INTRODUCTION

IMPORTANCE OF AN EFFECTIVE INTAKE EVALUATION AND SCREENING PROCESS

The establishment of a functional and effective medical and mental health intake screening process for men and women being newly admitted to a correctional facility is vital and absolutely elemental to a correctional facility’s health care system.

Failing to provide consistent, effective, and timely medical and mental health intake screening in a correctional facility exposes detainees to both immediate and long-term health risks and to potentially life-threatening deterioration of their medical conditions. The detainee with epilepsy who is not identified and not continued on antiseizure medicine will soon convulse, the asthmatic detainee will wheeze, and the diabetic detainee will deteriorate. Suicidal individuals will attempt to hurt themselves.

The National Commission on Correctional Health Care (NCCHC) has formally stated that “Receiving Screening” is the “most important” of all standards in the NCCHC jail and prison manuals (Standards #1-E-02 and #P-E-02).

Despite the recognized importance of this function, intake screening has not been subject to study and the current practice is based on legacy and expert opinion rather than on scientific evidence. No studies are available that establish the most appropriate type and timeliness of evaluations, the sensitivity or specificity of currently used screening instruments, or the level of staff who should perform intake screening evaluations. Although strong evidence exists regarding the value of screening diagnostic tests and interventions (e.g., the U.S. Preventive Health Services Task Force recommendations), this evidence is not often incorporated into screening protocols. As a result, tests without evidence of value continue to be performed, and tests or interventions of known benefit are not performed.

With minor modifications, current NCCHC Standards for intake screening have been in place since they were first developed in 1979 by the American Medical Association, based on its review of health care in jails and prisons during the preceding decade. The American Public Health Association Standards for Health Services in Correctional Institutions have been in place since 1976. These standards establish two critical elements of intake evaluations. First, all inmates should be physically examined to establish a baseline health status so that further health care needs can be identified, and necessary care can be provided. When these standards were developed, little information was available regarding the prevalence of chronic, contagious, or infectious diseases in the inmate population, and the prevailing screening interaction between a physician and patient in the civilian sector was a head-to-toe physical examination. Since then, more sophisticated evidence-based screening interventions have been developed, and significantly more information is available regarding prevalence of diseases in the inmate population.

Since 1980, approximately the time when correctional health care standards were first written, the population of jail and prison inmates has increased 314% from 503,586 to 2,085,620. Jail and prison construction has not quite kept pace with this growth. Therefore, many prisons and jails are overcrowded. At mid-year 2003, state prisons operated at between 1% to 17% above capacity, and Federal prisons operated at 33% above capacity. Although, on average, jails operated 6% below capacity, 36% of the largest 50 U.S. jails operated above their rated capacity. In 1999, the Department of Justice surveyed daily intakes in jails. Eighty-five percent of facilities responded, and from these data they estimated the number of intakes in jails for a week. A daily average based on their estimate is approximately 52 intakes per thousand per day. These numbers are very crude estimates and will vary widely, depending on the type of institution. Cook County Jail in Chicago, for example, incarcerates approximately 28 inmates per thousand per day or approximately 296 new intakes, on average, per day. For some jails, such as those that are booking or referral facilities, the numbers may be much higher.

With such large numbers of incoming inmates, health care personnel are under intense time pressure from correctional staff to move individuals into their housing assignment, which increases the risk of a hurried, inadequate evaluation. In response to these issues, intake-screening standards and systems have been developed to effectively screen these large populations for acute and chronic medical and mental health conditions. Accommodations based on custody concerns, which delay identification of medical conditions or timely treatment of acute or chronic conditions, can result in morbidity and mortality.

The responsibilities of medical personnel within this context are several-fold. Health care staff must:
• Conduct themselves empathetically and professionally toward inmate-patients.
• Ensure that medical evaluations are conducted in an appropriate clinical setting where privacy is ensured.
• Not participate in evidence gathering or body cavity searches because they are caregivers to inmate-patients.
• Identify persons with acute or chronic medical or mental illness in a careful and systematic manner.
• Ensure continuation of prescribed medication.
• Promptly identify persons with contagious diseases (e.g., tuberculosis) and isolate and treat them as indicated.
• Refer patients in a timely manner for any follow-up care.
• Use the opportunity of incarceration to participate in public health efforts to screen for contagious and infectious diseases prevalent in the community from which inmates come.

These tasks are difficult and cannot succeed without the cooperation of correctional staff, the willingness of the correctional authority to support the public health mission, sufficient space in which to conduct medical evaluations, and sufficient staff and supplies.

