remaining 32 standards. Only one jail, the Cobb County jail, was accredited at the time of this study. Of the ten essential standards, only one was met by all 23 jails; provision of 24 hour medical and dental care.

To assess health status, 275 inmates were interviewed. The inmate population was 93% male, an average of 27 years old, approximately half white and half black. When admitted to jail 50.9% of the inmates were using alcohol and 37.8% were using marijuana. The most commonly treated medical problem among the population was gonorrhea.

The findings demonstrate the need for various community agencies to take an active leadership role towards improving the level of health care delivered in area jails. To this end, recommendations are set forth which assign various responsibilities to the jails, the Medical Association of Georgia, and the North Central Georgia Health Systems Agency.

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I. INTRODUCTION

In accordance with the National Health Planning and Resources Department Act (Public Law 93-641), the North Central Georgia Health Systems Agency is charged with the responsibility of providing effective regional health planning for the residents of twenty-four Georgia counties, known as Area III. Since Congress established the provision of primary care services for medically underserved populations as one of the national health priorities and health systems agencies were established in part to increase accessibility to and quality of health services in their planning area, the North Central Georgia Health Systems Agency deemed it appropriate to analyze the health care of special population groups as one of their responsibilities.

The Primary Care Task Force of the North Central Georgia Health Systems Agency identified as one of their special concerns the health care of inmates in correctional facilities within the health service area. The goal and corresponding objective established by the task force are:

GOAL: Correctional facilities should meet current guidelines on the provision of health and medical care and services, and attempt to meet the AMA Standards for the Accreditation of Medical Care and Health Services in Jails (1978)[1]

OBJECTIVE: By 1981, support the modification of the Jail Standards Act of 1973 to clarify and improve the enforcement authority of the Department of Human Resources over jails.[2]

Since the Medical Association of Georgia (MAG) was active in the American Medical Association Program to Improve Health Care in Correctional Institutions, the North Central Georgia Health Systems Agency (NCG-HSA) coordinated with the Medical Association of Georgia to develop a project to meet the HSA objective. The NCG-HSA staff and the MAG staff developed the following study to assess the status of health care systems used in county jails and to obtain the perception of the inmates in these jails.

The objectives of this study are to (1) assess available health care services, (2) assess the health status of inmates, (3) document medical and health care received since incarceration, (4) assess currently unmet health and medical needs of

inmates, and (5) to measure a general level of compliance with AMA Standards in effect at the time of the data collection, Spring, 1979. With these objectives in mind, NCG-HSA will be able to develop a health care plan and make recommendations to meet the medical and health care needs of inmates incarcerated in the county jails of this region. This report represents a summary and analysis of these findings.

II. BACKGROUND

The AMA program to Improve Health Care in Correctional Institutions began activities in 1977 for a three year period with a Law Enforcement Assistance Administration (LEAA) grant. The Medical Association of Georgia was selected by the AMA to implement the program in Georgia and became one of the original six pilot states to participate. The first three year period has ended and the program has entered into a second three year phase in which it has expanded considerably. The program now encompasses twenty-two states and Puerto Rico, with Georgia remaining quite active in the program.

The early phase of the program emphasized development of minimum standards of health care in jails. This activity involved volunteer physician committees in the six pilot states as well as a specially appointed National Advisory Committee. In Georgia, the MAG Committee on Prison Health Care was organized to perform this function and to test the AMA's accreditation plan. J. Rhodes Haverty, M.D. (Atlanta) chaired this committee for the first three years. In June, 1979, Charles Allard, M.D. (Decatur), became the second and current chairman.

Five Georgia jails were original pilot sites for testing of the AMA Standards and accreditation process. Success in the accreditation process was varied and more enduring for some than others. The jails were of mixed location such as metropolitan, urban and rural with corresponding varieties in size. Of the original five sites, three received accreditation while two withdrew from the program. One of the original five sites is currently accredited.

During the second and third years, eight more Georgia jails volunteered to participate. Meanwhile, development of standards continued with a tendency towards increased minimum levels of care established by the AMA National Advisory Committee. Currently, three Georgia jails are accredited.

Twelve more Georgia county jails volunteered to participat in the program in October, 1979. These sheriffs, and several who participated earlier, have been showing a growing concern and interest in meeting the standards of health care developed

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by the AMA. As a result of this and efforts of other interested groups, voluntary jail standards entitled Standards for Georgia Jail Facilities (December, 1979) and published by the Georgia Jail Standards Study Commission, Department of Community Affairs and Georgia State Crime Commission. The MAG Committee and staff contributed to the development of the Georgia Standards. The Georgia health care standards were based on those developed by the AMA program.

Evaluation data about inmate health and health care were collected during 1977 and 1978 as part of the program. The results of these evaluations, encompassing all pilot jails in the six pilot states, have been published by the AMA. B. Jaye Anno, who was the project evaluator and is the author of these publications, also designed the data collection forms which were used for this study in either their original form or in modified form.

The Standards for the Accreditation of Medical Care and Health Services in Jails are the end product of more than a dozen drafts which have incorporated the advice of several hundred physicians, health care providers, and criminal justice officials throughout the country. During the two phases of testing Standards, thirty jails were involved. From the viewpoint of organized medicine, Standards reflects the definition of "adequate" medical care insisted upon by the courts, and serve as a basis for advising jail authorities and health care providers about the services and resources necessary to provide adequate medical care and health services to inmates. Standards are found in Appendix A.

The Standards focus on the critical importance of each jail's physician to develop, implement, and supervise the medical and health care program to meet legal and medical requirements which fit the situation of each particular jail. Standards also focus on the need to have written medical and health care policies and procedures and the need to document the care given to inmates. The standards also provide guidelines for handling mentally ill and retarded inmates, drug and alcohol abusers, special programs and examinations, and the management of medications and medical records. Another emphaisis is on training in receiving screening, first aid, CPR, emergency procedure, and recognition of illnesses common to inmates of jails.

In Georgia, liaisons have been established with a number of statewide and community organizations such as the Georgia Sheriffs Association, Jail Managers' Association, the Department of Human Resources, the Peace Officers Standards and Training Council in Atlanta, the Association of County Commissioners and local chapters of the American Red Cross, among others. In addition, presentations have been made at meetings of the Georgia Jail Managers' Association, the National Jail Managers'

Association, and local county medical societies. Further, the project chairman makes regular reports at MAG leadership meetings and submit editorials to the MAG Journal. Georgia physicians were also informed about the AMA's annual National Jail Conferences through items carried in the MAG Journal and Newsletter as well as other program activities.

Some unique achievements in the Georgia project include two training workships to teach jailers skills in receiving health screening. Materials developed for these workshops are available to appropriate instructors for additional training sessions for jailers. Recently a third training workshop was conducted which expanded instruction. The title of the workshop was "Abnormal Behavior in the Correctional Setting."

In March 1978 a Symposium on Health Care in Correctional Institutions was held in Atlanta. The Symposium was attended by thirty-seven physicians interested in jail health care in Georgia. The proceedings of this Symposium were made available to involved physicians.

In April 1980, a Second Symposium was held in Savannah, Georgia. This program featured speakers on both Georgia and AMA jail health care standards. Also, the program included four panels which deal with specific problem areas in correctional medicine: legal responsibilities, mental health problems, chemical dependency, and pharmaceutical control.

Another resource, developed jointly by the Georgia and Michigan pilot projects, is a workbook to orient each jail's administration and health care personnel to the AMA Standards and appropriate resource materials to facilitate compliance with each standard. This workbook was the basis of a one-day workshop held in July 1978 and which can be repeated when enough jails express appropriate interest.

The MAG has also developed a "written procedure manual" which can be adapted to a specific setting, computerized, and printed. This resource was the object of a workshop held in Macon in December 1979.

III. METHODOLOGY

The MAG coordinated activities with NCG-HSA to conduct a survey of all twenty-four county jails within the NCG-HSA health service area. One county, Rockdale, chose to withdraw from participation in the data collection process. The data analysis reported here includes all of the twenty-three remaining counties.

A. Jail Health Services

Using Anno's Jail Pre-Profile (February 7, 1977) as one basis for a systems questionnaire, the forms were modified substantially. The final questionnaires developed were also capable of measuring compliance to the AMA Standards in effect in Spring 1979, and the amount of satisfaction perceived by sheriffs and other jail administrators regarding several community services vital to the provision of adequate health care in their jail (ses Appendix B). Interviewed were either sheriffs or jail administrators who were familiar with health care services and procedures in their facilities. Twenty-three questionnaires about health care delivery systems in jails were completed for this study.

B. Inmate Health Services

The inmate data were collected using the same forms developed by Anno for earlier AMA studies and she agreed that these forms could be used for this purpose. Health histories, current health conditions and care received since incarceration are included in this interview.

C. Sample Procedures

Inmates were selected for interviews on a random sample basis using the following guidelines: (1) 10% of all inmates were interviewed in the larger jails with 100 or more average daily population (ADP), (2) 10 were selected at random where ADP was between 10 and 100 inmates, or (3) all inmates were interviewed in jails of ADP of 10 or less. Confidentiality of information was guaranteed to all inmates by the interviewers and consent forms were signed by all inmates who agreed to participate. Interviews were completed for 275 inmates, of whom 255 were male and 20 were female. An additional questionnaire about health services received in jail was given to 255 inmates in the sample who were in the jail one week or longer.

D. Analysis

All of the above data were collected in formats designed for easy entry for computer analysis which was done. The primary interviewers, Heather Gray (MAG) and Bruce James (NCG-HSA), also kept notes about their site visits including observations and perceptions and this forms another base of information to assist in understanding the data. Brief reports of these qualitative observations are included in a special section.

IV. RESULTS AND ANALYSIS

A. Health Services Provided by County Jails

1. Limitations of the Data

Respondents to the health services questionnaire were sheriffs, deputies and/or jailers.

Since many jails do not maintain records relating to health care services, responses were estimated in a number of cases (when records were lacking). The accuracy of the estimations depends upon the knowledge and memory of the person interviewed, as well as his/her amount of involvement in the jail's health care services. In some cases estimates were not attempted and the data were noted as "not available." As a result, some data are not available for every jail included in the study. Only where responses were made can the data be reported.

Since the questionnaire was based upon the Standards for the Accreditation of Medical Care and Health Services in Jails prepared by the American Medical Association, the discussion will follow that outline. These standards were distributed to all the jails at the time of the survey. Very likely, Cobb, DeKalb, Fulton, Gwinnett, Troup, and Upson counties had copies prior to the interviews as they have been part of the AMA project.

The present study, then, should be perceived as an exploratory look at the availability and extent of present health care services in the Georgia county jails which are located in Area III. This study will provide a basis for further program planning and educational development.

2. Characteristics of the Jails

a. Size and Age

Each Jail's average daily population (ADP) is an important indicator of organizational differences and differing needs among jails. Additionally jail size usually correlates well with the community's population. Using AMA definitions of jail size, small jails have an ADP of 20 or fewer inmates, medium jails have 21-249 ADP, and large jails' ADP is more than 249 inmates. The survey contained 10 small, 11 medium, and 2 large size jails for a total of 23. Compared with a national pilot survey conducted in 1976 by B. Jaye Anno, Research Consultant, the number of small and medium-sized jails is almost the same with more large-sized jails being included in the national survey.

The jails ranged in age from three years old to one that was over one hundred years old. The table below compares the age of the jails with those in the national survey.

Table 1

AGE OF JAILS

AGE	AREA III		NATIONAL	
	No.	%	No.	%
Less than 10 yrs.	5	22	6	20.0
10-25 yrs.	8	33	8	26.7
26-50 yrs.	4	17	10	33.3
51-75 yrs.	2	9	2	6.7
76-100 yrs.	3	13	2	6.7
More than 100 yrs.	1	4	2	6.7
TOTAL	23		30	
	Mean = 34.4 yrs.		Mean = 37.3 yrs.	

Whereas Georgia Area III has almost as many new jails under 10 years old (5 jails) as old jails over 50 years (6 jails), the majority (12 jails) are between 10 and 50 years old. Two of the old jails were to move the new facilities within weeks after the survey was taken. More than half the jails (13) had been renovated within the past eight years.

b. Inmate Population Size

Demographic information for each jail is summarized in Table 2. The wide range in size between facilities is reflected in the average daily population (ADP) varying from 4 to 776. Compared with their designed rate of capacity, two jails were overcrowded. In the Anno study, 30% of the jails were overcrowded.[5]

The average daily intake (ADI) ranged from 1 to 60. Male inmates outnumbered female inmates 7.8 to 1. No juveniles are held in county jails. Staffing ratios varied from the number of employees equaling or exceeding the ADP to a ratio of one employee

Table 2 .

