

**A Survey Assessment of Notifiable Condition Reporting,
Health Care Services and Medical Case Management
of Binational Inmates in New Mexico Border County
Detention Facilities and Select Border Impact Area
Detention Facilities**

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Executive Summary

Purpose

The New Mexico Department of Health (NMDOH) Infectious Disease Epidemiology Bureau (IDEB) is responsible for the collection of data, case management/ follow-up and analysis of select notifiable conditions. New Mexico statute requires that certain conditions, either confirmed or suspected, be reported to IDEB. Reports are received from individuals and institutions, including detention facilities. However, IDEB currently has limited contact with or understanding of detention facilities along the U.S.-Mexico border. In an attempt to improve understanding of and collaboration with border detention facilities, IDEB conducted a telephone survey with 12 facilities to characterize how notifiable conditions are identified and reported along the U.S. / Mexico border and in border impact areas of the state.

The purpose of this survey was to:

- Identify how notifiable condition reporting is being coordinated within detention centers
- Identify strategies to improve communication and coordination between IDEB and detention centers regarding notifiable conditions
- Identify how binational cases of infectious disease are managed in detention centers
- Help the infectious disease epidemiology bureau better understand detention center medical and behavioral health services availability and processes for accessing services

Selected Results

Among the 12 facilities that participated:

- Only half of the facilities surveyed coordinate with New Mexico Department of Health (NMDOH) public health staff for infectious disease testing (human immunodeficiency [HIV], tuberculosis [TB], hepatitis B and C, syphilis, gonorrhea, and chlamydia)
- Only half of the facilities perform systematic risk assessments for infectious disease
- Only 4 facilities reported procedures for discharge planning of any kind
- The majority of detention facilities surveyed report a need for increased behavioral health services
- Inmates with health benefits (Veterans Administration [VA], Medicaid, Medicare) may lose their benefits while incarcerated
- At the time of the survey, an estimated 946 inmates at participating facilities were in U.S. illegally
- All county detention centers reported following the same infectious disease reporting procedures regardless of inmate immigration status

Recommendations

Recommendations by IDEB to NMDOH Leadership: 1) Improve communication and coordination between NMDOH and county detention centers by creating **detention center liaisons** in each public health region; 2) Utilize **public health staff** (nurses, disease prevention specialists, clinicians) to increase targeted infectious disease screening in detention centers; 3) Advocate for **expanded behavioral health and substance abuse treatment services** in county detention centers; 4) Utilize **detention center liaisons** for referral coordination to community services (e.g., Extension for Community Health Outcomes (ECHO) providers, community mental health, addiction services) upon release; 5) Create/lead a statewide **Detention Center Health Task Force** that includes detention center representatives, Regional Health Officers and **detention center liaisons** for purposes of improving public health screening and essential medical services in all county detention centers.

Introduction

The New Mexico Department of Health (NMDOH), Epidemiology and Response Division (ERD), Infectious Disease Epidemiology Bureau (IDEB) is responsible for the collection of data, case management/ follow-up, analysis and reporting of the majority of communicable notifiable conditions in the state of New Mexico (the exceptions include sexually transmitted infections, tuberculosis and HIV, which are managed out of Public Health Division). IDEB recognizes that they have many partners around the state that contribute to the timely and accurate reporting of notifiable conditions.

Three groups of partners in IDEB's surveillance efforts are the federal, state, and county detention facilities housing inmates in and near New Mexico. Inmate populations are at higher risk for certain infectious diseases which may be identified while in a detention facility. Inmates who have infectious conditions and are transferred to another facility or released to the community (whether in the U.S. or another country) could potentially infect others. Because inmates frequently move in and out of facilities and communities (and across borders) and are at high risk for some infectious diseases, there is a strong need for discharge planning, contact follow-up, and an overall partnership between detention facilities and IDEB.

IDEB intermittently receives reports of suspected, probable and confirmed communicable notifiable conditions in detention facilities along the U.S.-Mexico border. IDEB's recent experience with certain correctional facilities along the U.S./Mexico border has raised concerns about how and if notifiable conditions identified in detention facilities are being reported.