Two-Stage Intake Screening: Reception Screening and Physical Examination

Standards for intake screening have evolved into a two-stage evaluation process that divides the identification of problems by reception screening and the physical examination of patients for any identified problems into two separate events. Specifically, standards call for a first-stage reception screening when an inmate first comes into a jail or prison and a physical examination at a later time. The time spread between the identification of a problem and the physical examination may be as long as 14 days. In jails and with short length of stays, this time spread results in many patients not receiving any examination, which reduces the screening burden on the casulary and health care staff. However, patients with certain chronic illnesses and with acute medical or mental health problems need an examination promptly upon identification of their medical problem. Most obvious is in persons who are taking medications that must not be interrupted but require physician evaluation before establishing the dosage (e.g., in type 1 diabetes mellitus). In this respect, for inmates with certain clinical conditions, the intake process should be seen as a continuum in which the identification of the problem is continuous with the examination. The time frame of the examination should depend on only the type of condition and severity of the illness. Based on expert opinion, better quality programs are ones in which the identification of a problem is immediately followed by an appropriate evaluation for that condition along with necessary prescription medication and other therapy.

The American Psychiatric Association estimates that 20% of inmates have a mental illness. The NCCHC estimated rates of hypertension, asthma, and diabetes in the correctional population as 18.3%, 8.5%, and 4.8%, respectively. Therefore, it should be expected that approximately 30% of persons entering jails and prisons will have a medical problem, and approximately 15% to 20% of persons will have a mental health problem. Although a delayed time-separated physical examination may be adequate for the 50% to 70% of persons without medical or mental health conditions, delaying evaluation for those with medical conditions may result in deterioration of status. No known studies evaluate morbidity or mortality arising from these delays, but expert opinion based on reviews of jails during audits provides anecdotal evidence of morbidity and mortality based on these delays. Delayed or inadequate treatment of persons with medical conditions often results in liability exposure and publicity.

Reception Screening. Reception screening is that medical intervention that occurs soon after an inmate arrives in a correctional facility. Reception screening should include an inventory of medical conditions and include a brief evaluation to identify urgent conditions. Urgent conditions are best identified by a careful history, visual inspection, mental status evaluation, and vital signs. The visual inspection identifies serious impairment (e.g., injury, intoxication, or signs of withdrawal) that results in referral for immediate medical examination or may require special housing within the correctional facility. Vital signs are an inexpensive and efficient way to screen for urgent medical conditions and should be included for all patients on reception screening. In addition to symptom screening for tuberculosis disease, many systems include in reception screening a Mantoux skin testing or chest x-ray screening for active tuberculosis disease.

Those with medical conditions identified at this screening evaluation should be physically examined to determine their medical status and to ensure continuation of medication at the appropriate dose. For that reason, when persons have medical conditions, the physical evaluation of the inmate by a physician should be continuous with or shortly follow the identification of the problem. This is especially true for jails where patients tend to be more unstable and less well cared for than for persons entering prisons. The length of time between the identification of the problem and the physical examination increases the probability that errors may occur. Current standards require examinations of all newly arrived inmates, including those without identified problems, yet allow wide discretion to delay physical examinations for those with medical conditions. This area should be studied because once adequately screened by a health care person, it makes sense that those without medical conditions (especially young persons) do not need a head-to-toe physical examination. But those with medical conditions should be seen promptly. If this does not occur, there must be a procedure in place for the timely continuation of chronic medications so that there will not be an interruption in the care of the patient.

Screening Process and Goals

Thus, the cornerstone of the delivery of timely and necessary health care services in correctional facilities is reception screening that is provided during the very first hours of detention and incarceration. Comprehensive, focused intake screening will ensure the continued delivery of viral medications to the chronically ill, will identify acute illnesses or injuries, will detect actively suicidal or at-risk-for-suicide individuals, will properly medicate and house the acutely or chronically mentally ill, and will rapidly identify, isolate, and treat contagious entities to protect the staff and other inmates, and ultimately protect the public health of the nonincarcerated communities upon discharge of the detained inmate to his or her community of origin. These goals can be accomplished during intake screening by any of various methods and models in place throughout the country.

The method by which intake screening is accomplished will invariably differ in different types of facilities, yet the core goal
remains constant. Sick individuals must be expeditiously identified and proper care initiated without undue delay. The size of the facility, the volume and flow of new admissions, the average or predicted length of stays, and the prevalence of acute and chronic conditions must be considered in the thoughtful establishment of intake screening processes and tests. The scope of screening provided in correctional facilities, for the most part, has been based on long-standing traditional practices. Although some components of the intake screening process are intuitively obvious, little has been done to incorporate data-based and outcome-proven methodology into the selection of the questions and tests administered during the intake medical screening. Over the next decade, proven health identifiers, tests, and procedures, based on recognized nationally accepted expert guidelines such as the United States Preventive Services Task Force (USPSTF), will be incorporated into the intake screening process.