INDIVIDUAL JAIL DATA

COUNTY	POPULATION OF COUNTY	1978 ADULT ADMISSIONS MALES	FEMALES	AVERAGE DAILY INTAKE	AVERAGE DAILY POPULATION	DESIGNED CAPACITY OF JAIL	AGE OF JAIL	NUMBER OF EMPLOYEES
BUTTS	13,000	611	0	1	8	20	41	6
CARROLL	56,000	12,410	365	5	30	34	54	8
CHEROKEE	42,000	1,445	72	5	30	38	51	6
CLAYTON	130,000	6,600	1,452	22	92	118	20	28
COBB	263,000	8,084	2,060	29	158	130	10	43
COWETA	37,000	14,235	365	3	30	60	3	10
DEKALB	473,000	16,332	4,697	57	347	435	7	80
DOUGLAS	44,000	NA	NA	5	40	40	31	14
FAYETTE	18,000	548	41	5	16	24	22	8
FORSYTH	23,000	1,396	172	5	21	50	3	11
FULTON	577,000	26,680	2,320	60	776	1000	19	115
GWINNETT	134,000	8,100	100	22	67	82	5	13
HEARD	6,000	253	16	5	4	28	14	4
HENRY	20,000	NA	NA	3	20	20	82	11
LAMAR	11,000	NA	NA	2	4	14	49	10
MERIWETHER	21,000	5,475	365	3	12	42	83	13
NEWTON	32,000	800	0	4	22	34	78	6
PAULDING	22,000	1,046	100	9	20	17	22	5
PIKE	8,000	561	50	2	5	12	4	5
ROCKDALE *								
SPALDING	44,000	12,304	3,109	8	45	59	118	22
TROUP	43,000	7,157	780	9	45	60	40	6
UPSON	24,000	944	88	5	18	32	11	5
WALTON	28,000	998	47	2	12	28	24	8

NA = Not Available

* Rockdale County did not participate in the study.

to every 6.7 inmates in the larger jails. Electronics monitors supplement the staff in some of the jails. The National Advisory Commission on Criminal Justice Standards and Goals recommends a minimum ratio of one correction officer for every six inmates. The figures for this study include only persons employed in the jail.

c. Availability of Health Care Facilities and Services

Thirty-nine percent of the jails have a medical examining room and 13% have medical bed space. This compares to 37% and 23% respectively in the Anno study.[6] All facilities have arrangements with a hospital for inmate care, however, in only five cases do the hospitals provide security measures for the inmates. In the other hospitals a deputy must be present if an inmate is hospitalized.

The estimated annual number of inmates sent by each jail to the hospital for care ranged from 2 to 201 for a total of 956 hospitalizations. Deputy cars are most often used to transport inmates to outside medical facilities to see physicians, dentists, or providers of alcohol and drug treatment. It was estimated that 5,059 outside trips were made in a deputy's car. These ranged from 20 to 960 trips per year per jail. The number of deputies accompanying an inmates to the hospital varies depending upon the crime of the inmate. Most jails will assign two deputies per inmate if the inmate is a felon and one deputy per inmate if the inmate is a misdeamenant. Ambulances are used only in emergency situations to transport inmates to appropriate facilities. All jails have ambulance service available. One of the large jails has its own ambulance which is used for emergency and sometimes non-emergency situations.

Within the past five years, 10 facilities have had law suits against them where the adequacy of the health care services offered was an issue and 5 of those were pending at the time of the survey.

d. Compliance with AMA Standards

According to a 1972 AMA survey of 1,159 of the nation's jails[7] the availability of health care services in the jails was inadequate. This study of Area III jails found that this sample of jails varies very little from the national sample cited above and agree very closely to the findings of studies completed by Anno in 1977 and 1978. Our findings of availability of health care facilities and services are presented in the aggregate and in most cases do not reflect the size of the jail, the average length of inmate stay, and other available community resources. A summary of the Area III jails' compliance with the ten essential AMA Standards is presented in Table 3a, 6, and 7.

Table 3a

AREA III JAILS COMPLYING WITH AMA ESSENTIAL STANDARDS (N=23)

STANDARDS		NUMBER COMPLYING	% COMPLYING
1001	Licensed physician responsible for medical services and having a contract with the government agency	15	65
1002	No restrictions imposed on physician by facility regarding practice of medicine	15	65
1004	Written SOP approved by responsible physician	1	4
1005	State licensure and/or certification requirements and restrictions apply to health care personnel and verification of current licensing on file	4	17
1006	Written job description for qualified medical personnel	4	17
1007	Treatment by medical personnel other than a physician is performed pursuant to written standing or direct orders	5	22
1008	All examinations, treatments and procedures affected by informed consent standards in the community are observed for inmate care	19	83
1011	Receiving screening performed and recorded before inmate placed in general population	3	13
1012	Health appraisal completed for each inmate within 14 days after admission	2	9
1018	24-hour emergency medical and dental care	23	100

Table 3b
JAILS COMPLYING WITH AMA NONESSENTIAL STANDARDS

	STANDARD	JAILS COMPLYING		JAILS NOT COMPLYING	
		NO.	%	NO.	%
1003	Quarterly report on the health delivery system and health environment and an annual statistical summary	1	04	22	96
1009	If medical services are delivered in the facility, adequate space, equipment, supplies and materials are provided	3	13	20	87
1010	Adequate number of first aid kits	18	78	5	22
1013	Health history and vital signs are collected by medically trained or qualified medical personnel. Review of screening is done by physician or designated qualified medical personnel	2	09	21	91
1014	At time of admission, inmates receive written communication explaining procedures for gaining access to medical services	5	22	18	78
1015	Inmate's medical complaints are collected daily and acted upon by medically trained correctional officers or allied health personnel. Appropriate triage and treatment by qualified medical personnel follows.	2	09	21	91
1016	Sick call is conducted by a physician and/or other qualified medical personnel once a week or more according to ADP	9	39	14	61
1017	When sick call is not conducted by a physician, the responsible physician arranges for the availability of a physician at least once a week. The responsible physician reviews the medical services provided.	1	04	14	61[1]
1019	Facility personnel are trained in basic first aid equivalent to that defined by the American Red Cross	21	91	2	09
1020	At least one person per shift within sight or sound of all inmates has training in receiving screening, CPR, and recognition of symptoms of illnesses most common to the facility	12	52	11	48
1021	Chronic care, convalescent care and medical preventive maintenance are provided	13	57	10	43
1022	Medical and dental prostheses are provided when the health of the inmate-patient would otherwise be adversely affected	17	74	5	22[2]
1023	On-going dental care is provided under the direction and supervision of a dentist	0	0	23	100
1024	Facility personnel are trained regarding recognition of symptoms of mental illness and retardation	20	87	3	13
1025	Screening and referral for care are provided to mentally ill or retarded inmates whose adaptation to the jail environment is significantly impaired. The responsible physician has provided a written list of symptoms of behavior indicative of mental illness and retardation.	2	10	20	87
1026	A special program exists for inmates requiring close medical supervision	22	96	1	4
1027	Detoxification from alcohol and drugs, when not provided in a hospital or community detoxification center, is performed at the facility under medical supervision	22	96	0	0[3]
1028	Facility's SOP for proper management of pharmaceuticals include a formulary, policy regarding prescription of all medications, policies regarding medication dispensing and administration; and policies regarding security storage and weekly inventory of all controlled substances, syringes, needles and surgical instruments.	3	13	20	87
1029	The person administering medications has training from the responsible physician and the official responsible for the facility; is accountable for administering medications; and records the administration of medications on an approved form.	5	26	17	74
1030	The medical record file contains all pertinent medical records. The method of recording entries, and the form and format, are approved by the responsible physician	5	26	17	74
1031	Access to the medical record is controlled by the responsible physician. The physician-patient privilege applies to the medical record	14	61	9	39
1032	The medical record file is not in any way part of the confinement record	20	87	3	13
1033	Summaries of the medical record file are routinely sent to the facility to which the inmate is transferred.	1	04	22	96
1034	Each inmate is allowed a minimum of one hour of exercising daily away from the cell on a planned programmed basis	5	22	18	78
1035	Bathing facilities with hot and cold running water are provided	23	100	0	0
1036	Regular bathing is permitted twice each week	23	100	0	0
1037	In jails without air temperature control, daily bathing is permitted in hot weather	23	100	0	0
1038	To maintain personal hygiene, inmates are furnished with soap, toothpaste, toothbrush, toilet paper, and feminine hygiene supplies	12	52	11	48
1039	Implements for shaves and haircuts are made available to inmates	17	74	6	26
1040	All inmates and other persons working in the food service are free from diarrhea, skin infections and other illnesses transmissible by food or utensils	15	65	0	0[4]
1041	All food handlers wash their hands upon reporting to duty and after using toilet facilities	15	65	0	0[4]
1042	Special medical diets are prepared and served to inmates according to the orders of the treating physician or as directed by the responsible physician	20	87	1	4[5]

1. Not applicable in eight cases;
   Sick call already conducted by a physician
2. Not applicable in one case;
   Sheriff has not had this problem in eleven years
3. Not applicable in one case;
   Alcohol and drug detoxification handled by referral to community resources
4. Not applicable in eight cases;
   Food service handled by outside contract services
5. Not applicable in two cases; jail has not had this problem

Additionally, a summary of compliance to non-essential standards is presented in Table 3b. It is helpful to understand adequacy of care in terms of compliance for accreditation as defined by AMA: for one year accreditation a jail must comply to all essential and at least 70% of nonessential standards, for two years accreditation, a jail must comply to all essential standards and at least 85% of nonessential standards. At the time of this survey only one jail in this sample met sufficient compliance for accreditation, - Cobb County with a two year accreditation certificate.

All area III jails have a licensed physician responsible for the organization and operation of the facility's medical services, but only 15 of these have a written agreement between the physician and governmental funding agency responsible for the facility (AMA Standard 1001). However, in more than half the jails (12) the physicians are spending four or less hours per month seeing inmates. In only 4 jails do the physicians allocate more than 40 hours per month to inmate health care. This positively correlated with ADP except for one of the large jails which has two nurses on duty 24 hours a day and the doctor visiting less than 40 hours per month. An estimated 1,425 inmates per month are seen by the physicians (this estimate is probably conservative as two jails provided no estimate). Respondents from all those facilities that have a physician responsible for the medical services were satisfied with the physician's health care delivery. Tables 4 and 5 show the estimated number of inmates sent to the doctor per month and the cost per visit.

Table 4

NUMBER OF INMATES SEEING THE PHYSICIAN BY MONTH BY SIZE OF JAIL (N=21)*

NUMBER OF INMATES SEEING PHYSICIAN	SMALL JAIL	MEDIUM JAIL	LARGE JAIL	TOTAL
Less than 10	6	2	0	8
10-19	2	4	0	6
20-99	0	3	0	3
More than 100	0	2	2	4
	8	11	2	21

*Two jails did not respond to this question.

Table 5

COST PER INMATE VISIT TO DOCTOR (N=23)

COST/VISIT	# OF JAILS
Under $10	2
$10 - $14	2
$15 - $19	5
$20 - $24	4
Not Applicable	2
No Response	8

Average Cost = $15.00 per visit

Sixteen of the jails do not impose any restrictions on the physician regarding the practice of medicine. In 7 jails, restrictions are imposed. However, in all jails those regulations applicable to the facility personnel also apply to medical personnel (AMA Standard 1002).

Nineteen jails report allied health personnel such as nurses, mental health personnel, physicians' assistants, county paramedics, and emergency medical technicians providing health care to inmates. All but one of these facilities require the medical and health care personnel who work in the jails to meet the state's licensure and/or certification requirements and restrictions (AMA Standard 1005). Only 4 jails have verification of current licensing and certification credentials on file. However, while jails report the availability of allied health personnel only three jails employed such personnel at the jail site at the time of this study. Most services are provided in facilities outside the jail, requiring transportation from the jail which tends to inflate medical costs. Consequently, the cost of access to medical care very likely exceeds the costs of direct medical care in most cases.

AMA Standard 1006 states that "the work of qualified medical personnel is governed by written job descriptions approved by the responsible physician". Only 4 jails comply to this standard. As for treatment by medical personnel other than a physician, only 5 jails have a policy that this treatment be performed to written standing or direct orders (AMA Standard 1007).

Although not an essential standard the AMA suggests there be a "quarterly report on the health delivery system and health environment and an annual statistical summary" (AMA Standard 1003). Except for inspections conducted quarterly by county and/or state health agencies in 20 jails regarding sanitation, there are virtually no reports compiled by the jails. Only two jails prepare reports on the health delivery system, and one of these also completes an annual statistical summary of medical care provided.

As can be seen in Table 6, less than half the jails have written standard operating procedures (SOP) of any kind for providing various types of medical services, and most of these have not been approved by the responsible physician (AMA Standard 1004).

Table 6

AMA STANDARD 1004

JAILS WITH WRITTEN STANDARD OPERATING PROCEDURES APPROVED BY RESPONSIBLE PHYSICIAN N=23

STANDARD OPERATING PROCEDURES	JAILS WITH SOPs	JAILS WITH M.D. APPROVED SOPs
Receiving screening	11	4
Health appraisal data collection	5	4
Non-emergency medical services	7	3
Emergency medical and dental services	8	4
Deciding emergency nature of illness	6	4
Dental screening, hygiene, exam, and treatment	5	2
Provision of medical and dental prosthesis	5	3
First aid	5	4
Notification of next of kin or legal guardian in case of serious illness, injury or death	6	4
Chronic care	4	3
Convalescent care	4	3
Medical preventive maintenance	1	1
Screening, referral, and care of mentally ill and retarded inmates	6	3
Implementing special medical program	4	3
Delousing	5	3
Detoxification	4	3
Pharmaceuticals	5	3

Eleven, or almost half, have a SOP for receiving screening. Only 4 of these have SOPs approved by the physician. Eight jails with written SOPs have procedures for emergency medical and dental services and 7 have procedures for non-emergency medical services. Only 3 jails with SOPs provide for medical preventive maintenance. It should be noted that in a nationwide pilot study only 30% of the jails had any written policies and procedures. Comparisons by item however are difficult because specific procedures were not documented in the pilot study. For the majority, physicians responsible for the jail's health care are concerned primarily with medical treatment and are rarely involved with the delivery system at the institutional level concerning staff procedure, documentation and training needs. Often the sheriff has not requested such assistance of the physician since few SOPs have been written and fewer still approved by the physician. When jails have SOPs and appropriate training, delivery of inmate health care is greatly facilitated.