The ability of detention facilities to appropriately identify and report notifiable communicable conditions is of particular concern as it relates to binational cases, the majority of whom in IDEB's experience are undocumented Mexican nationals. Recently, IDEB was informed anecdotally of individuals being diagnosed with notifiable communicable conditions while in a detention center who were being released back into the community without notification to the appropriate public health authorities on either side of the border. This places other members of the community at risk for contracting diseases for which isolation, quarantine and/or treatment may be necessary.

IDEB currently has limited contact with or understanding of correctional facilities along the U.S-Mexico border. In an attempt to remedy this situation, IDEB conducted a survey to characterize how notifiable conditions are identified and reported within detention centers along the U.S.-Mexico border.

The purpose of the survey was to:

- Help IDEB better understand detention center medical and behavioral health services availability and processes for accessing services;
- Identify how notifiable condition reporting is being coordinated within detention centers;
- Identify how binational cases of infectious disease are managed in detention centers; and
- Identify strategies to improve communication and coordination between IDEB and detention centers regarding notifiable conditions.

In New Mexico there are three general categories of detention facilities that incarcerate adult populations: federal agencies, state correctional facilities, and county detention centers. The funding, services, and inmate populations are different at each type of facility thus resulting in different challenges in providing health services to inmate populations. This intention of this survey was to collect information from all three types of facilities to examine how they identify illness, provide health services and report notifiable communicable conditions among their inmates.

Methods

A group of detention facilities were selected to participate in this project based on their location (border counties) and the understanding that certain facilities might be more likely than others to house inmates who are in the U.S. illegally (border impact areas). Limited resources precluded the survey of all county facilities in the state. Facilities in the following counties (locations) were selected for this project:

Table 1. Facilities selected to participate in survey

County/Location	Facility Name
Bernalillo	Metropolitan Detention Center
Chaves	Chaves County Detention Center
Dona Ana	Dona Ana Detention Center, Southern New Mexico Correctional Facility, Federal Corrections Institution-La Tuna
Eddy	Eddy County Detention Center
Grant	Grant County Detention Center
Hidalgo	Hidalgo County Detention Center
Lea	Lea County Detention Center
Luna	Luna County Detention Center
Otero	Otero County Detention Center, Immigration and Customs Enforcement
San Juan	San Juan County Detention Center
Santa Fe	Santa Fe County Detention Center and Penitentiary of New Mexico
Sierra	Sierra County Detention Center
Torrance	Torrance County Detention Center
El Paso, Texas	Immigration and Customs Enforcement Center

A standardized survey instrument was developed to be administered in-person or by phone interview. The survey and a cover letter describing the project purpose were emailed to each participant after an initial phone call and before the interview. Prior to contacting the detention facility staff, NMDOH public health infectious disease nurses and some public health regional directors were contacted to explain that a survey was being conducted by IDEB and to ask for regional detention center contact information. It was important to collect any background information on the relationships between local and regional public health offices and detention centers.

Once a detention center contact list was developed, facilities were contacted by phone. Initially, health services administrators were the main targets for participation. However, if a facility did not have this position, contact was made with the jail administrator. Upon connection with the appropriate staff, detention facility staff were offered the option of doing a phone or in-person interview and an appointment was made to conduct the interview. In cases where the participant said they were not available to do a phone or in-person interview, they were asked if they could self-administer the survey, write the responses on the survey document and either mail a paper copy or email an electronic copy to the interviewer. The interviews consisted of an interviewer reading the questions from the survey to the participant and documenting responses. By using an interview format, the interviewer was able to define and explain questions and ask follow-up questions to elicit qualitative responses. In some cases, participants agreed to provide IDEB with copies of intake forms to serve as examples. Additionally, some participants reported not having the most current notifiable conditions list from IDEB and were sent laminated copies by the interviewer after completion of the phone interview.

Once a survey was completed, the data collected was entered into a spreadsheet. Responses to questions were aggregated and are reported in this document.