### Importance of Jails on Public Health

The intake exam at a jail or detention facility may be the only health care encounter that a detainee may have had for a significant period. A 2002 survey at the Cook County Department of Correction (CCDOC) revealed that 58% of women identified the jail as their main or only source of ongoing care. Many individuals with chronic illnesses do not seek follow-up care in the community after discharge, and repeat offenders may actually defer addressing health care needs until their next incarceration. Detainees who are substance users, mentally ill, or homeless are predictably less likely to pursue routine care upon discharge.

Multiple studies have identified high prevalences of sexually transmitted disease, hepatitis B, hepatitis C, HIV, and tuberculosis in persons entering jails and prisons. Correctional facilities have also been implicated as having pivotal roles in the epidemiology of various epidemics. By participating in screening for contagious and infectious diseases, correctional facilities take advantage of a public health opportunity of immense importance. Therefore, it is increasingly imperative that local public health departments become actively involved in the development and funding of infectious and contagious disease screening programs at local detention facilities. Large urban jails that screen for syphilis, gonorrhea, and chlamydia become the leading site for the diagnosis for sexually transmitted diseases in their cities. Ultimately, all jails need to be electronically linked with local health departments so that individuals with untreated and lost-to-treatment tuberculosis and sexually transmitted diseases can be tracked and treated upon entrance to the detention facility and to facilitate continuity of care upon their discharge to the community.

Jails, and especially prisons, are also potentially effective sites for the vaccination of at-risk men and women for various preventable diseases (e.g., tetanus, influenza, pneumococcal pneumonia, hepatitis A and B, human papilloma virus, meningococcal meningitis) and for treatment of latent tuberculosis infection.

When designing admission screening at a jail or prison, correctional health providers must be cognizant of the unique role that intake screening examinations have in addressing and improving the health of both the incarcerated and the nonincarcerated communities. Every correctional facility should develop, in collaboration with their local health department, a written agreement that describes the relationship between the two organizations and develops a public health screening program based on the prevalence of infectious and contagious disease in the community in which the prison or jail is located. It is in the best interest of the public's health to take advantage of the opportunity that intake exams present to identify, treat, and even prevent infectious and chronic illnesses that have high prevalence rates in the incarcerated community.

### The Layout and Location of the Intake Screening

One of the common barriers to the implementation of an effective intake screening process is the selection of a location that is inadequately sized or configured. The majority of intake screening in jails occurs in physical areas that have been retrofitted to deliver this service. Compromises in flow have been made because of the restrictions of the existing space. Many facilities that were built before the dramatic increases in inmate population during the 1980s were designed for lower volumes of admissions and are now screening significantly higher numbers of detainees and prisoners. Some newer facilities were designed to accommodate the correctional components of the admission process but not the medical and mental screening. Even facilities that were developed to provide designated medical screenings have not been remodeled to accommodate changing screening exams and new technologies.

The setting for medical and mental health screening must primarily allow for audiovisual privacy without compromising the safety and security of the staff and institution. Long-established community standards concerning patient-provider confidentiality have been recently reinforced by Federal legislation, that is, the Health Information Privacy and Portability Act (HIPAA). The interview must be performed in a room or booth where the detainee or prisoner is confident that only the health provider can hear the responses. Correctional health experts experience that men and women are less likely to reveal sensitive or potentially embarrassing or possibly threatening information, such as HIV infection, symptoms suggestive of sexually transmitted diseases, or a current or past history of mental illness or suicide ideation, if they perceive that other inmates or the correctional staff may overhear their responses. If clinical exams are performed in the intake area, it is mandatory that the exam table be positioned in a separate exam room that protects the privacy of the patient. In addition, examination rooms must contain adequate space, lighting, equipment (peak flow meter, glucometer, scale, etc.), and either a sink for hand washing or available alcohol-based cleansing wipes.

The intake screening area must be designed to accommodate a logical patient flow that ensures that patients do not miss any component of the medical screening processes, which is a key concern in large urban jails and detention facilities that process high volumes of admissions in contracted time frames. Screening processes with multiple steps or stations must be structured and coordinated to ensure that not a single detainee exits the intake screening area without having fully completed the entire established medical and mental health screening process.

Admission screening should be performed in a continuous, uninterrupted flow with the medical and mental health interview, physical assessment, observation and examination, and diagnostic testing (chest x-rays, phlebotomy, sexually transmitted
disease screening) completed, sequentially. No detainee should be allowed to leave the intake area until the health screening process is fully completed.

In smaller centers with low numbers of admissions, intake screening can be expeditiously provided in a single interview and exam room by a single provider.