AMA Standard 1008 states that "all examinations, treatments and procedures affected by informed consent standards in the community are likewise observed for inmate care." Most (19) jails comply with this standard.

All jails have some medical services provided in the facility. Twenty two jails provide space for examinations and medical care but only 13 respondents feel the space is adequate for the purpose. The larger jails tend to have more adequate space for bed care and examinations while the smaller ones tend to use an empty cell or the sheriff's office. With the exception of recently built jails which are more likely to comply with federal and state standards, most jails tend to be planned with no room specifically for physicians examinations or for inmates requiring bed rest. Respondents from six jails state that the facility provides some medical equipment but only 4 respondents indicated that the equipment is adequate. Of 4 jails furnishing supplies and materials only in 3 jails do respondents believe these are adequate. (AMA Standard 1009)

Although 21 of the jails have first aid kits (AMA Standard 1010) the kits vary from adequate to a very few supplies such as bandaids, Mercurochrome, aspirin, etc. Eighteen felt their kits were adequate for their needs, but few ever expect to have to administer first aid - they will call the paramedics or take the inmate to the hospital. Some kits are kept in the deputies' cars or sheriffs' offices, removed from the jail site.

All earlier studies of jail health care have found a health screening process when the inmate is booked into the jail is critically needed to determine the immediate risk of medical and health problems, and whether the inmate may need to see a physician soon.

A number of medical problems can be detected at screening. Receiving screening is conducted by 91% of the jails (AMA Standard 1011) before the inmate is assigned to a cell. The inmate is asked about current illnesses and health problems, current medications, and special health requirements. Less than a third of the jails investigate the other conditions recommended by the AMA which are deamed serious and/or common for inmate populations. (See Table 7) Many ask the inmates only if there are any problems or note obvious conditions. The Anno study found that only 13% of the jails studied conducted routine health screenings for all inmates on admission[8] which included specific recommended questions and/or observations.

Table 7

AMA STANDARD NUMBER 1011

FACTORS CHECKED AND RECORDED DURING RECEIVING SCREENING (N=23)

	NUMBER OF JAILS	NUMBER OF JAILS RECORDING
Current illness and health problem	21	20
Current medications	21	20
Special health requirements	21	20
Problems specific to women	7	7
State of consciousness	5	5
Mental status	5	5
Notation of body deformaties	5	5
Trauma markings	5	5
Ease of movement	5	5
Jaundice	5	5
Condition of skin	6	5
Condition of body orifices	4	3

In the majority of cases the screenings are conducted by the jailor or clerk (10 jails) or the arresting officers (7 jails) or a combination. Sometimes there is no communication between the person conducting the screening and the person in the jail responsible for health care. Only the three largest jails have allied health personnel on staff who check the inmate at the time of imprisonment. All 21 jails were satisfied with their health screening process.

In most Georgia jails, the arresting officer is responsible for the person until he/she is medically able to be incarcerated. Jails do not receive critically injured or sick persons and incur responsibility for these serious conditions unless they are not detected at booking, or they must accept them according to existing rules or regulations.

AMA Standard 1012 suggests that a health appraisal data collection form be completed for each inmate within 14 days after admission to the facility. This appraisal should include a medical history, lab tests, vital signs, physical examination, etc.; however, only two jails do this

Procedure for the inmate to express a need for medical services varies not only between jails but within them. This seems to be a problem area and one which is affected by individual biases and perceptions. Only five of the jails provide written communication explaining the procedure for gaining access to medical services (AMA Standard 1014); however, as seen in the Inmate Report, only 8.7% of the inmates interviewed who had been in the jail for more than a week said they did not know what the procedure was for getting medical assistance. Obviously, most inmates learn the procedure by "grapevine" or by observation however, this method still does not inform all inmates.

Methods for informing jail staff about medical complaints varies. The inmates in two jails fill out their own complaint slips when they believe they need to see a doctor. The slips are then passed on to allied health professionals for triage. Triage is the sorting and allocation to treatment of patients according to priorities of need. In the remaining 91% of the jails the inmates generally tell either the jailer or the runaround (an inmate trustee). In some of these cases decisions about whether an inmate will be reported for sick call is likely to be made by staff who are not trained in medical triage. This kind of training is not available presently. In the Anno study, in 90% of the jails inmates' access to health care services was controlled by correctional personnel.[9] Runarounds were not specifically mentioned in the Anno report, but our data indicates that jailers are much more likely to report complaints than runarounds. Table 8 shows who performs triage when a complaint is received.

Table 8

PERSONS WHO CONDUCT MEDICAL TRIAGE IN AREA III JAILS (N=23)

TITLE OF PERSON	NUMBER OF JAILS
Physician	1
Allied health professionals	5
Jailer	5
Sheriffs and/or deputies	5
Jailer and sheriff	4
Jailer and other	2
Deputy and other	1

Thus in only 26% of the jails are qualified medical personnel conducting triage (AMA Standard 1015). In 10 jails (43%) there is a regular daily sick call. In 8 jails sick call is conducted by a physician and in two jails by other qualified medical personnel (AMA Standard 1016). It is interesting to note that in the Anno study 17% of the jails reported having regular, daily sick call.

All the jails have 24-hour emegency medical care as well as a plan for emergency evacuation of the inmates from the facility, the use of an emergency vehicle and the use of designated hospital emergency rooms or other health services. Only two jails are located further than 15 miles from a hospital; however, in these two cases where emergency health facilities are not located in a near-by community both jails have emergency on-call physician and dentist services. Nineteen jails have 24-hour emergency dental care (AMA Standard 1018). However, in the remaining three jails, a dental emergency could be stabilized at the emergency facility until a dentist could be reached.

AMA Standard 1019 states that "facility personnel are trained in basic first aid equivalent to that defined by the American Red Cross and use emergency care procedures." Depending upon how the respondent interpreted "facility personnel" all jails could respond positively, because deputies have had mandated first aid training if they have been employed by the

sheriff for at least a year. However, in at least four and possibly more facilities, jail personnel had not received training, and these are the people stationed at the jail, while the deputies spend much of their time on the road. Usually, road deputies get mandated training whereas no mandated training exists for correctional officers. Training for deputies does not include special skills for making observations needed to decide when an inmate needs medical attention. Even skills in taking vital signs can be crucial in the jail setting.

In only one jail which was slated to move to a new facility were jail personnel neither within sight or sound of inmates. Only three jails have personnel within sight of inmates, although this is usually accomplished by monitor. However, monitors usually show hallways and communal areas, not individual cells. Except for the jail mentioned above, all have personnel within sound of inmates. Since cells are located on separate floors from the administrative offices in a number of jails, the sound may have to be rather loud to be heard. One inmate reported that they all had to bang their dinner trays on the bars for an hour before the jailer came and took an inmate to the hospital. He had appendicitis. Similar comments have been made by other inmates. In one case, a nurse said they're always within sound because you can hear them banging and rattling the bars. Such noises are commonplace in all jails observed during our visits and it would be difficult to differentiate an emergency from other noises.

Those jails reporting that there is at least one person per shift within sight or sound of all inmates who has the following training in basic health care are eighteen providing receiving screening training, twelve providing CPR training and twenty-one providing training to recognize symptoms of illness most common to jails (AMA Standard 1020).

When necessary, 21 jails provide chronic care in the facility for such conditions as diabetes and heart problems (in one case, the nurse comes to the facility to administer the insulin). The other two facilities take the inmates to the hospital or send them to another jail that has better facilities for both chronic and convalescent care. Nineteen jails provide convalescent care in the facility, while only 12 offer medical preventive maintenance (AMA Standard 1021). While these jails claim to provide these services, in only three jails were SOPs written for the provision of these services.

In 17 jails medical and dental prostheses are provided when the health of the inmate would otherwise be adversely affected as determined by the responsible physician (AMA Standard 1022).

Dental care is provided on an emergency basis for all the jails. Extractions are the primary dental treatment provided to inmates. One jail has a dentist who comes to the jail once a week and preventive care may be provided in this case, but all others take inmates to the dentist's offices and usually for dental emergencies only. Even when the dentist comes to the jail it is still necessary to take some to the office if they cannot be seen in the one day. The estimated number of inmates per year who receive dental care is 1179. One large and two medium sized jails have more than 100 inmates per year receiving dental care. The other large and two medium sized jails have approximately 70 inmates per year who receive dental services. In nine jails the number of inmates ranges from 24 to 48 while six jails have 12 or less inmates per year receiving dental care. One sheriff reported that he has not had to use the dentist during his two and a half years in office. None of the jails provide dental care as outlined in AMA Standard 1023. The Anno study found that 20% of the jails provided in house dental services but a third of these were limited to emergency extractions.[10]

All but three jails have personnel trained regarding recognition of symptoms of mental illness and retardation (AMA Standard 1024). As in the case of first aid training, those trained may only be the deputies which have this as a part of their mandated training, and those such as the jailer and support personnel stationed in the jail may not have received relevant training.

Georgia laws mandate that sheriff departments are responsible for transporting mentally ill persons to appropriate facilities for evaluation and/or committment usually outside the community. Generally mentally ill persons are referred to the legal system by their families who wish them detained while they obtain a peace warrant. The family then contacts a physician who examines the inmates and decides what type referral, if any, is needed. In the case where the family is not involved the sheriff will contact the physician and obtain the necessary court order.

When a misdemeanor is involved the mentally ill inmate is usually referred to a local or regional hospital; if there is a felony, the inmate is sent to the Central State Hospital at Milledgeville which has the necessary security facilities. Most of the jails do not want the responsibility of incarcerating the mental ill and will attempt to have them referred, released on bond, or affect an early release as soon as possible. On the other hand, there is considerable criticism by respondents in our study, mostly sheriffs, of the treatment, or more specifically the lack of it, when inmates are referred to mental hospitals. Criticisms tend to focus upon the length of time allowed for treatment and that treatment is not sustained. There is

consequently a high rate of recurrence that is attributed to insufficient time allowed for adequate therapy. One sheriff reported that after transporting an inmate to a regional hospital, the inmate beat the sheriff back to the county! After being admitted to the hospital an inmate may voluntarily check himself out.

Fourteen jails have referral for emergency mental health treatment only, while nine provide referral for both on-going and emergency treatment. Only four jails have a written list of symptoms of behavior indicative of mental illness and retardation available in the jail (AMA Standard 1025). The estimated number of inmates per year who are referred for mental health treatment or evaluation is 2,439.

All but two of the jails are satisfied with their procedure for the treatment of the mentally ill inmates. Sixteen jails, including these same two, indicate dissatisfaction with the treatment the inmates receive after they are referred to an outside treatment facility.

All jails except one have a special program for inmates requiring close medical supervision. In these cases there is a written individual treatment plan for each patient developed by the physician (AMA Standard 1026).

Medically supervised alcohol detoxification is offered by all jails: five jails offer in-house detoxification, seven refer to community detoxification centers and eleven offer both procedures as the case requires. All jails also offer medically supervised drug detoxification: six jails offer in-house detoxification, twelve refer to community detoxification centers and five offer both procedures as needed. There seems to be no uniform, prescribed treatment for alcohol and drug detoxification. Most jails will attempt to detoxify the alcoholic and release him within 24 hours if there are no complications and no crime was committed. Detoxification treatment varies from administering nothing - going "cold turkey" - to giving alcohol, vitamins, and prescribed drugs. If there are complications, such as delerium tremens (D.T.s), or if the facility is not equipped to handle detoxification, inmates are referred to a hospital. Sometimes a social service agency is suggested for counseling.

Although drug detoxification is not as often a problem as alcohol, basically the same procedure is followed, but usually there are more referrals to hospitals. Some jails treat drug intoxicants as mentally ill and follow a procedure similar to handling the mentally ill.

All 23 jails are satisfied with their procedures for handling both alcohol and drug detoxification; however, of those facilities that refer inmates for treatment by outside medical facilities for alcohol and drug detoxification, seven jails consider the alcohol detoxification treatment effective and four consider the drug detoxification effective. For the 23 Area III jails responding the estimated total number of detoxification referrals are 1041 for alcoholic treatment and 394 for drug treatment during the last year.

The stocking and administering of medications is covered in AMA Standard 1028. Only six of the jails have a formulary (list of medications) in the jail. All stock aspirin and some have antacids and laxatives. Controlled substances are kept in all the jails while only 8 have syringes and needles, and three have surgical instruments. Controlled medications and instruments are kept in a locked place in 18 jails; three keep them closely guarded by the radio operator but not locked. Most jails maintain a record (either a master list or individual) of medications to be administered. Only a few record when a dosage is given, and fewer still indicate that they observe while inmates swallow the pills. This can result in inmates abusing medications by hoarding pills or selling them, a commonplace occurence in jails. Most jails have reported instances of hoarding medication.

If inmates have medications with them when they are booked they are taken from them. Fourteen jails said they consulted a physician to positively identify the medication and to confirm that the medication was needed while the inmate would be incarcerated. Good procedure would be for physician reevaluation of the inmates condition except where common chronic conditions are observed at screening and appropriate medication are prescribed.