Participants

Repeated attempts to contact health services administrators and jail administrators were made at each facility (see Table 1). Ultimately, 12 facilities participated by completing the survey by phone interview or self-administration, for a response rate of 67%. Ten participants were county detention centers, one was a state correctional facility, and one was a federal facility. Staff from the following facilities participated in the survey:

- Metropolitan Detention Center (Bernalillo County)
- Chaves County Detention Center
- Dona Ana County Detention Center
- Eddy County Detention Center
- Grant County Detention Center
- Hidalgo County Detention Center
- Lea County Detention Center
- San Juan County Detention Center
- Santa Fe County Detention Center
- Sierra County Detention Center
- Penitentiary of New Mexico (Santa Fe)
- Immigration and Customs Enforcement (ICE) in El Paso, TX

One participating facility reported that the contracted company providing health services at the facility refused to allow the release of information required to complete the survey. The regional infection control coordinator at the company providing contracted health services for 9 state correctional facilities reported that he was unable to complete the survey for 9 state correctional facilities because the information requested was deemed to be proprietary. Two other facilities expressed willingness to participate in the survey, but said that due to personnel constraints, they could not take the time to complete the survey.

Results

Facility Characteristics

Funding

All participating detention centers reported that they were publicly funded and administered facilities. Five of the 12 facilities have in-house health services provided by a contracted company; 3 facilities have no in-house or facility-based health services; and 4 facilities have facility run in-house health services. The county detention facilities reported that from 74% (1 facility) -100% (9 facilities) of facility operational funds were from their respective counties. The state facility reported 90% of funds from state and additional funding from federal agencies. The federal facility reported that 100% of funding was from Immigration and Customs Enforcement and the department of Homeland Security.

Capacity

Inmate capacity ranged from 17 - 2,238 inmates. The majority of facilities had the capacity to hold 100 or more inmates. Six of the facilities had been at or below maximum capacity in the past 6 months. Four facilities had a maximum daily census in the past 6 months above their inmate capacity level. One detention center is in the process of building a new facility; they currently house the majority of their inmates at other facilities. Most detention centers had an average daily census at or below the facility capacity level.

Length of Incarceration

The average length of incarceration ranged from 10 days to 6 months among the county facilities and 15 years for the state facility participating in this survey. The federal facility participating in the survey reported a range of incarceration from 1 day to 2 years. County detention centers reported inmates could be incarcerated at their facilities from less than 1 day up to 7 years (most reported a range from less than 1 day to 3 years).

Inmate demographics

The majority (74% - 91%) of inmates at participating facilities were male (the 1 state facility participating in the survey only houses male inmates and is not counted in the range above). Females comprised 9% - 26% of inmates. The average age of males ranged from 22 - 40 years across the participating facilities. The average age of female inmates ranged from 23 - 34 years.

At 8 facilities, the majority of the inmates were Hispanic. At 2 facilities the majority of inmates were White. Of the remaining two facilities, one reported that a majority of the inmates were Native American and one reported no single majority race or ethnicity.

All county facilities and the federal facility reported that they have inmates from other countries and all but 2 of these facilities reported that individuals end up in their facility upon arrest in their county's jurisdiction. Five of the participating facilities reported that they estimate 0-5% of their inmate population in the past 6 months have been residing in the U.S. illegally. Two facilities estimated 5-10% of their inmates were in the U.S. illegally, two estimated that 10-20% of their inmates were in U.S. illegally, and one estimated 20-30% of their inmate population was in the U.S. illegally. The federal facility reported greater than 50% of inmates were believed to be in the U.S. illegally. Table 2 shows the estimated number of inmates in the U.S. illegally among the participating facilities

Table 2. Estimated percent of inmates in facilities who are in the U.S. illegally

Estimated percent of inmates in U.S. illegally	Percent of facilities (n)	Total number of inmates estimated to be illegally in U.S. *
0-5%	45 (5)	155
5-10%	18 (2)	81
10-20%	18 (2)	15
20-30%	9 (1)	275
30-50%	0 (0)	0
>50%	9 (1)	420
Total	100 (11)	946

*Total number of inmates estimated to be illegally in U.S. was calculated by multiplying the percent of inmates estimated to be in U.S. illegally by the number of inmates reported as the average daily census. The high end of the estimated percent ranges were used (i.e. for the 0-5% category, the average daily census was multiplied by .05). The resulting numbers of people from each calculation for each facility were summed for each category.

Health Services

Budgets

Eight of the twelve participating facilities were able to provide information on the annual health services operating budget. Of these 8, the amount varied according to inmate capacity and availability of in-house health services. The health budgets ranged from \$15,000 - \$10,000,000. The average health services budget among all facilities except the two that reported the lowest and highest budgets was about \$1,091,949. Eight facilities reported that inmates pay something for health services, either on a sliding fee scale or a co-payment of \$5, \$10 or \$20. Inmate fees are charged for sick call requests (visits with a health care provider) and/or medications.