Screening Personnel in Jails and Prisons

Trained, qualified, and licensed health personnel should perform the health screening during the admission of detainees and inmates to jails and prisons. Throughout the United States, different correctional systems use paramedics, nurses, physician assistants, nurse practitioners, mental health specialists, psychologists, and physicians supported by laboratory and radiology technicians to perform intake medical and mental health screening. Although some facilities choose to use a single provider to perform all aspects of the intake on an individual inmate, most large systems have installed a team approach with integrated but separate medical and mental health components. In any case, a health professional should only perform that aspect of an evaluation for which he or she is licensed to perform. Evaluations or examinations that require a diagnosis should be performed by professionals licensed to do so, specifically nurse practitioners, physician assistants, or physicians. Some high-volume systems have instituted a stepped screening process in which new admissions receive a primary health interview, history, vital signs, and screening diagnostic tests; but only those identified as having an illness, serious medication or treatment, health problem, or symptom are then evaluated in a secondary assessment by a high-level health provider (mid-level provider, psychologist, physician).

Use of Health-Trained Correctional Officers as Screening Personnel in Jails

Although it is the subject of ongoing debate among correctional health care experts, both NCCHC and the American Correctional Association allow small facilities to use health-trained correctional officers to perform initial receiving screening. These health-trained officers must be instructed in taking a medical history, making required observations, documenting their findings, and determining appropriate dispositions and referrals. It is indeed understandable that difficult and costly for extremely small jails to have continually on-site medical personnel. However, there are also potential medicolegal liabilities that arise when nonmedical personnel are, by policy, directed to make potentially life-threatening health dispositions.

Whenever correctional officers are used to perform receiving screening, the threshold for expedited referral to a medical provider or health facility (clinic, urgent care center, emergency room) must be extremely low. Any detainee who is taking a chronic medication, who has been recently injured, who is a substance user, or who is in pain, or who is confused, disoriented, or manifesting bizarre or inappropriate behavior must be immediately referred for medical attention. This will invariably result in a high percentage of new admissions having to be transported outside the correctional facility for care. It would appear to be a logical conclusion that it would be cost-effective and medically preferable simply to contract with an off-site provider or facility to perform medical and mental health assessments before accepting the detainee at the jail.

Reception Screening in Jails

Intake screening at jails and detention facilities is not uncommonly structured in a different manner than that at prisons. Jails receive men and women who have been recently arrested. Some detainees arrive at jails within hours of their initial contact with the criminal justice system. Individuals may arrive with acute injuries not previously treated. Sixty percent of detainees report histories of substance abuse. Many are still intoxicated or under the influence of drugs and alcohol. Some have begun or will soon begin the withdrawal from drugs and alcohol. Homeless individuals enter detention facilities with a high prevalence of mental illnesses, infestations, and tuberculosis. Many chronically and mentally ill persons, whose current incarceration is, at least in part, the result of the discontinuation of psychotropic medications, are admitted in florid psychosis. Those with diabetes, epilepsy, asthma, hypertension, and other chronic illnesses have not taken or had access to their medication for a variable period before detention. Intake screening processes in jails must be prepared to expeditiously identify, evaluate, reinstitute treatment, and place appropriate patient-detennees in housing settings where appropriate monitoring can be provided.

New admissions to jails must be questioned about chronic and past medical and mental illnesses, current medications, allergies, recent surgeries and injuries, pain, symptoms of infectious diseases (e.g., cough, fever, weight loss, sweats, rash, abscesses, genital discharge, or ulcers), legal and illegal substance use, pregnancy, and symptoms of withdrawal from drugs. The U.S. Preventive Services Task Force recommends screening for hypertension in all adults. Therefore, blood pressure should be taken on all incoming inmates. Because the other vital signs involve no potential adverse effects, and because vital signs are important markers for withdrawal syndromes and serious illness, performing vital signs as part of reception screening should be done. None of the other elements of the hands-on physical examination have proven validity and usefulness as screening tools in the correctional intake setting. Only the inspection of skin for purulent ulcerations compatible with methicillin-resistant Staphylococcus aureus, blistering lesions and exanthems suggestive of varicella or herpes zoster, and dermatological findings of infestations and the inspection of the mouth may have value as vital screening examinations. All new admissions must be observed for abnormal appearance, behavior, state of consciousness, alertness, ability to ambulate, and breathing difficulties.

The short stays of a significant portion of jail admissions may justify the practical use of a streamlined intake screening process. Only vital data and examinations that are justified by the needs and health demographics of the patient population are mandated to be elicited during a jail’s intake procedure. Valuable health care resources should be expended on performing screening exams, tests, and questions that have proven efficacy and have a reasonable opportunity to be of benefit to the patient-detainee and to the institution before the individual is discharged from the jail. The obvious importance is that jails study the health status of its catchment community and the health characteristics of those individuals being admitted to their correctional facility. Screening questions and tests should be determined by the needs and risks of the admissions to the jail. Table 5-1 provides a listing of questions and screening tests to be considered for intake evaluations in jails and prisons.
## TABLE 5-1. Intake screening and evaluation