In most facilities the jailer, deputy, or other facility personnel administer the medication; however, in three jails this was the job of the runaround. (Under new AMA Standards, the practice of using runarounds to administer medication, take sick call complaints or have access to health records is not acceptable). In more than half (12) of the jails the person administering medication has not had training from the physician and the official responsible for the facility (AMA Standard 1029). The majority of jails (16) identify some staff person who is accountable for administering medications according to orders, yet only in 9 cases is the administration of medications recorded. However, the jail's procedures for the administration of medication are considered satisfactory by respondents in 20 of the facilities.

An inmate medical record file is kept by 52% of the jails and/or 78% of the physicians maintain a file in their office. Table 9 shows the information contained in the medical record file (AMA Standard 1030). The Anno study found that 73.4% of

the jails kept records of the number and types of drugs being dispensed and the number of inmates receiving medical, dental or psychiatric care. However, only 40% of the jails in that study kept in-house records regarding inmates' medical histories or any diagnostic or treatment services given while incarcerated."

Table 9

INMATE MEDICAL RECORD FILE MAINTAINED BY JAILS (N=12)

ITEM	NUMBER OF JAILS	%
Complete receiving screening form	8	67%
Health appraisal forms	4	33
Findings, diagnosis, treatments	10	83
Prescriptions and administration of medicine	12	100
Notes concerning patient education	9	75
Place, date, and time medical encounters	11	92
Termination of treatment from long term or serious medical or psychiatric treatment	8	67%

Again, the majority (18 jails) are satisfied with their system of recording inmates medical care.

Access to the medical records is controlled by the responsible physician in 14 jails. The privacy of the physician/patient relationship also applied to the medical records in these same facilities (AMA Standard 1031). In only two jails is the medical record file part of the confinement record (AMA Standard 1032). None of the jails routinely sends summaries or copies of the medical records file to the facility to which the inmate is transfered; however, upon written authorization of the inmate, 14 jails will send medical record information to specific designated physicians and medical facilities in the community (AMA Standard 1033). The current system of inmate transfer in the state does not include a systematic tranferral of medical information for inmates under treatment or who were treated during their confinement period at the county jail. This is not to say that such information is never passed along for inmates under treatment or medication.

It seems that this information may get passed along but it isn't written procedure and is not systematic and consequently very likely omitted in some cases under treatment.

AMA Standard 1034 suggests that "each inmate is allowed a minimum of one hour of exercise daily away from the cell on a planned, programmed basis." Regular exercise is provided by only 5 jails. Many facilities have little for the inmates to do and this inactivity can lead to other problems. For example, it is reported that some inmates think more about their complaints, and some request to see the doctor only because it provides a break in the dull routine. In most jails it also means getting out of the jail to go to the doctor's office which is costly in terms of security required and in some cases, in terms of potential risk to the community. Escape attempts often occur during sick call transport.

All facilities provide hot showers and permit bathing daily (AMA Standard 1035 and 1036). Soap, toilet paper, and feminine hygiene supplies are furnished by almost all the jails; however, inmates are expected to furnish their own toothbrush and toothpaste in more than half the facilities (AMA Standard 1038). Eighteen jails provide implements for shaves and haircuts (AMA Standard 1039).

AMA Standard 1040 states that "all inmates and other persons working in the food service are free from diarrhea, skin infections and other illnesses transmissible by food or utensils." All fifteen jails that prepare meals in-house comply with this standard. The other eight jails contract with an outside firm to provide the meals.

When special medical diets are ordered by the physician, 20 jails indicate they are provided. One county has the inmate's family bring in the specially prepared meals. In two jails the need for special diets has never occurred. In the Anno study it was found that only 67% of the jails made provision for special diets.[11] (AMA Standard 1042) In Area III jails, 87% provide special medical diets.

B. Health Status Profile of Inmates

By answering the "Inmate/Patient Profile," a sample of 275 inmates, 255 males and 20 females, provided information on the health status of inmates in 23 county jails. The sample was selected by interviewing all inmates in jails of ADP of 10 or less, 10 were randomly selected where ADP was between 10 and 100 inmates, and 10% of all inmates were selected in jails with ADP of 100 or more.

The questionnaire, divided into three sections, sought background characteristics, health histories, and recent medical complaints from each participating inmate. Each of these sections will be discussed below and briefly compared to results obtained by Jaye Anno in previous use of the "Inmates/Patient Profile."

1. Inmate Characteristics

Inmates who participated in the interview ranged in age from 17 to 74 years, with a mean age of 27 years. Young adults comprise the majority the jail population; more than 50% of the inmates were under 25 years old. The sample population was 92.7% male. By race 52.4% were white, 47.6% were black, and no other race was noted among our sample of inmates. An average of 73 days had been served on current terms in jail, but the median number was 30 days, demonstrating that county jails are short term holding facilities. Only 45.1% of the sample population had been sentenced. Of those knowing the duration of their sentence, 44% were to be released within one year. A majority of inmates, 60.4% had been in the same jail on previous arrests. Data produced from this study are similar to results found in Anno's report of May, 1978 drawn from a sample of 495 inmates in six states. This earlier study characterized an inmate population which was an average of 27.5 years old, and 90.5% male, 56.0% white, 35.9% sentenced and 62.1% who were in the same jail before.

2. Health History

Table 10 summarizes prior medical care received by inmates regardless of whether the care was administered in jail or before incarceration. While 94.9% of the sample population had been treated by a doctor at some time, only 61.9% had received treatment within the last year. Of those 83.6% who had received physical exams 52.6% were conducted more than one year prior to the interview. Almost three out of every four hospitalizations occurred more than 12 months prior to the interview. Approximately half of the population (53.1%) had been operated upon, with most operations occurring over five years earlier. A dentist had provided services to 90.2% of the inmates at some time in their life. In the area of mental health services, 35.8% of the inmates had seen a psychiatrist and 16.7% had been hospitalized for mental illness, or for alcohol and/or drug detoxification. An eye exam had been given to 77.8% of the inmates at some time in their life. All of the data obtained in this section were comparable to the statistics obtained by Anno for the multi-state study.

Table 10

PAST MEDICAL PROBLEMS OF INMATES

HAVE YOU EVER BEEN	NEVER		YES								YES, OVER 5 YEARS		YES, DO NOT KNOW		TOTAL	
					TREATED WITHIN PAST											
			1 WEEK		1 MONTH		6 MONTHS		1 YEAR		5 YEARS					
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
TREATED BY DOCTOR	14	5.1	26	9.5	37	13.5	53	19.3	54	19.6	69	25.1	21	7.6	1	0.4	275	100
GIVEN PHYSICAL EXAM	45	16.4	2	0.7	12	4.4	44	16.0	51	18.5	91	33.1	30	10.9	0	0	275	100
HOSPITALIZED (MEDICAL)	95	34.5	0	0	7	2.5	17	6.2	22	8.0	65	23.6	66	24.0	3	1.1	275	100
OPERATED UPON	129	46.9	0	0	3	1.1	4	1.5	12	4.4	51	18.5	74	26.9	2	0.7	275	100
TO SEE A DENTIST	27	9.8	4	1.5	20	7.3	51	18.5	51	18.5	84	30.5	36	13.1	2	0.7	275	100
TO SEE A PSY-CHIATRIST	176	64.2	1	.4	8	2.9	14	5.1	17	6.2	32	11.7	24	8.8	3	1.1	275	100
HOSPITALIZED (MENTAL)	229	83.3	2	.7	1	.4	12	4.4	11	4.0	13	4.7	5	1.8	2	0.7	275	100
GIVEN AN EYE EXAM	61	22.2	3	1.1	3	1.1	24	8.7	48	17.5	80	29.1	46	16.7	10	3.6	275	100

Past medical problems of the sample population are given in Table 11. These responses do not reflect the actual incidence of these problems, rather they indicate the number of treated cases. Gonorrhea, for which treatment had been given to approximately one-fourth of the inmates at some time, was identified as the most prevalent problem among the inmates. Less than 10% of the sample population had been treated for each of the other listed problems except allergies (16.4%), high blood pressure (13.5%), and asthma (11.3%). These results were comparable to figures found by Anno in 1978, except her multi-state study showed allergies as the problem most often treated. The only medical problems that differed by more than 3% between studies were hepatitis and attempted suicide, both having approximately six percent higher incidence in the Anno study.

The inmates responding to the questionnaire were asked about their use of alcohol and drugs at the time of admission to jail. Although questions were asked on daily and sustained usage in order to classify inmates according to high, medium, or low usage, it was decided the most meaningful classification would be non-user, user, and addicts. The assignment of these categories removed much of the arbitrary decision making. Inmates experiencing withdrawal were considered addicts and those not using alcohol or drugs at the time of incarceration were considered non-users for purposes of this study. The inmates who were using any substances, regardless of quantity, were classified as users. Table 12 provides information on utilization of alcohol and drugs. Approximately half of the inmates, 50.9%, were using alcohol at the time they were brought to jail. Marijuana was being used by 37.8% of the sample population at the time of their arrest. Fewer than 10% of the inmates were actively using any one of the other drugs at the time of booking. Percentages on alcohol and drug utilization were almost identical to Anno's study.

The final division of the health history section deals with some miscellaneous questions. At the time of the interview, 24.4% of all inmates were using some type of medication. Allowing for normal weight fluctuations, weight loss was reported by 30.9% of the sample population, while significant weight gain was reported by 22.2%. Gains were often reported by substance abusers who were likely served more nutritional food than obtained before incarceration. Less exercise in jails might also contribute to weight gains. Exposure to tuberculosis was reported by 14.2% of the participants and exposure to hepatitis was reported by 9.5%. Eyeglasses or contact lenses were worn by 18.5% of the inmates.

Table 11

HEALTH CARE RECORD OF INMATES

HAVE YOU HAD TREATMENT FOR	NEVER		YES										YES, OVER 5 YEARS		YES, DO NOT KNOW		TOTAL	
			TREATED WITHIN PAST															
			1 WEEK		1 MONTH		6 MONTHS		1 YEAR		5 YEARS							
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ALLERGIES	230	83.6	0	0	1	0.4	8	2.9	6	2.2	11	4.0	14	5.1	5	1.8	275	100
ASTHMA	244	88.7	1	0.4	2	0.7	3	1.1	1	0.4	11	4.0	9	3.3	4	1.5	275	100
EPILEPSY/SEIZURES	260	94.5	2	0.7	1	0.4	5	1.8	2	0.7	2	0.7	1	0.4	2	0.7	275	100
DIABETES	266	96.7	2	0.7	2	0.7	0	0	2	0.7	2	0.7	0	0	1	0.4	275	100
TUBERCULOSIS	262	95.3	2	0.7	0	0	3	1.1	3	1.1	3	1.1	2	0.7	0	0	275	100
HEPATITIS	266	96.7	1	0.4	0	0	0	0	1	0.4	3	1.1	2	0.7	2	0.7	275	100
HIGH BLOOD PRESSURE	238	86.5	1	0.4	2	0.7	11	4.0	11	4.0	4	1.5	3	1.1	5	1.8	275	100
HEART ATTACK	269	97.8	0	0	0	0	0	0	1	0.4	3	1.1	2	0.7	0	0	275	100
HEART MURMUR	265	96.7	0	0	1	0.4	0	0	1	0.4	0	0	3	1.1	4	1.5	275	100
OTHER HEART TROUBLE	256	93.1	0	0	3	1.1	0	0	4	1.5	3	1.1	6	2.2	3	1.1	275	100
GONORRHEA	207	75.3	2	0.7	1	0.4	7	2.5	5	1.8	22	8.0	25	9.1	6	2.2	275	100
SYPHILIS	260	94.5	0	0	0	0	0	0	3	1.1	5	1.8	6	2.2	1	0.4	275	100
ATTEMPTED SUICIDE	257	93.4	0	0	1	0.4	3	1.1	3	1.1	5	1.8	3	1.1	3	1.1	275	100

Table 12

EXTENT OF ALCOHOL AND DRUG USAGE BY INMATES AT TIME OF ADMISSION TO JAILS

	NONUSERS		USERS		ADDICTS		TOTAL	
SUBSTANCE	N	%	N	%	N	%	N	%
ALCOHOL	135	49.1	119	43.3	21	7.6	275	100
HEROIN	266	96.7	3	1.1	6	2.2	275	100
METHADONE	266	96.7	6	2.2	3	1.1	275	100
AMPHETAMINES	258	93.8	16	5.8	1	0.4	275	100
BARBITUATES	261	94.9	12	4.4	2	0.7	275	100
TRANQUILIZERS	255	92.7	17	6.2	3	1.1	275	100
MARIJUANA	171	62.2	104	37.8	0	0	275	100
OTHER DRUGS	252	91.6	21	7.6	2	0.7	275	100

3. Recent Medical Complaints

When inmates were asked about health problems they were currently experiencing or had experienced in the recent past, the most common complaints were headaches (46.9%) and indigestion (36.7%). A summary of results can be found in Table 13. The list of problems was not comprehensive, so additional complaints were recorded as "other". Of the 29.1% of the inmates reporting additional complaints, the most common problem related to the back. Complaints specific to males or females were asked and are also recorded in Table 13. Anno's multi-state study yielded complaints of approximately the same percentage of the total population in each category asked. Only two complaints, "other injuries" and "other", had a difference in excess of 10% (responses from Anno's study were lower). The largest variation in complaints were the female specific questions dealing with lumps in breast and vaginal bleeding. None of the participants of this study experienced these problems, while 15.2% and 19.6% of the females reported these respective problems in the multi-state study.