Coordination

Eight facilities reported that they incarcerate individuals transferred from other facilities. While two facilities reported not taking transfers, they did report that they transfer individuals from their facility to other facilities. Two facilities did not provide this information. Participants were asked about the systems of notification regarding health status used for inmate transfers in and out of their facility. The participating facilities varied in how they share that information. One facility reported that copies of medical records were always sent with an inmate when transferring in or out of facility. Three facilities reported that they give a verbal summary and copies of medical records for inmates, but only written information upon request from the receiving facility. Four facilities reported that they send a letter or transfer form to the receiving facility. Some facilities mentioned during the phone interview that the health services department staff were not always notified of inmate transfers ahead of time making it difficult to compile the information for an inmate and get the appropriate documents together to send with the transferring inmate. Similarly, upon inmate release to the community, health services staff may or may not be notified of the release in advance.

Health Intake

All participating facilities reported that they use a medical/ health intake form, completed for each inmate, in most cases within the first 24 hours of the inmate's arrival (only one facility reported completing the health intake 1-2 days after the inmate arrived at facility). Content of the health intake forms varied by facility but all contained questions about inmate medical and psychiatric history and risk assessment for mental health (see table 3). Two facilities provided copies of their medical/health intake forms. These forms are available upon request.

Table 3. Percent of facilities with sections as part of medical/ health intake

Items included in Medical/health intake	Percent of Facilities (n)
Medical and psychiatric history form	91 (10)
Physical exam by health care provider	55 (6)
Risk assessment for possible blood borne pathogens (HIV, Hepatitis B and C, syphilis)	55 (6)
Risk assessment for mental illness	91 (10)
Risk assessment for drug and alcohol use	82 (9)

Note: Percentages are based on 11 facilities that responded to the questions about content on the medical/ health intake forms.

Accreditation

Three facilities reported some type of national certification of their health services. When asked about protocols followed, those with in-facility health services noted that although not accredited, their facility followed ‘guidelines’ published by national organizations such as National Commission on Correctional Health Care (NCCHC).

Accessing Health Services

Participants were asked about processes for inmates to receive non-emergency and emergency services while incarcerated at their facility. The processes to receive non-emergency health services were similar across facilities. To receive non-emergency health services, an inmate had to submit a “sick call” request (a form requesting medical services). Upon request for medical services, those facilities with health services in-house (9 facilities surveyed) would provide care to the inmate and those without health services in-house (3 facilities surveyed) would contact a provider in the community to provide services to the inmate.

The process for inmates to access emergency care at facilities without in-house health services consists of an inmate telling a corrections officer that they have an emergency and the inmate being taken to an emergency room/ hospital. For those facilities with in-house health services, the process was similar in that the inmate would tell a corrections officer that they have an emergency, but then health services staff would evaluate the severity of the medical need and treat in-house or transport to an emergency room if needed. The average wait time from request to receipt of non-emergency services ranged from 1-14 days. Most (10 of 12 facilities) reported an average wait time of 7 days or less to receive non-emergency services.

Medical Personnel/ In-house services

Nine participating facilities reported providing health services at the facility (in-house). Eight of these facilities reported services from a medical doctor at their facility at least 8 hours per week (6 facilities had a doctor available at least 20 hours per week). At one facility the medical doctor was an employee while at the others, the doctor worked by contract. One facility that provides health services has no medical doctor but employs a half-time (20 hours/week) nurse practitioner. The nine facilities with health services all employed 1 or more full-time registered nurses. Emergency Medical Technicians are employed at 5 facilities; 4 facilities employ social workers; and 5 facilities reported part-time dentists.

Table 4. In-house health services

Service provided in-house	Percent of facilities (n)
Primary care	100 (9)
Urgent care	100 (9)
Prenatal care	44 (4)
Family planning	33 (3)
Referrals to specialty care	100 (9)
Behavioral health	78 (7)

Note: Total of 9 facilities reported in-house health services

Minimal lab services are provided at some detention facilities. Urinalysis tests and TB tests are conducted at 5 of the 12 facilities. All other lab tests for inmates are done through the state lab, private labs, or local hospital labs. In those facilities that have NMDOH public health staff come into the facility to do testing for sexually transmitted diseases, the lab work is done by the NMDOH lab. Six facilities reported having in-house pharmacy services. Other facilities either use local hospital pharmacies for inmate medications or contract community pharmacies that provide medications for inmates. The survey also asked about the location and provision of other health services (table 5).