<table>
<thead>
<tr>
<th>Jails</th>
<th>Prisons</th>
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<tbody>
<tr>
<td><strong>Medical/Surgical</strong></td>
<td><strong>Medical/Surgical</strong></td>
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<tr>
<td>Recent and past surgery</td>
<td>Recent and past surgery</td>
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<td>Recent injury</td>
<td>Recent injury</td>
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<tr>
<td>Current medication</td>
<td>Current medication</td>
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<tr>
<td>Currently under care of a doctor</td>
<td>Currently under care of a doctor</td>
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<tr>
<td>Allergies</td>
<td>Allergies</td>
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<tr>
<td>Assistive device (oxygen, CPAP, crutch, WC)</td>
<td>Assistive device (oxygen, CPAP, crutch, WC)</td>
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<tr>
<td>Chronic illnesses</td>
<td>Chronic illnesses</td>
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<tr>
<td>Asthma/COPD</td>
<td>Asthma/COPD</td>
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<tr>
<td>Cancer</td>
<td>Cancer</td>
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<tr>
<td>Diabetes</td>
<td>Diabetes</td>
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<tr>
<td>Cardiovascular disease (CAD, CHF, HTN)</td>
<td>Cardiovascular disease (CAD, CHF, HTN)</td>
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<tr>
<td>Epilepsy</td>
<td>Epilepsy</td>
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<tr>
<td>Human immunodeficiency disease</td>
<td>Human immunodeficiency disease</td>
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<tr>
<td>Liver disease</td>
<td>Liver disease</td>
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<tr>
<td>Renal disease (dialysis)</td>
<td>Renal disease (dialysis)</td>
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<tr>
<td>Tuberculosis</td>
<td>Tuberculosis</td>
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<tr>
<td>Substance abuse (quantity, frequency last use)</td>
<td>Substance abuse (quantity, frequency last use)</td>
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<tr>
<td>Tuberculosis symptom screening (current cough, fever, night sweats, weight loss)</td>
<td>Tuberculosis symptom screening (current cough, fever, night sweats, weight loss)</td>
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<tr>
<td>Tobacco use</td>
<td>Tobacco use</td>
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<tr>
<td><strong>Family</strong></td>
<td><strong>Family</strong></td>
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<tr>
<td>Cancer (breast, ovary, colon)</td>
<td>Cancer (breast, ovary, colon)</td>
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<tr>
<td>Coronary artery disease</td>
<td>Coronary artery disease</td>
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<tr>
<td>Cerebrovascular accident</td>
<td>Cerebrovascular accident</td>
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<tr>
<td>Other</td>
<td>Other</td>
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<tr>
<td><strong>Mental Health</strong></td>
<td><strong>Mental Health</strong></td>
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<tr>
<td>History of psychotropic meds</td>
<td>History of psychotropic meds</td>
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<tr>
<td>History of psychiatric hospitalizations</td>
<td>History of psychiatric hospitalizations</td>
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<tr>
<td>History of suicide attempts</td>
<td>History of suicide attempts</td>
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<tr>
<td>Hallucinations</td>
<td>Hallucinations</td>
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<tr>
<td>Suicidal ideation</td>
<td>Suicidal ideation</td>
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<tr>
<td>Observation for abnormal behavior</td>
<td>Observation for abnormal behavior</td>
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<tr>
<td><strong>Vital Signs</strong></td>
<td><strong>Vital Signs</strong></td>
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<tr>
<td>Weight</td>
<td>Weight</td>
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<tr>
<td>Blood pressure</td>
<td>Blood pressure</td>
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<td>Pulse</td>
<td>Pulse</td>
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<tr>
<td>Respiration</td>
<td>Respiration</td>
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<tr>
<td>Temperature</td>
<td>Temperature</td>
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<tr>
<td>Pain</td>
<td>Pain</td>
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<tr>
<td><strong>Examination</strong></td>
<td><strong>Examination</strong></td>
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<tr>
<td>Observation and inspection</td>
<td>Observation and inspection</td>
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<tr>
<td>Skin inspection for infectious entities</td>
<td>Skin inspection for infectious entities</td>
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<tr>
<td>(MRSA lesions, varicella, herpes zoster)</td>
<td>(MRSA lesions, varicella, herpes zoster)</td>
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<tr>
<td>Oral screening</td>
<td>Oral screening</td>
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<tr>
<td>Focused exam based on history</td>
<td>Focused exam based on history</td>
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<tr>
<td><strong>Laboratory/Diagnostic Tests</strong></td>
<td><strong>Laboratory/Diagnostic Tests</strong></td>
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<tr>
<td>Chest x-ray* or Mantoux skin test for TB</td>
<td>Chest x-ray*</td>
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<tr>
<td>Gonorrhea*</td>
<td>Gonorrhea*</td>
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<td>Chlamydia*</td>
<td>Chlamydia*</td>
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<tr>
<td>Syphilis*</td>
<td>Syphilis*</td>
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<tr>
<td>Pregnancy test (age)</td>
<td>Dental x-rays</td>
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<tr>
<td>(If diabetic, do finger stick blood glucose)</td>
<td>HIV test*</td>
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<tr>
<td>(If asthmatic, peak expiratory flow rate)</td>
<td>Lipid</td>
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<tr>
<td></td>
<td>TB skin test or QuantiFERON</td>
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<td></td>
<td>Colon-rectal cancer screening</td>
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<td></td>
<td>Papanicolaou*</td>
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<td>Pregnancy test (age)</td>
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<td>Mammography</td>
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<td>(If diabetic, do finger stick blood glucose)</td>
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<tr>
<td></td>
<td>(If asthmatic, peak expiratory flow rate)</td>
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*If indicated based on prevalence, age, health status, risk factors, outbreaks, projected length of stay.
Reception Screening in Prisons