C. Inmate Assessment of Jail Health Services

Of the 275 inmates interviewed for this study 242 inmates had been incarcerated at least one week or longer at the time of our visit. All of these inmates were asked to assess their views of the health services provided by the jail in a separate interview. AMA Standard 1011, one of the essential standards, requires receiving screening be performed on all inmates upon admission to the facility before being placed in the general population. Another essential standard, 1012, requires health appraisal data collection be completed for each inmate within 14 days after admission to the facility.

Only 7.9% of the sample population was given an admission physical, but 68.4% of these physicals were given within 24 hours after incarceration. Aside from the admission physical, 44.2% of the inmates saw some type of medical personnel while in jail. A physician was seen by 82.2% of these inmates. The majority of inmates saw medical personnel within the previous month (78.3%) for sick call, or reported illness to jailers (79.6%). Three out of four times the inmate received some type of medication. Approximately half of the sample population felt their contact with the medical personnel made them feel better. Anno's six state study showed an overall 29.5% of the inmates received admission physicals, however only 7.8% of the Georgia inmates in that study received admission physicals and this figure almost duplicates the percentage found for the inmates of the 23 county area. The multi-state

Table 13

INCIDENCE OF INMATE COMPLAINTS

COMPLAINT	REPORTED HAVING		REPORTED NOT HAVING		TOTAL RESPONDING	
TOTAL SAMPLE (N=275)	N	%	N	%	N	%
Frequent Headache	129	46.9	146	53.1	275	100
Head Injury	71	25.8	204	74.2	275	100
Other Injuries	86	31.3	189	68.7	275	100
Periods of Unconsciousness	29	10.5	246	89.5	275	100
Trouble Hearing	47	17.1	228	82.9	275	100
Discharge from Eyes	46	16.7	229	83.3	275	100
Pain in Eyes	58	21.1	217	78.9	275	100
Other Trouble with Eyes	46	16.7	229	83.3	275	100
Toothaches	82	29.8	193	70.2	275	100
Persistent Cough	71	25.8	204	74.2	275	100
Sore Throat	79	28.7	196	71.3	275	100
Skin Trouble	58	21.1	217	78.9	275	100
Itchiness	73	26.5	202	73.5	275	100
Night Sweats	66	24.0	209	76.0	275	100
Trouble Breathing	47	17.1	228	82.9	275	100
Chest Pain	65	23.6	210	76.4	275	100
Coughing up Blood	19	6.9	256	93.1	275	100
Heartburn (Indigestion)	101	36.7	174	63.3	275	100
Burning on Urination	27	9.8	248	90.2	275	100
Trouble with Bowels	47	17.1	228	82.9	275	100
Other	80	29.1	195	70.9	275	100
TOTAL	1327	23.0	4448	77.0	5775	100
MALES ONLY (N=256)						
Discharge from Penis	9	3.5	247	96.5	256	100
Sores on Penis	14	5.5	242	94.5	256	100
Pain in Testicles	7	2.7	249	97.3	256	100
FEMALES ONLY (N=19)						
Lumps in Breast	0	0	19	100.0	19	100
Unusual Vaginal Discharge	5	26.3	14	73.7	19	100
Unusual Vaginal Bleeding	0	0	19	100.0	19	100
Pregnancy	4	23.5	13	76.5	17	100

study reported 66.3% of the participating inmates had seen medical personnel for other than an admission physical. The remaining data in Anno's report were comparable those for this study which were mentioned above.

The most important component of any jail health care system is the inmates' knowledge of how to obtain medical assistance. Only 8.7% of the inmates did not know the correct manner in which to inform the jail adminstration that they desired to see some type of medical personnel. Compliance with Standard 1014, providing inmates with written communication explaining the procedures for gaining access to medical services at the time of admission to the facility, would eliminate this problem. The first step in acquiring medical assistance was generally direct personal contact, 40.5% of the inmates contacted the jailor and 20.2% contacted a runaround, or trustee. Sick calls held on a regular basis were reported by 27.7% of the sample population only in a few larger jails.

Standards 1015, 1016, and 1017 refer to sick call procedures. Standard 1015 calls for medical complaints to be collected daily and acted upon by medically trained correctional officers or allied health personnel. Standard 1015 establishes the number of times per week that jails should have a sick call directed by a physician and/or other qualified personnel dependent upon the size of inmate population. Special arrangements for availability of a physician are called for when a sick call is not conducted by a physician. After requesting to see medical personnel, 68.3% of the inmates reported that they were able to see someone within 24 hours. Most of the sample population, 88.8% were allowed to see medical personnel within one week.

When inmates were asked if they had ever been prevented from seeing a doctor or any other type of medical person they wanted to see, 17.5% said they had been stopped. One-third of the inmates indicated they knew of at least one incidence where other inmates had been sick and were refused the right to see a doctor. Anno's study reported 18.1% and 33.5% for the same questions respectively.

As well as being asked about physical health services, the inmates were questioned about their satisfaction of dental and psychiatric services provided by the jails. Of the 12.4% of the sample population who had received dental care, 63.3% who requested to see the dentist were taken within 24 hours. The remainder were seen within a week except for one who said it was a month later. Ten percent of the sample population stated they had requested dental care, but had not been allowed to see the dentist. In the earlier, multi-state study 15.5% of the participants reported receiving dental care, which

was similar to results found in this study; however, 24.9% of the multi-state study reported not being able to see a dentist upon request, a figure almost 15% higher than in the current study.

Few inmates, 5.8%, had seen a psychiatrist or counselor while in jail, and most of them, 71.4%, felt that the person did not help them. An additional, 5.8% had requested to see someone for mental health care, but had not been given the opportunity at that time. The area of mental health care in jails produced the greatest differences between this study and Anno's multi-state study. The earlier study reported 27.8% of the inmates saw a mental health worker; 55.7% felt this person helped; and 21.1% had requested, but not yet received, help.

When asked to rate their own health, 14.5% inmates reported excellent health, 36.9% claimed to be in good health, 38.0% felt they could be classified as having fair health, 9.5% indicated their health was bad, and 1.2% stated their health was very bad. It is not surprising, in view of the overall youth of the inmates, that few considered themselves in bad or very bad health. More of the inmates (46.3%) felt their health had not changed since they had been in jail, than felt their health had deteriorated (36.8%) or improved (16.9%). Over half of the sample population, 58.5%, considered the health care they received in the jail to be inferior to the health care received on the outside. However, 53.2% of the inmates rated the health care personnel as having a good attitude towards the inmates. All of these data were similar to responses in Anno's previous study.

The final question of the interview gave the inmates the opportunity to make comments or suggestions regarding health care services in the jail. The most common responses related to delivery of health care. Inmates felt there should be a better quality of care, and jail administration should give more attention to inmates and make health care services more accessible. Also, many inmates suggested steps be taken to improve food served in the jails.

D. Interviewer Observations

The previous section on the health care provided by the jails to the inmates is compared to current A.M.A. standards, as mentioned. In the course of the survey observations were made and recorded of other factors related to the quality of health care but not necessarily addressed in the A.M.A. standards. Factors observed that might effect the quality of health care provided were (1) the amount and consistency of communication between the jail staff and inmates; (2) the links of communication from receiving screening to incarceration; (3) continuity of contact with community health service agencies. The reader is advised that the following comments are qualitative and not empirically tested. However, the content is important for further planning and/or research in the area of jail health care.

1. Amount of Consistency of Communication

It was observed that when contact was limited and not consistent between jail staff and the inmates anxiety and suspicion tended to arise. This was especially indicated when inmates were left alone for long periods of time and were seen primarily when meals were given or on rounds that were not consistent. This problem became more acute when inmates were located in areas not in close proximity to the jail administration (i.e. in small jails on the floor above administration), where, unless policy specified consistent contact, inmates were often left to themselves for long periods of time.

When little contact and lack of consistency of communication occured, the constant monitoring of inmates needs became problematic for both the inmates and jail staff. Efforts on the part of inmates to attract attention to jail administration for their needs were sometimes strained where techniques such as "yelling" or the "banging of bars" were the modes for seeking attention. Further, due to the limited contact there was often lack of familiarity with the inmates' needs and suspicions were sometimes aroused on the part of jail staff when inmates complained. In these instances the assessment of inmates needs on the part of jail staff were difficult and often distorted.

In jails where frequent and consistent contact between jail staff and inmates occured there appeared to be more satisfaction on the part of both staff and inmates toward the health care provided in the jails. In addition, frequent contact with the inmates as a part of jail policy was facilitated when inmates were not far removed from the jail administration.

2. Links of Communication: Receiving Screening to Incarceration

As mentioned previously, initial health screening in some jails was performed by deputies or others who did not have contact with the inmate after incarceration. In these jails, unless policy specified otherwise, the person responsible for the immediate needs of the inmates (i.e. jailer) often did not have knowledge of the health status of the inmates. Further, if the health needs of the inmates were not recognized or requested by the jailor or not repeated verbally by the inmates, the jailer would likely not have knowledge of relevant health information.

If the person(s) responsible for the immediate needs of the inmates does not perform receiving screening it is suggested there should be a policy for that person(s) to review the screening forms. Such a policy would allow for a link of communication from receiving screening to incarceration. It is also assumed that such a policy would foster (1) continuity of care, and (2) less chance of emergency situations arising soon after incarceration.

3. Continuity of Contact: Community Health Service Agencies

It was observed that in many of the small to medium sized jails the contact with community health agencies was at the discretion of the sheriff. For example, it was often the sheriff who called to make health-related appointments for the inmates. When new sheriffs are elected the links of communication with the community health services often have to be re-established. In the interim, until contact is established by the new sheriff with appropriate health services, the inmates needs are sometimes not met.

Continuity of contact with community health service agencies can be maintained where persons other than sheriffs (i.e. jailers or jail managers) perform the task of communicating with the agencies. In the event of a new administration, then, the care provided the inmates will likely be maintained when the communities health services agencies are required.

4. Discussion

The above comments point to the needs for individuals in the jail administration to have appropriate health training and management skills when working with the inmate population. This is particularly indicated for the small and medium sized jails where organizational policies to provide inmates with appropriate health care (as specified by A.M.A. and state standards) is sometimes lacking. Based on observations in this research it appears that

persons other than the sheriffs are more appropriate for receiving health screening training and management skills. It is suggested that training should be made available to those who tend to be primarily responsible for the immediate needs of the inmates, such as jailers, in order to foster consistency and continuity of care for incarcerated inmates.

V. CONCLUSIONS

To the extent that AMA Standards represent current guidelines on the provision of health and medical care to inmates only a few Area III County Jails meet a substantial number of the AMA Standards. Only one Area III jail was accredited by AMA at the time of data collection and this is reflected in the data. Only this one jail met all ten of the Standards designated as "essential" by the AMA and a substantial number of the non-essential Standards.

Related to AMA Standards and degree of compliance is participation in the AMA project. Six jails in this study have participated at some time since 1977, some of which have attempted to make changes in health care delivery and some actually implementing services to meet Standards. This study has found that those jails who implemented recommended changes have continued to keep these procedures although not all have attained or maintained accreditation. In fact, the inmates of these particular jails tend to confirm that the health care received while incarcerated was good or at least as good as that received in the community.

Likewise, those jails who participated but did not actively implement recommended changes did not measure any better than jails who were never in the AMA program. Furthermore, inmates in these jails did not rate health care received since incarceration very well. In one of these jails, the usual inmate comment was they need more medical care. Probing further on these comments, the reasons were said to be understaffing of the qualified persons to provide access to health care.

The most critical question in regard to prison medicine is <u>access</u>. How does the inmate who is sick get the information to the appropriate person and/or place so that a response is made to the need? This question was actively pursued in this study. The courts also address the issue of access more predominantly than other types of problems in regard to inmate medical and health care. The courts usually look at access to health care and the <u>intent</u> of the jail's administration to provide appropriate access. Cost is not usually considered by the courts to be an appropriate reason to deny access. Consequently, specific procedures to provide access, especially when documented, can facilitate delivery of needed and appropriate services and this is usually recognized by the courts as good intent. According to William Isele, Legal Consultant for the AMA project, these issues are critical in the courts and form an important basis for the AMA Standards in providing guidelines for health care delivery.

Except in the instance where "runarounds" collect sick call complaints, the jailers or correctional officers are the persons who must convey the inmates complaints to the appropriate authority. This is true even when there is an allied health staff person employed in the jail or if the jailer must call the physician directly. The jailer is oftern placed in the position of making a "medical" decision simply because his role is custody. Appropriate training and procedures for jailers on recognition of symptoms related to both physical and mental illness as well as emergency situations are critical needs in the link to provide the necessary access. Such training is now available only through the efforts of the MAG/AMA program in Georgia.

The next step in access is that either a qualified allied health person can do health triage for a physician or else complaints are referred directly to a physician. Here adequate procedures should be written and followed. Consequently, a physician must take responsibility in the development of written procedures and must also define adequate health care in the jail where he accepts responsibility. Except as mentioned above, these important links in the health delivery system for most Area III are missing.

In addition to physician services and procedures and training for correctional officers, there are a number of health services available in the local communities of the jails which could provide more direct service to jails. This need is emphasized by the large number of inmate trips per year for detoxification of chemical abusers (1435), and for mental health services (2,439). Many of these referrals now require long distance trips to regional hospitals and likely require two deputies. Consequently, because of security and transportation costs, the costs for delivery of medical and health services to inmates is very inflated. It can be predicted that with continued increasing costs of transportation that access to such services will become less or at least more costly. More community services can be provided with far greater security and less cost for the community at large if they are delivered at the jails on a regular basis.