Table 5. Other health services by location

Service	Percent of facilities offering service in-house (n)	Percent of facilities reporting service offered in community (n)
Psychiatry	58 (7)	42 (5)
Substance abuse counseling	67 (8)	25 (3)
Opiate replacement	8 (1)	17 (2)*
Rape counseling	25 (3)	67 (8)
Domestic violence counseling	42 (5)	33 (4)
Anger management	50 (6)	33 (4)
Health education	67 (8)	25 (3)
Medical detoxification	50 (6)	25 (3)
Dental	58 (7)	42 (5)

*8 facilities reported these services were not available in facility or community

Note: Percent totals may not total 100%, in some cases facilities reported a service not existing in-house or in the community.

Testing and screening

At 5 facilities, most of the testing for HIV, TB, hepatitis B and C, syphilis, gonorrhea, and chlamydia is done in the facility by the NMDOH local public health office, using the NMDOH lab. Two facilities send their inmates to a public health office for testing, again using the state lab. Two facilities do these tests in-house and use a private lab. One facility uses the local hospital for these tests, while another uses the local hospital for HIV, TB, and hepatitis B and C tests, but the local public health office for syphilis, gonorrhea, and chlamydia. This information was not available for two facilities. The majority (9) of facilities reported that they test inmates for these diseases (HIV, TB, hepatitis B and C, syphilis, gonorrhea, and chlamydia) only if requested the by an inmate or when an inmate shows clinical need. Two facilities reported only testing for these diseases in those inmates with risk factors and one facility reported that all inmates are tested. Two facilities reported a relationship with Extension for Community Health Outcomes (ECHO) project, a telehealth project through University of New Mexico.

Infection Control

All 9 of the facilities with in-house health services reported having protocols in place for nurses and clinicians to manage chronic and infectious disease cases. Five of the 9 facilities reported having an infection control coordinator, six have infection control plans, and five have an infection control committee (some committees are sub-groups of quality improvement/assurance committees). Only 3 facilities reported having a current notifiable conditions list from NMDOH. Those without lists were sent laminated copies of the list (excluding the federal facility in El Paso, TX). At 10 facilities the health services administrator or medical director are responsible for reporting notifiable conditions among inmates to the NMDOH local public health office. One facility reported contact with IDEB in Santa Fe.

Processes for reporting notifiable conditions varied; however, most often the local NMDOH public health nurse is called and in a few cases, the local hospital is called. When asked how many times the facility reported a notifiable condition in the past 6 months, only 5 facilities said they had reported cases; 3 facilities reported 5 or fewer cases in past 6 months and two facilities reported more than 30 cases. The other facilities either reported no cases, the information was unknown to them, or they stated that the NMDOH public health office reported the cases and they did not know how many.

Discharge Planning

Four facilities reported that they had procedures for discharge planning. The discharge procedures differed among the four facilities. At one facility, a team works with an inmate starting 90 days before release. Another facility reported that a social worker provides information sheets to inmates about community resources before release. The third facility reported that staff make future appointments for health services in the community for the inmate being released. The fourth facility reported participating in a “meet and greet program” and TB Net. Among the facilities that do not provide discharge planning, it was reported that the health services unit does not always know when an inmate is going to be released which makes discharge planning very difficult. Health services staff are not always aware that an inmate is being released or transferred and therefore are not always able to 1) prepare/ compile an inmate’s medical information before release/ transfer and 2) make arrangements in the community for follow-up care for the inmate.