The majority of new admissions to prison systems come from jails and detention facilities in which at least basic medical care has been provided. A lower percentage will have sustained recent injuries. A higher percentage will be free of alcohol and illegal drugs. Many with identifiable mental and medical illnesses have already been initiated or continued on treatment. Although the screening process in prisons must screen for the same acute manifestations of trauma, infectious diseases, substance abuse, and chronic and acute medical and mental health conditions that are seen in jails, prisons must also focus on providing more comprehensive screenings that would set the course for the long-term achievement and maintenance of health for the inmates (see Table 5-1). A noted additional difference between jails and prisons concerns the approach to tuberculosis screening. Jails focus almost exclusively on identifying individuals with active, contagious stages of tuberculosis, whereas prisons must screen not only for active disease but also should aggressively identify men and women who are candidates for chemoprophylaxis of latent tuberculosis infection. (See Chapter 17.)

Physical Examinations in Jails and Prisons

The NCCHC standards require that all inmates be physically examined within 14 days in jails and 7 days in prisons. Although this timeframe may be acceptable for persons who are well, it is inappropriate for persons whose disease is not in good control or for those with acute disorders. These persons should be examined promptly and as soon as possible after the identification of their medical problem. In addition, recommendations for persons not residing in correctional facilities are moving away from routine head-to-toe physical examinations, especially for persons who are otherwise asymptomatic.

More study is necessary to establish the necessary requirements regarding screening physical examinations of young, incarcerated persons who have no symptoms or history of disease.

Established standards of the NCCHC (J-E-02) and the ACA (3-ALDF-4E-19) mandate that jails focus on identifying acute and chronic medical and mental health conditions that require immediate or continued treatment, on quickly identifying infectious entities that can spread in the jail environment, and on evaluating and instituting appropriate interventions and observation of detainees at risk for rapid deterioration (e.g., alcohol withdrawal, suicide) in the jail.

Jails and prisons should therefore have in place a mechanism to ensure prompt physician, nurse practitioner, or physician assistant examination of persons with chronic illness, especially for those requiring medication for their illness. The American Diabetes Association is the first national organization that has produced new correctional guidelines that include recommendations for intake screening for persons with diabetes. These recommendations include: capillary blood glucose within 1 to 2 hours of arrival, prompt physician evaluation, immediate referral for a pregnant woman with diabetes to a provider who knows how to care for pregnant persons with diabetes, and uninterrupted continuation of a patient’s usual diabetes medication. In lieu of other consensus recommendations, it is prudent for nurses performing intake screening to consult with a physician, nurse practitioner, or physician assistant for all patients with chronic illness to determine the time frame for referral for examination. All persons with chronic disease should have their physical examination performed by someone who can diagnose and modify diagnoses, that is, nurse practitioners, physician assistants, or physicians.

Suicide continues to be a leading cause of mortality in jails. Mental health screening must be quick and consistently administered to all new admissions to short-term detention centers. Correctional facilities must be prepared to rapidly house individuals with unstable mental health conditions in safe, protected, and well-monitored units, pending full evaluation by the on-site mental health providers or referral to off-site medical centers.

Persons with alcohol or other drug withdrawal should be identified and examined promptly. Detoxification protocols and recommendations are contained in Chapter 26.

Oral Health Screening

Dental and oral health is one of the greatest unmet health care needs of low-income populations in the United States. Access to both preventive and therapeutic dental care is limited in many low-income communities. Given that residents of low-income
communities have higher rates of incarceration and detention, it is of no surprise that the dental health needs of detainees and prisoners are significant. Correctional health experts estimate that an average of four teeth in every jail admission requires either filling or extraction (personal communication).

NCCHC standards J-E-06 and P-E-06 require that oral screening and oral hygiene education be performed within 14 days of admission to jails and 7 days of admission to prisons. The standard can be met by performing oral screening at the time of intake. Health care providers trained in oral screening examinations can identify obvious decayed teeth and gingival inflammation. Oral thrush, a potential marker for acquired immunodeficiency disease, can also be readily identified by health providers with limited instruction. This would expedite the referral of individuals with overt dental and oral disease to dental or medical care. This is especially important for men and women whose medical condition may be negatively impacted by dental disease (e.g., diabetes, HIV infection, pregnancy, valvular heart disease).