Another practice found to be common in this study is the tendency for all physician services to be provided either in the physician's office or in the hospital emergency room after hours. The latter practice can be quite costly and may unduly influence decisions to seek medical care. For the smallest jails, taking inmates to the doctor's office may be the most efficient procedure. However, even then the responsible physician should monitor the health delivery system periodically at the jail.

Also common was the lack of any kind of communicable disease screening for inmates in counties with public health departments fully equipped to provide this service. The jail population data shows a substantial history of both venereal disease and tuberculosis.

Gonorrhea treatment was reported by 24.7% of inmates questioned, treatment for syphilis by 6.5%, and treatment for TB by 4.7%. These services should be routinely provided to jails as a service to the community.

Jails are considered as part of a community and as such are eligible for all public services unless specifically denied by law. Consequently, medical, public health department (VD. TB), alcoholism clinics, drug clinics, and mental health services which are provided in the community are available to inmates. Some services are state supported and some have federal support. Every attempt should be made where these services are not now provided in Area III jails to coordinate and have them routinely delivered at the jail site based on need relevant to size of jail.

Recent information from Joe Rowan, Director of the AMA Jail Programs, indicates that costs to implement AMA Standards varies by size of jails. Small to medium sized jails will spend less for the same amount of health care after complying to Standards while larger jails may very well experience an increase in costs. The increase in large jails is usually due to the need to employ health trained personnel and/or allied health professionals in the jail to do routine tasks and triage complaints. However, it must be noted that much greater numbers of inmates are affected in these situations, which indicate that costs can not be a primary consideration. Obviously, the same staffing situation for a jail with 60 inmates is not adequate for a jail holding 200, 300, 400, or 800 inmates. However, some efficiency in costs can very well be achieved with appropriate planning. Whereas large jails may spend more money for health care than the small jails, they may easily spend less per inmate with good management and procedures in the use of qualified health care personnel and the responsible physician. Furthermore, physician responsibility is also much different in each situation. There have been many comments made about differences by size of jail in this study. Consequently, size should be a major consideration used to determine the distribution of services to jails and how they shall be delivered, as well as a criterion for future planning to meet needs. Basically, larger jails need more services on a daily basis, whereas smaller jails may require some services only once or twice a week and other services only once a month or intermittently. Less used services, however, need to be routinized by written policies and procedures and be an important consideration in coordination activities.

VI. RECOMMENDATIONS

In making appropriate recommendations the first goal is coordination among the different administrations, agencies, and physicians. Many needed services and resources are available, while others may require some additional development. The primary goal of this coordination is to have needed services provided, especially in those jails where many services are lacking now. Whereas most Area III jails must transport inmates to obtain basic health services, a practice which is in many cases costly, inefficient, and on occasion creating high risks for the community, it is further recommended that procedures be established wherever feasible to provide basic and routine services inside the jails.

Considering that coordination of services and feasibility of alternative methods of delivery require monitoring and study, it is recommended that NCG-HSA identify and plan for the establishment of these functions by an appropriate provider. This study and experience in the AMA jail project have identified a tendency for community services provided to the jails by various county and state agencies to "lapse" due to staff turnover, policy changes, budget cuts, and for "unknown" reasons. Consequently, it is further recommended that to maintain services after implementation and/or improve delivery of needed health services over time that this monitoring function be provided by a non-government organization with a recognized authority.

Whereas access to health care is the acknowledged right of the inmate and the responsibility of providing access is the role of the Sheriff, it is recommended that Sheriff's actively seek to obtain the needed medical services and cooperation from physicians and other community health providers; and to seek development of procedures' and training for effective and efficient delivery; and to establish effective communication between inmates and staff to ensure appropriate access for inmate health care. In regard to effective communication, several more specific recommendations are that staff and inmates establish and maintain close contact, so health problems can be more readily identified; that jail staff routinely review health screening data to learn of known problems at the time of incarceration and thus provide continuity of care. Finally, staff who have contact with inmates require a number of health related skills and it is recommended that Sheriff's actively seek the establishment of such health skills training on a routine basis for these officers. Recognition should be made that mandatory training for deputies is not adequate nor appropriate for correctional staff and furthermore, this and the AMA study have repeatedly discovered that correctional officers usually don't have the "mandatory" training.

Further recommendations are set forth in three parts. Each part recommends a specific plan of action which will assist Area III jails to comply with current AMA Standards or the newly published

set of Georgia Jail Standards. Parts have been identified as those parties interested and involved in this study: (A) Area III jails, (B) the Medical Association of Georgia, and (C) the North Central Georgia Health Systems Agency.

A. Jails

Recommended:

1. All Area III jails identify the responsible physician who will assist in developing appropriate procedures for the jails health care delivery system as well as provide medical treatment as needed.

2. All Area III jails develop written procedure manuals based on AMA Standards (with the responsible physician) with the objective of meeting each Standard over a reasonable period of time. (A basic resource manual is available through this project.)

3. All Area III jails obtain first aid and CPR training for their correctional officers and arrange for routine recertification periodically.

4. All Area III jails obtain appropriate training for correctional officers in receiving health screening, recognition of symptoms of illnesses common to jails including alcohol and other chemical abuse emergencies, mental illness, suicide and other emergency situations, and distribution of medications. (Such training is currently available in Georgia through this program, albeit on a limited basis.)

5. That since jail size is an important criteria for distribution of services, the larger jails employ qualified health personnel to do triage and other needed tasks in the jails to ensure appropriate delivery of health care; and that medium and small jails employ part-time qualified health personnel to coordinate the needed services with outside providers. In some cases, deputies with appropriate health skills can perform these functions.

6. That newly elected Sheriffs have orientation training provided by the Georgia Sheriff's Association to ensure continuity in jail medical operations and services.

7. That the jails utilize the MAG for services identified in Part II, following.

B. Medical Association of Georgia

1. The Medical Association of Georgia (MAG) can help the jails to identify physicians through its affiliation with the local medical societies.

2. The MAG has developed a basic written procedures manual that can be computerized. It is necessary that jail administrators and physicians be involved in the initial development of this manual which can then be computerized. Written procedures can facilitate the coordination of services and resources.

3. The MAG remains active in the development of appropriate health training for correctional officers. Appropriate resources have been identified. What remains to be accomplished is the training of instructors who have recognition by the county jail administrators. One potential source for these instructors is the Georgia Peace Officers Standards and Training Council who can give appropriate certification for such training.

4. The MAG Committee on Prison Health Care can function to review the jails compliance to Standards, either Georgia's and/or the AMA Standards, and make appropriate recommendations. AMA accreditation site visits are conducted via this Committee.

C. North Central Georgia Health Systems Agency

1. The NCG-HSA should identify community resources that could supply needed health services to Area III jails and negotiate plans for the systematic delivery of these services to the jails. Wherever possible, appropriate training should be given to correctional officers to facilitate the interaction between agencies and to help correctional officers know when and how these services can be utilized to the best advantage.

2. The NCG-HSA should contact Area III Red Cross offices and Heart Association affiliates to get First Aid and CPR training scheduled for correctional officers of all Area III jails. This needs to be an ongoing activity since staff turnover is often high and recertification is also necessary.

3. The NCG-HSA should identify an appropriate source to provide a monitoring function in regard to available community services in that they continue to function after implementation and over the long term, and to continually be ready to make recommendations to improve delivery of services.

Further Considerations to Implement Recommendations:

Sources for funding some of the recommended actions are required. Several of the recommendations require the interaction of all parties. A workshop sponsored by both NCG-HSA and MAG can meet this need in several ways. First, a workshop will bring together those involved to develop written procedures, to develop implementation plans, to impart some skills training, to organize for future training needs. The workshop can be entitled "Initiating and Improving Health Services in Area III Jails." Some computerization costs will also be involved in this activity.

Several approaches may serve to locate appropriate training in this area. The Georgia Peace Officers Standards and Training Council may be in the position to facilitate this with some coordination with MAG. Also, the Georgia Sheriff's Association should establish orientation workshops for the new Sheriffs at least once every four years.

VII. REFERENCES

[1]North Central Georgia Health Systems Agency Health Systems Plan 1980-1985 Update, North Central Georgia Health Systems Agency, 1980.

[2]1980 Annual Implementation Plan, North Central Georgia Health Systems Agency, 1980.

[3]Anno, B. Jaye, Analysis of Jail Pre-Profile Data: American Medical Association's Program to Improve Medical Care and Health Services in Jails, June, 1977. Five Georgia jails paricipated in the survey and one was dropped from the follow-up round.

[4]Anno, B. Jaye, op. cit., p.11.

[5]Ibid. p.13.

[6]Ibid, p.38.

[7]American Medical Association, Medical Care in U.S. Jails - A 1972 AMA Survey. Chicago, Illinois: Division of Medical Practice (February, 1973).

[8]Anno, op. cit., p.45.

[9]Ibid, p.40.

[10]Ibid, p.45.

[11]Ibid, p.41.

[12]Ibid, p.44.

[13]Ibid, p.54.

[14]Ibid, p.42.

APPENDIX

SAMPLE QUESTIONNAIRE FORMS

Jail: _____

INFORMED CONSENT

I, _____, agree to furnish personal
(name of inmate)
health and medical information to the North Central Georgia Health Systems Agency, Inc. and I give my consent to all the following actions which will be taken by the Agency.

I fully understand that my participation is voluntary; that I do not have to answer every question; and, that I may withdraw from this activity at any time without any harmful effects to me, and without any penalty against me or my record.

I have been told that the purpose of this information collection is to determine what the medical and health needs of inmates are and I authorize the use of the information I provide for this purpose.

I agree to provide the Information Collector with information about my health and health care since incarceration. I understand that there are no foreseeable risks or discomforts reasonably to be expected from my participation in this activity, and that it is hoped the results of this data collection may lead to improvements in the health services of jails.

I have been promised nothing that will be of benefit to me. I understand that this information gathering is not the start of, nor is it in the nature of, medical treatment for me.

The Information Collectors have agreed to answer to their best ability any questions I may have.

By signing below, I acknowledge that I have read and/or understand all of the above provisions and hereby give my voluntary consent to them.

_____ _____
(Signature of Inmate) (Date)

WITNESS: I, _____, witness to the
(name of witness)
above signature, acknowledge that this "Informed Consent" was orally explained to the Inmate prior to signing, and that the Inmate acknowledged understanding the form and further acknowledged that he or she signed it voluntarily and without any coercion, force, promises or special inducements.

_____ _____
(Signature of Witness) (Date)

INTERVIEWEE: DATE:

INTERVIEWER:

MEDICAL ASSOCIATION OF GEORGIA

NORTH CENTRAL GEORGIA HEALTH SYSTEMS AGENCY

Survey and Analysis of Area III
Jails Health Needs and Services, 1979

CARD NO: 1 (1)

1-1. Name of facility: ID (2-4)

1-2. Address of facility:

1-3: Facility phone number: ( )

1-4. Approximate population of area (county) served by facility:
(code by thousands) (5-7)

2-1. Title of official legally responsible for facility:

2-2. Name of official:

2-3. Address of official:

2-4. Phone number of official: ( )

2-5. How long held position? (8-9)

3-1. Year facility was built: (10-12)

3-2. Any major renovations? 1 Yes 0 No (13)

3-3. Year of renovation: (code latest only, in age) (14-15)

3-4. Briefly describe:

Number of admissions to facility in previous year:

4-1. Adult males: (16-20)

4-2. Adult females: (21-24)

4-3. Juvenile males (25-27)

4-4. Juvenile females: (28-30)

TOTAL ADMISSIONS: (31-35)

5-1. Design rated capacity: (36-38)

5-2. Average daily population for previous year: (39-41)

5-3. Average daily intake: (42-43)

5-4. Number of persons employed in the jail:
(Not including road deputies) (44-46)

In the previous year, what percent of your inmates would you estimate stayed:

6-1. Less than 24 hours: ___% (47-48)

6-2. One day to a week: ___% (49-50)

6-3. One to two weeks: ___% (51-52)

6-4. Longer than two weeks: ___% (53-54)

7-1. Does your facility have a medical examining room? 1 Yes 0 No (55)

7-2. Does your facility have any medical bed space? 1 Yes 0 No (56)

8-1. Does your jail have arrangements with a hospital for inmate care? 1 Yes 0 No (57)

8-2. Name of hospital:

8-3. Explain the conditions of hospital use: (i.e. security arrangements? Amount of bed space available? Restrictions on hospital use?) (58)

8-4. Estimate how many inmates monthly the jail sends to the hospital for care: (code by year) (59-61)

9-1. How are inmates transported to outside medical facilities? (PROBE: Ambulance, deputy car; does it differ for emergency or ongoing care?) (62-63)

(64-66)

9-2. What are security arrangements for inmate transportation to outside facilities?

9-3. Estimate how many times monthly (or weekly) the jail sends inmates to outside facilities by ambulance: _____ by Deputy car: _____

1001 Is there a physician responsible for the facilities medical services? 1 Yes 0 No (67)

If yes, is the physician licensed in this state? 1 Yes 0 No (68)

(MD) Is there a written agreement or contract between the physician and a governmental agency for the services provided to the inmates? 1 Yes 0 No (69)

Does the physician provides services

____ (1)in [illegible]il
____ (2)in [illegible]er office
____ (3)both of the above, more jail
____ (4)both, more office
____ (5)other (explain)

(70)

**If the physician provides services in more than one place what is practiced most [illegible] and under what conditions?

What is the number of physician hours monthly (approximate)? _____ (71-72)

How long has the jail used this physician? (months/years) _____ (73-74)

Name of physician responsible for medical care?