In prisons, the need for a complete dental examination, including the appropriate use of dental x-rays, is required. The long stays in prison will allow time for reparative dental procedures to be staged and completed.

Laboratory and Diagnostic Testing and Infectious Disease Screening in Jails

The NCCHC allows jails to defer all screening laboratory testing until up to 14 days after arrival. However, many jails in the United States, especially large urban facilities, have incorporated screening and lab tests that protect the health of the institution and the individual detainees into the intake screening process.

Tuberculosis. Tuberculosis spreads rapidly in the crowded confinement of jails and prisons. Symptom-based screening performed at reception screening fails to efficiently and effectively identify all cases of active tuberculosis. Outbreaks of pulmonary tuberculosis have occurred in correctional facilities. All facilities need to incorporate some form of tuberculosis testing into their intake screening process that is best done as soon as possible and preferably at reception screening, if possible. (See Chapter 17.) Tuberculosis skin testing (purified protein derivative), blood tests measuring the interferon-gamma response to tuberculin purified protein (QuantiFERON), or chest radiography are more effective than symptom screening and should be part of every jail’s intake screening program. Large urban jails, such as in Los Angeles, Chicago, and Harris County in Texas, have demonstrated that chest x-ray screening for infiltrates or abnormalities compatible with pulmonary tuberculosis significantly decrease the time before respiratory isolation is initiated and have identified significant numbers of active contagious tuberculosis patients who would not have been detected by symptoms or skin testing. Large and medium-sized jails should consider the practical use of chest x-rays screening to prevent intramural transmission of tuberculosis. It is acceptable for smaller facilities and institutions with low incidences of tuberculosis to use purified protein derivative skin tests or interferon-gamma–based blood testing to screen for tuberculosis infection, performing chest x-rays only on individuals with positive skin or blood tests or who are immunocompromised. (See Chapter 17 for more information.)

HIV Testing. Because of the success in treating HIV infection with highly active antiretroviral therapy (HAART), early diagnosis is advantageous. In addition, knowing one’s serostatus assists in preventing transmission by reinforcing preventive measures. The USPSTF recommends HIV testing for persons at risk. Recently, widespread routine HIV screening has been recommended as clinically and economically sound practice in the civilian sector. HIV in incarcerated individuals is higher than in civilian populations. Given that HIV risk is high in jails and prisons, routine confidential HIV testing should be considered appropriate public health practice.

Hepatitis B and C. The Centers for Disease Control and Prevention (CDC) recommends that all long-term inmates of any type of correctional facility be vaccinated for hepatitis B infection. This can be initiated at intake when indicated. For
hepatitis C infection, the CDC recommends questioning all inmates for risk factors for hepatitis C and testing all those with positive risk factors. Risk factors include:

- History of engaging in injection drug use
- Having received clotting factors before 1987
- Long-term hemodialysis
- Chronic liver disease
- History of transfusion

Physical Examinations in Prisons as the Initial Step in a Continuum of Routine Health Maintenance

Prisons will be providing the health care services for significant portions of the remaining adult lives for a large percentage of the men and women admitted to their systems. The intake screening process is an optimal time to initiate the plan for the attainment of health and the prevention of illness and disease for newly incarcerated inmates. The intake screening process in prisons should include the first evaluations and interventions that assess the health risks of an inmate and develop a plan to address these risks and any existing illnesses that are identified. Annual follow-up maintenance evaluations are a standard practice in most prison facilities and are part of NCCHC standards. Although the public continues to believe that an annual physical exam and panel of laboratory testing are an important part of their health, several expert panels have concluded that many components of the annual exam and testing have not been proven to have a positive impact on either patient morbidity or mortality. As in jails, the components of a prison screening risk assessment, examination, and diagnostic testing process that are the initiation of an inmate’s routine health maintenance plan must be based on the prevalence of diseases in the population being admitted and national recommendations based on the age and risk behaviors of the inmate population.

Family History and Personal History and Risk Behavior Assessment during Prison Intake Evaluation

Family and personal histories and risk behaviors should be solicited in greater detail in prisons than in jails. Strong family histories of certain cancers (e.g., colon, breast, ovary), early-age coronary artery disease and stroke, hypertension, and diabetes would influence the health care plan and the selection of screening tests for men and women anticipated to spend years incarcerated. Personal histories of tobacco use, injectable substance abuse, and high sexual activity need to be identified aggressively. Based on the risks identified in the individual’s family and personal histories, appropriate tests, interventions, and monitoring should be initiated.

Laboratory and Diagnostic Testing and Infectious Disease Screening in Prisons

Prisons should screen for sexually transmitted diseases (e.g., syphilis, gonorrhea, and chlamydia) in the same manner as jails. Only when the prevalence rates are documented to be below the threshold for screening should STD screening be deferred in prisons.