Are you satisfied with this physician's health care delivery? 1 Yes 0 No
If no, why? (75)

CARD NO 2 (1)

(3)

(MD)1002 Does the physician have any restrictions imposed upon him by the facility regarding the practice of medicine? If yes, explain.
1 Yes 0 No (2)

Do security regulations applicable to facility personnel apply to medical personnel? 1 Yes 0 No (3)

Are other persons providing medical care to inmates of the jail? (i,e, nurses, physician's assistants, etc.) If yes, who are they? Where are they from (i.e county, public health)? How many hours (approximately) do they work monthly? (PROBE) 1 Yes 0 No (4)

1. RN 4. EMT
2. PA 8. Other Allied SUM: (5-6)

1. Jail 4. MD
2. PhD 8. Contract Employ SUM: (7-8)

ALLIEDHR (9-10)

1005 (Where applicable) Do this state's licensure and/or certification requirements and restrictions apply to health care personnel working in the jail? 1 Yes 0 No (11)

Do you have verification of current licensing and certification credentials on file in the jail? 1 Yes 0 No (12)

1006 (Where applicable) Is the work of qualified medical personnel covered by written job descriptions? 1 Yes 0 No (13)

1007 Is treatment by medical personnel other than a physician performed to written standing or direct orders? 1 Yes 0 No (14)

1003 Is there a report on:

Health delivery system? 1 Yes 0 No (15)

Health environment? 1 Yes 0 No (16)

How often prepared and by whom?

Is there an annual statistical summary of medical care provided? 1 Yes 0 No (17)

1004 Are there written standard operating procedures for the following:

	PROCEDURES	APPROVED
Receiving screening? 1 Yes 0 No	(18)	(19)
Health appraisal data collection? 1 Yes 0 No	(20)	(21)
Non-emergency medical services? 1 Yes 0 No	(22)	(23)
Emergency medical and dental services? 1 Yes 0 No	(24)	(25)
Deciding the emergency nature of illness or injury? 1 Yes 0 No	(26)	(27)
Dental screening, hygiene, examination and treatment? 1 Yes 0 No	(28)	(29)

	PROCEDURES	APPROVED
Provision of medical and dental prosthesis? 1 Yes 0 No	_(30)	_(31)
First aid? 1 Yes 0 No	_(32)	_(33)
Notification of next of kin or legal guardian in case of serious illness, injury or death? 1 Yes 0 No	_(34)	_(35)
Chronic care? 1 Yes 0 No	_(36)	_(37)
Convalescent care? 1 Yes 0 No	_(38)	_(39)
Medical preventive maintenance? 1 Yes 0 No	_(40)	_(41)
Screening, referral, and care of the mentally ill and retarded inmates? 1 Yes 0 No	_(42)	_(43)
Implementing the special medical program? 1 Yes 0 No	_(44)	_(45)
Delousing? 1 Yes 0 No	_(46)	_(47)
Detoxification? 1 Yes 0 No	_(48)	_(49)
Pharmaceuticals? 1 Yes 0 No	_(50)	_(51)

Which of these procedures have been approved by the physician?

1008 Are all examinations, treatments, and procedures affected by informed consent standards in the community likewise observed for inmate care? 1 Yes 0 No (52)

In case of minors, does the informed consent of parent, guardian, or legal custodian apply where required by law? 1 Yes 0 No (53)

1009 Are medical services delivered in the facility? 1 Yes 0 No (54)

If yes, are the following provided? If yes, are the following adequate?	PROVIDED	ADEQUATE
Space (Explain what kind of space): 1 Yes 0 No	_(55)	_(56)
Equipment (Explain): 1 Yes 0 No	_(57)	_(58)
Supplies, materials (Explain): 1 Yes 0 No	_(59)	_(60)

1010 Are first aid kit(s) on hand? 1 Yes 0 No (61)

In your opinion, do you have an adequate number for your needs? 1 Yes 0 No (62)

If yes, do you know the contents of the first aid kit?

What are the contents?

Are you satisfied that they are located for easy access in the event of an emergency? 1 Yes 0 No (63)

Describe the procedure for periodic inspection of the kit(s):

1011 Is receiving screening performed on all inmates upon admission to the facility before being placed in general population or housing area? (Is standard form used or other?) 1 Yes 0 No (64)

If no, what is done at booking for health or medical problems?

If yes, who performs the screening?

1. Jailor, booking officer, clerk
2. Arresting officer, or other deputy, not in jail
4. Allied health professional
8. Other

SUM : (66-67)

How soon after incarceration is screening performed?

1. Before cell assignment
2. After cell assignment
3. Other

(68)

If yes, are findings recorded on a printed screening form? 1 Yes 0 No (Sample?) (69)

Is the screening form approved by the responsible physician? 1 Yes 0 No (70)

CARD NO 3 (1)

Does the screening include inquiry into:		RECORDED?
Current illness and health problems? 1 Yes 0 No	_(2)	_(3)
Current medications taken? 1 Yes 0 No	_(4)	_(5)
Special health requirements? 1 Yes 0 No	_(6)	_(7)
Problems specific to women (pregnancy)? 1 Yes 0 No	_(8)	_(9)
Does the screening include observations including:		
States of consciousness? 1 Yes 0 No	_(10)	_(11)
Mental status? 1 Yes 0 No	_(12)	_(13)
Notation of body deformaties? 1 Yes 0 No	_(14)	_(15)
Trauma markings (bruises, lesions)? 1 Yes 0 No	_(16)	_(17)
Ease of movement (gait)? 1 Yes 0 No	_(18)	_(19)
Jaundice? 1 Yes 0 No	_(20)	_(21)

RECORDED

Condition of the skin? 1 Yes 0 No _(22) _(23)

Condition of the body orifices(rashes and infestations)?
1 Yes 0 No _(24) _(25)

What is the procedure for disposition or referral of inmates needing care at screening? (PROBE)

1. Sent to emergency room
2. Sent to physician
4. Held for sick call

SUM: (26)

Are you satisfied with your health screening at booking? 1 Yes 0 No
If no, why? (27)

Are you satisfied with your procedure for disposition and referral?
1 Yes 0 No If no, why? (28)

1012 Is there a routine health appraisal of the inmates (medical history and physical examination)? 1 Yes 0 No (29)

When is the health appraisal done?

1. By 2 weeks 2. After 2 weeks (30)

If yes, the health appraisal data collection includes:

Does the physician review the earlier receiving screening? 1 Yes 0 No (31)

Are medical and psychiatric histories done? 1 Yes 0 No (32)

Are lab tests done for communicable disease? 1 Yes 0 No (33)

If yes, which tests?

Is there a standard medical examination completed by the physician?
Sample? (If yes, continue) 1 Yes 0 No (34)

Are vital signs recorded (Height, weight, pulse, blood pressure and temperature)? 1 Yes 0 No (35)

Are other tests and examinations done when indicated? 1 Yes 0 No
Example? (36)

If yes, what is included in the examination:

Are you satisfied with the above procedure? 1 Yes 0 No
If no, why? (37)

1013 (Where applicable) Who collects the health histories (by job title)?

1. MD 3. PA 5. Inmate 7. Other
2. RN 4. EMT 6. Jailor (38)

Who does the following: (Code from above)

57< Vital signs: _(39) Reviews screening: _(41)
Lab tests: _(40) Physical exams: _(42)

1014 At the time of admission to the facility do the inmates receive a written communication explaining the procedure for gaining access to medical service? 1 Yes 0 No (43

If no, how are the inmates informed of this access?

1015 Do inmates fill out medical complaint slips? 1 Yes 0 No (44

If yes, how often? 1. Daily 2. Less than daily (45

Who distributes the complaint slips? _____

How are the slips distributed? (Describe)

Who collects the complaint slips? _____

If complaint slips are <u>not</u> used, how do inmates inform the jail staff of medical complaints? (Describe)

1. Runaround
2. Jailor
4. Other inmate
8. Other

SUM: (46-47

Who decides what is to be done about the complaints? (Describe)

1. MD
2. Allied health professional(s)
4. Jailors
8. Sheriffs, Deputies
16. Other

SUM: (48-49

Should a physician be needed, who <u>calls</u> the physician? (Describe)

1. Sheriff, Deputy
2. Jailor
4. Allied health professional
8. Secretary, Other

SUM: (50-51

Are you satisfied with the above procedure? 1 Yes 0 No
(If no, why?) (52

1016 Does the jail have a sick call? 1 Yes 0 No (53

If yes, how often is sick call held?

1. Daily 2. 2-4 times/week 3. Once/week 4. Less than once/week (54

Who performs sick call? (Probe for title)

1. MD 2. Allied health professional 3. Other (55

Explain the sick call process: (PROBE: who decides which inmates are to be seen; where do inmates go for sick call; who takes inmates to the sick call area, etc.)

Are you satisfied with the above procedure? 1 Yes 0 No
(If no, why?) (56

1017 (Where applicable) If sick call is not conducted by a physician, does a physician respond to inmates complaints regarding services which they did or did not receive from other medical providers? 1 Yes 0 No (57)

If yes, how often?

Does the responsible physician review the medical services provided? 1 Yes 0 No

If yes, how often?

1018 Does the facility provide 24-hour emergency medical care? 1 Yes 0 No (58)

Emergency dental care? 1 Yes 0 No (59)

Does the emergency plan include:

Emergency evacuation of inmate from the facility? 1 Yes 0 No (60)

Use of an emergency vehicle? 1 Yes 0 No (61)

Use of one or more designated hospital emergency rooms or other appropriate health facilities? 1 Yes 0 No (62)

If an emergency facility is not located in the nearby community, are there emergency on-call physician and/or dentist services available? 1 Yes 0 No (63)

Are you satisfied with the above procedure? 1 Yes 0 No (64)

1019 Are facility personnel trained in basic first aid equivalent to that defined by the American Red Cross? 1 Yes 0 No (65)

What percentage of the personnel have the training? (66-68) %
(Use as a base answer to 5-4)
Does training of staff incorporate the following steps:

Awareness of potential emergency situations? 1 Yes 0 No

Notification or observation-determination that an emergency is in progress? 1 Yes 0 No

First aid and resuscitation? 1 Yes 0 No

Transfer to an appropriate provider? 1 Yes 0 No

1020 Are facility personnel always within sight of inmates? 1 Yes 0 No (69)

Are facility personnel always within sound of inmates? 1 Yes 0 No (70)

If yes, is there at least one person per shift within sight or sound of all inmates who has training in:

Receiving screening? 1 Yes 0 No (71)

Basic life support cardiopulmonary resuscitation? (CPR) 1 Yes 0 No (72)

Recognition of symptoms of illness most common to the facility? 1 Yes 0 No (7

(MD)1021 Are the following types of care provided to inmates in the facility? (If yes, ask how many receive each type of care)

Chronic care (i.e. diabetes, heart problems): 1 Yes 0 No (74)

Convalescent care (i.e. post-surgical care): 1 Yes 0 No (75)

Medical preventive maintenance, if needed: 1 Yes 0 No (76)

If no, please explain how this care is provided:

(MD)1022 Are medical and dental prostheses provided when the health of the inmate/patient would otherwise be adversely affected as determined by the responsible physician? 1 Yes 0 No (77)

CARD NO 4 (1)

1023 Does your jail offer on-going dental services, just emergency service, or both? 1. On-going 2. Emergency 3. Both (2)

Where does the dentist provide services?

1. Office 2. Jail 3. Both (3)

If on-going, is dental care provided to each inmate under the direction and supervision of a dentist licensed in the state as follows:

Dental screening within 14 days of admission? 1 Yes 0 No (4)

Dental hygiene services within 14 days of admission? 1 Yes 0 No (5)

Dental treatment, not limited to extractions, within 3 months of admission when the health of the inmate would otherwise be adversely affected? 1 Yes 0 No (6)

What is your procedure for providing dental service to inmates? (PROBE)

Are you satisfied with the above procedure? 1 Yes 0 No
(If no, why?) (7)

How many inmates monthly receive dental care? (code by year) (8-10)

Name of dentist or dental clinic providing services (city):

Are you satisfied with the dentist's dental care delivery? 1 Yes 0 No
(If no, why?) (11)

1024 Are facility personnel trained regarding recognition of symptoms of mental illness and retardation? (PROBE: how many) 1 Yes 0 No (12)

If yes, explain what kind of training. (PROBE: is it on the job or formal training)

1025 Are screening and referral for care provided to mentally ill or retarded inmates whose adaptation to the ja environment is significantly impaired? 1 Yes 0 No (13)

If yes, is the referral for on-going mental health services (i.e. counseling) or just emergency mental health treatment or both?

1. On-going 2. Emergency 3. Both (14)

What is the procedure for referral of mentally and/or retarded inmates? (PROBE)

How many inmates monthly are referred for mental health treatment or evaluation? (code by year) (15-17)

Name of hospital providing psychiatric in-patient services (city?):

Name of facility providing out-patient mental health services (city?):

If there is no screening and referral for mentally ill and/or retarded inmates, what is the procedure for treatment? (PROBE: placing inmates in isolation)

Is there a written list of symptoms of behavior indicative of mental illness and retardation available in the jail? (Describe) Sample? 1 Yes 0 No (18)

Are you satisfied with your procedure for the treatment of mentally ill inmates? 1 Yes 0 No
(If no, why?) (19)

(MD)1026 Does a special program exist for inmates requiring close medical supervision? (i.e. what is done if inmates have flu, etc.) 1 Yes 0 No (20)

Is there a written individual treatment plan for each of these patients developed by the physician? 1 Yes 0 No (21)

If yes, does the treatment plan include directions to medical and non-medical personnel regarding their roles in the care and supervision of these patients?

1027 Does your jail offer medically supervised alcohol detoxification? 1 Yes 0 No (22)

If yes, is it: 1. In-house 2. Referral 3. Both (23)

What is the procedure for alcohol detoxification? (PROBE: will you give liquor if necessary?)

Are you satisfied with the above procedure? 1 Yes 0 No
(If no, why?) (24)

If you utilize a medical facility for detoxification, what is it's name (city?):

How many inmates with alcoholic problems monthly would you refer to outside facilities? (Estimate) (code by year) (25-27)

Does your jail offer medically supervised drug detoxification? 1 Yes 0 No (28)

If yes, is it: 1. In-house 2. Referral 3. Both (29)

What is your procedure for detoxification from barbiturates and similar drugs? (PROBE)

What is your procedure for detoxification from opiates? (PROBE)

Are you satisfied with the above procedure? 1 Yes 0 No (30)
(If no, why?)

If you utilize a medical facility for detoxification, what is it's name (city?):

How many inmates with drug problems monthly do you refer to outside facilities? (Estimate) (code by year) (31-33)

1028 Do you have a formulary (a list of medications) in the jail? (PROBE) Sample? 1 Yes 0 No (34)

If no, do you have stock medications maintained in the jail? 1 Yes 0 No (35)

If yes, what are they?

Do you keep any of the following medications in the jail?

Controlled substances _(36)
Syringes _(37)
Needles _(38)
Surgical instruments _(39)

If yes, how are they stored for maximum security?

Also, if yes, are these inventoried?

If yes, how often?

What is your procedure for prescription of medications? (Describe)

What is your procedure for medication dispensing and administration? (Describe: who administers; how is it recorded?)

Do you have a procedure/policy regarding behavior modifying medications and/or those subject to abuse? (Sample, if written) 1 Yes 0 No (40)

What is done when inmates have medications with them at booking? (Do you take it from them? If prescription, is a physician called to confirm?) 1 Yes 0 No (41)

Do you have a copy of regulations established by the State Board of Pharmacy regarding medications? 1 Yes 0 No Sample? (42)

(MD)1029 Does the person administering medication:

Have training from the responsible physician and the official responsible for the facility? 1 Yes 0 No (43)

Explain any training:

Account for administering medications according to orders? 1 Yes 0 No (44)

Record the administration of medications in a manner and on a form approved by the responsible physician? 1 Yes 0 No (45)

Are you satisfied with your procedure for administration of medication? 1 Yes 0 No (If no, why?) (46)

1030 Is there an inmate medical record file in the jail? (PROBE: if yes, where is it kept; what is the procedure for recording medical care received) 1 Yes 0 No (47)

(Where applicable) Does the physician keep a file on inmates at his office? (48)

(Where applicable) Does the medical record file contain:

The complete receiving screening form? 1 Yes 0 No (49)

Health appraisal data collection forms? 1 Yes 0 No (50)

All findings, diagnoses, treatments, dispositions? 1 Yes 0 No (51)

All prescriptions and administrations of medicine? 1 Yes 0 No (52)

Notes concerning patient education? 1 Yes 0 No (53)

Notations of place, date and time of medical encounters? 1 Yes 0 No (54)

Terminations of treatment from long term or serious medical or psychiatric treatment? 1 Yes 0 No (55)

Is the method of recording entries in the medical record and the form and format of the record approved by the responsible physician? 1 Yes 0 No (56)

Are you satisfied with your system of recording inmates medical care? 1 Yes 0 No (If no, why?) (57)

1031 Is access to the medical record controlled by the responsible physician? 1 Yes 0 No (58)

Does the physician/patient privelege apply to the medical record? 1 Yes 0 No (59)

1032 Is the medical record file in any way part of the confinement record? 1 Yes 0 No (60)

1033 Are summaries or copies of the medical records file routinely sent to the facility to which the inmate is transferred? 1 Yes 0 No (61)

Do you obtain written authorization by the inmate for transfer of medical record information (unless otherwise provided by law or administrative regulation having the force and effect of law)? 1 Yes o No (62)

Do you transmit medical record information to specific designated physicians or medical facilities in the community upon written authorization of the inmate? 1 Yes 0 No (63)

1034 Do inmates exercise regularly? If yes, please describe. 1 Yes 0 No (64)

CARD NO 5 (1)

1035 Do you furnish:

1. Tubs 2. Showers 4. Hot water 8. Cold water (check all that apply) SUM: (2-3)

1036 How often during the week is bathing permitted? (If not daily, ask 1037) (Code by # of days per week allowed) (4)

1037 Is there air temperature control? 1 Yes 0 No (5)

If no, is daily bathing permitted in hot weather? 1 Yes 0 No (6)

1038 To maintain personal hygiene, are inmates furnished with the following items:

Non-irritant soap? 1 Yes 0 No (7)

Toothpaste or powder? 1 Yes 0 No (8)

Toothbrush? 1 Yes 0 No (9)

Toilet paper? 1 Yes 0 No (10)

Feminine hygiene supplies when necessary? 1 Yes 0 No (11)

1039 Are implements for shaves and haircuts made available to inmates? 1 Yes 0 No (12)

1040 Are all inmates and other persons working in the food service free from diarrhea, skin infections, and other illnesses transmissable by food or utensils? 1 Yes 0 No (13)

1041 Do all food handlers wash their hands upon reporting to duty and after using the toilet facilities? 1 Yes 0 No (14)

1041 Are special medical diets prepared and served to inmates according to the orders of the responsible physician? (PROBE) 1 Yes 0 No (15)

10-1 Have there been any law suits against your jail within the past five years where the adequacy of the health care services offered was an issue? 1 Yes 0 No (16)

10-2 Is your jail currently under such a suit? 1 Yes 0 No (17)

11-1 What do you find are the inmates illnesses, health care problems most common to your facility?

12-1 What do you perceive as being the most problematic in your current health care program? (i.e. lack of cooperation from the community health facilities; funding; etc.)

12-2 What would you like changed in your current program?

13-1 What types of benefits do you think your jail would derive from being in a health care program?

14-1 Would you be willing to make changes in your jail's health care system? Yes ____ No _____

If yes, what difficulties do you perceive in making the changes? (i.e. funding; staff trimming; community involvement)

15-1 If improving health care in your jail required an increase in the jail's medical budget, would you be willing to go to the funding body and request additional funding?

16-1 If you are unable to provide information on the cost of current medical care, are you willing to help obtain this information and develop records to reflect future changes?

17-1 If other hospital/health care facilities are utilized but not mentioned, what are they? (PROBE: What are the conditions for usage; if out of county, what are the security arrangements?)

COST DATA

1. Give the total amount expended for the jail during 1978: $ _____

2. Give a breakdown of the above amount:

3. Are any funds presently received that are earmarked only for health care?

   Yes (give amount and sources) _____ No _____

4. Is the total amount expended only for health care in 1978 available?

   Yes _____ No _____

   If yes, give the amount: $ _____ and obtain copy of the budget.

   Please estimate the answers to the following:

   a) the salaries of all staff members involved in delivering health care:

   b) the total of all monies paid out on a contract or fee-for-service basis to physicians, hospitals, dentists, psychiatrists, etc.:

   c) the cost of transporting inmates to outside facilities:

   d) the cost of security personnel for outside medical services:

   e) the amounts expended for drugs, laboratory services and other medical supplies:

   f) if health services are provided within the jail, estimate the amount of overhead applicable to these facilities:

5. Procedure for payments:

   a) What is the procedure for payment of services to the physician? (county contract - specific amount from the county; fee-per-inmate; private physician - bills jail per inmate) (PROBE)

   b) What is the procedure for payment of services to the dentist? (county contract - specific amount from the county; fee-per-inmate; private dentist - bills jail per inmate) (PROBE)

   c) What is the procedure for payment of services to the hospital? (county contract - specific amount from the county; fee-per-inmate; private service - bills per inmate) (PROBE)

6. How many inmates does the physician see weekly? (Approximate) (Code by year) (18-20)

   What is the average cost per inmate per physician visit? (21-22)

INMATE/PATIENT PROFILE

NAME OF JAIL | STATE | DATE

BASIC DATA

INMATE ID	AGE	SEX	RACE/ETHNIC GROUP	ADMISSION DATE	SENTENCED?	IF SENTENCED-RELEASE DATE	HERE BEFORE?
		☐ MALE ☐ FEMALE	☐ WHITE ☐ SPAN ☐ AMER IND ☐ BLACK ☐ ASIAN		☐ YES ☐ NO		☐ YES ☐ NO

HEALTH HISTORY

PRIOR CARE: Have you ever been...?	YES	NO	IF YES, MOST RECENT EXPERIENCE. 1 WK	1 MO	6 MOS	YEAR	5 YRS	OVER 5
treated by a doctor								
given a physical exam								
hospitalized (medical)								
operated upon								
to see a dentist								
to see a "psychiatrist"								
hospitalized (mental)								
given an eye exam								
PAST MEDICAL PROBLEMS Have you had RX for...?								
allergies								
asthma								
epilepsy/seizures								
diabetes								
tuberculosis								
hepatitis								
high blood pressure								
a heart attack								
a heart murmur								
other heart trouble								
gonorrhea								
syphilis								
an attempted suicide								

IN THE SPACE PROVIDED BELOW, SPECIFY ALL HOSPITALIZATIONS, OPERATIONS, PSYCHIATRIC PROBLEMS, AND ALLERGIES REPORTED.

When you came into the jail were you using...?

	YES	NO	IF YES, WHAT AND HOW MUCH PER DAY? SPECIFIC NAME OR BRAND NAME.	QUANTITY PER DAY	FOR HOW LONG? (SUSTAINED USAGE)	UNDERGO WITHDRAWAL? YES	NO
alcohol							
heroin							
methadone							
amphetamines							
barbituates*							
tranquilizers**							
other drugs							

*For example: nembutal, seconal, tuinal, etc. / ** For example, valium.

	YES	NO
Are you taking any medicines now?		
If yes, what? _____		
Have you gained or lost weight lately?		
If yes, how much? +____ lbs -____lbs		

As far as you know, have you lived with, or been exposed to, anybody who has:	YES	NO
tuberculosis		
hepatitis		
Do you wear eyeglasses or contact lenses?		

REVIEW OF SYSTEMS

Do you presently or have you had:	YES	NO
frequent headaches?		
a head injury?		
other injuries? (Specify below.)		
any periods of unconsciousness?		
trouble hearing?		
discharge from your eyes?		
pain in your eyes?		
other trouble with your eyes?		
toothaches?		
a persistent cough?		
a sore throat?		
any skin trouble?		
any itchiness anywhere?		
night sweats?		
trouble breathing?		
chest pain?		
coughing up of blood?		
heartburn (indigestion)?		
burning on urination?		
trouble with your bowels?		

MALES: Do you have any:	YES	NO
discharge from your penis?		
sores on your penis?		
pain in your testicles?		
FEMALES: Do you have any:		
lumps in your breasts?		
unusual vaginal discharge?		
unusual vaginal bleeding?		
Do you think you might be pregnant?		
Are you presently menstruating?		

Are there any other health problems that are bothering you? If yes, specify:

INMATE ASSESSMENT OF JAIL'S HEALTH SERVICES | NAME OF JAIL | STATE | DATE

NOTE: This questionnaire should be applied only to individuals who have been in the jail one week or more.

	YES	NO	VERIFY
1. Did a doctor or a medical staff person examine you when you were admitted to the jail?	☐	☐	☐
If yes, how soon after admission? _____			☐
2. Aside from an admission physical, have you seen a medical person since you've been in jail?	☐	☐	☐
If yes:			
(a) Who? (level of staff) _____			☐
(b) When? _____			☐
(c) Why? _____			☐
(d) Were you given any medicine (pills, shots, etc.)?	☐	☐	☐
(e) Did you feel better after you saw this person?	☐	☐	☐
3. What's the procedure for getting medical assistance here? _____			☐
4. Has anyone ever stopped you from seeing a doctor or any other medical person that you wanted to see?	☐	☐	
If yes, explain: _____			
5. Have any other inmates, that you know of, been sick and haven't been able to see a doctor?	☐	☐	
If yes, explain: _____			
6. How long do you usually have to wait to see a doctor? _____			
7. Have you seen a dentist since you've been in jail?	☐	☐	☐
If yes, how long did you have to wait to see the dentist? _____			
8. Have you ever felt the need to see a dentist and couldn't?	☐	☐	
If yes, why couldn't you? _____			
9. Have you seen a psychiatrist or counselor since you've been in jail?	☐	☐	☐
If yes, did you feel this person helped you?	☐	☐	
If no help, why? _____			
10. Since you've been in jail, have you wanted to see a psychiatrist or counselor and couldn't?	☐	☐	
If yes, explain: _____			

11. How would you rate your health? Would you say it was: ☐ Excellent ☐ Good ☐ Fair ☐ Bad ☐ Very bad

12. Since you've been in jail, do you think your health has: ☐ Gotten better ☐ Stayed about the same ☐ Gotten worse

If better or worse, why? _____

13. In comparison to the health care you were receiving on the outside, do you think the health care here in the jail is: ☐ Better ☐ About the same ☐ Worse

If better or worse, why? _____

14. What is the attitude of the health care personnel, serving the jail, towards the inmates?

15. Do you have any over-all comments or suggestions to make regarding health care services in this jail?

END

DATE

FILMED

1-16-81

NTIS