Prisons should screen for active tuberculosis as do jails, but prisons should also screen all men and women for latent tuberculosis infection (LTBI) to identify potential candidates for chemoprevention. Inmates in prisons are generally incarcerated for sufficient time to allow the completion of isoniazid prophylaxis. (See Chapter 17.)

All women entering prisons must be tested for pregnancy. It would even be prudent to do pregnancy testing on women being transferred from jails where they may or may not have had an admission-negative pregnancy test.

Given the lengthy stays in prisons, prison health systems and providers should also view the intake evaluation of all new inmates as the ideal moment to perform additional lab tests that are indicated by the age, personal history, and family history of the inmate.

As discussed in another section of this chapter, the intake medical evaluation in prisons should be incorporated into the routine health maintenance plan for all new admissions. The selection of screening tests in prisons should be guided by the recommendations of expert panels, such as the United States Preventive Services Task Force (USPSTF) and the prevalence of both chronic and infectious diseases in the inmate population.

The USPSTF is an independent panel of experts in primary care convened by the Agency for Healthcare Research and Quality (AHRQ) that systematically reviews the evidence of effectiveness of clinical preventive services and makes recommendations for their use in primary health care. Its recommendations are assigned grades A–D and I (“A” ratings being strongly recommended, “D” not recommended, and “I” indicating insufficient evidence to make a recommendation based on the strength of evidence and magnitude of net benefit to the patients being treated). (See Table 5–2.)

Based on USPSTF A & B recommendations, the following tests, examinations, and counseling should be offered during the intake evaluation process in prisons.

Osteoporosis: All men and women should be assessed for osteoporosis. High body mass index is strongly associated with diabetes, hypertension, and coronary heart disease.

Diabetes: The USPSTF concluded that there was insufficient evidence to screen all adults for diabetes, but it gave a “B” grade recommendation to screen all adults with hypertension and hyperlipidemia for diabetes. Up to 30% of the U.S. adult population is at risk for diabetes. Early detection and proper intervention can prevent many of the ophthalmological, neurological, cardiovascular, and renal complications of diabetes.

Cholesterol and lipids: Cholesterol and lipid profile screening (“A” grade) are recommended for all men over age 35 and women over age 45.

Cancer: Colon-rectal cancer screening by any of the established screening modalities (i.e., fecal occult blood, colonoscopy, double-contrast barium enema) is indicated for individuals over age 50 (“A” grade).

Pap/HPV test: Women of all ages should have Pap smears (“A” grade), unless they have had a hysterectomy for a noncancer diagnosis.

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<th>TABLE 5–2. United States Preventive Services Task Force (USPSTF) grading system</th>
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Mammography. Females over age 40 should have screening mammo- 
graphy performed every 1 to 2 years (A grade).

■ MAMMOGRAPHY

A screening mamogram with or without a clinical breast exam is 
recommended every 1 to 2 years for women age 40 or older.

Health Counseling and Education

Exercise, healthy eating, dental hygiene, and safe sex counseling 
should be provided to all men and women being admitted to 
correctional facilities. Tobacco cessation education should be given 
to all inmates entering one of the ever-dwindling number of cor-
tectional facilities that permit smoking and other tobacco use.

Vaccination During Intake Screening at Jails and Prisons

Few, if any, jails vaccinate new admissions during the intake 
evaluation process. In jail influenza, pneumococcal, and meningococcal vaccination might be provided during outbreaks or 
epidemics in the facility or in the community.

The intake process in prison systems should be an optimal set-
ting to administer adult vaccines and to initiate vaccination series to appropriately screened men and women. Based on the date of 
previous vaccination, measles, mumps, rubella, influenza A and B, 
diphtheria-tetanus-booster vaccines may be indicated. Pneumococcal 
vaccine should be administered to inmates over age 65 or with 
chronic illnesses or during outbreaks in facilities.

During flu season influenza vaccine should be given to at-risk 
candidates, including pregnant women. Hepatitis A vaccine series 
should be initiated during intake for those individuals whose stay 
would allow them to complete the 6-month series. In some cir-
cumstances and settings, meningococcal vaccination might be 
considered to all new admissions. Once fully tested and available, 
the human papilloma virus vaccine would be indicated for 
women entering prison systems. The 2003-2004 Adult Immunization Schedule developed and approved by the Advisory 
Committee on Immunization Practices should be used by cor-
rectional facilities in determining vaccination programs for incar-
cerated populations.

■ CONCLUSION

In summary, jails and prisons play an important public health 
function in their intake screening process. Also, intake evaluations 
ensure that inmates with chronic medical and mental health conditions and contagious and infectious diseases are 
safely housed and treated while they are incarcerated. This 
inmate screening process plays an important part in establishing a 
safe correctional environment for detained persons.

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