Binational cases

Of the 11 facilities reporting that they believe they have inmates who are not in the U.S. legally, all said they manage all infectious disease cases the same with no regard for nationality or legal status. When a notifiable condition is identified in a binational inmate, facilities reported that they follow the same reporting procedure for all inmates; they contact the local NMDOH public health office. Since neither county detention center nor state correctional facilities repatriate inmates in the U.S. illegally, their inmates would either be released to the community or transferred to another facility. Only the inmates at the federal facility in El Paso, TX may be repatriated to another country. Four facilities reported that if the inmate is being transferred to Immigration and Customs Enforcement (ICE), they notify the officers transferring the inmate about any medical conditions. When transferring inmates to ICE, 5 of the 10 (not including ICE) facilities reported they transfer the inmates with a transfer summary of pertinent medical information and 4 facilities reported that they send inmates with copies of their medical records and a treatment plan for continuation of medical care to the accepting agency. Additionally, 4 facilities reported that they send a full course of medication with a transferring inmate. Five of the 10 facilities that transfer inmates to ICE reported that they coordinated case management for inmates with ICE. The federal facility reported that for those inmates with an infectious disease slated for repatriation, a transfer summary with pertinent medical information and 7 days of medication are provided to the detainee. For those inmates who are contagious at the federal facility, the inmate is isolated and it is recommended that the inmate not be deported until the infectious period ends or treatment is completed.

Areas of Need

Participants were asked, out of a list of items related to providing health services to inmates, which 2 were the most difficult to provide in a safe and timely manner. More than half the facilities reported that providing behavioral health services was difficult. The second most difficult service to provide (4 facilities) was assessment of inmates (history, physical, screening) within the first 14 days of incarceration. Three facilities indicated that discharge planning was also a difficult service to provide in a safe and timely manner.

Participants were asked to identify a single category of health problems that would benefit most from added resources to the facility’s health services budget. They were given a choice of three areas: infectious diseases, chronic diseases, or behavioral disorders. Eight of 12 facilities identified behavioral disorders as the area that would benefit most from additional funds to their facility’s health services budget. This corresponds to the reported lack of behavioral health providers and services being offered in facilities.

Lastly, the survey asked participants what they thought the New Mexico Department of Health could do to help detention centers improve health services for inmates. There were 4 main themes to the responses for this question.

- 1) Designate/create liaisons between NMDOH and county detention centers – Detention center staff noted that many of the health, mental health and substance abuse issues could begin to be addressed if existing services were coordinated between detention centers and NMDOH public health staff at a local level.
- 2) Increased public health presence - Participants said that they would like to have more NMDOH public health collaboration. Additionally, one facility thought it would be helpful to have Disease Prevention Specialists or nurses in the facility on a regular basis to coordinate infectious disease testing and treatment.
- 3) Behavioral health services - Facilities would like to have more behavioral health services available in-house, more community behavioral health beds, and quicker referral in the community for behavioral health services, including substance abuse treatment services. One facility specifically would like to have 30, 60, and 90 day substance abuse treatment programs in the detention facility.
- 4) Address the issue of people losing benefits while in jail - Detention center staff noted that many inmates lose medical benefits from the VA, Medicaid, and Medicare while in jail. When these people are released, they cannot pay for the medications or health/mental health services they require to function.
- 5) Prenatal care by public health in detention centers - Two facilities reported that they always have several pregnant women at their facilities and they are in need of prenatal care services in the detention center.
- 6) Develop and maintain a directory of NMDOH public health staff and detention center staff.
- 7) Present infectious disease information at statewide detention center meetings.

Lessons Learned

The plan for this survey included interviewing county detention centers, some state corrections facilities and a couple of federal facilities. After interviewing one state corrections facility, it became clear that state and county facilities have very different issues regarding health services and infectious disease reporting and management. The average length of incarceration at the state facility was 15 years, compared to 6 months for the county detention centers. These were averages: some county detention centers reported that individuals could be in their facility for 1 or 2 days, making it difficult to get assistance for people who may need to be referred elsewhere for services. It may be useful to follow up this survey with questions to the county detention centers to collect detailed information on length of incarceration, length of wait time for specific types of service, and loss of medical benefits. Additionally, detention centers could be asked about whether or not they collect inmate information on nationality and immigration status.

In this study, one integrated survey tool was used to collect administrative information and health services related information. In most cases, at least two different people were needed to answer the questions. Health services staff were required to research the administrative information (e.g., average length of incarceration, average age by sex, race distribution). In the future, it may be easier for participants if all of the administrative information was on a 1 page sheet that could be faxed or emailed straight to the facility administrator and the interview could focus on the health services related questions. In doing this, more detailed information could be collected on inmate demographics providing more specific characterization of the inmate populations served by detention facilities.

Recommendations

While most facilities interviewed for this project did report contact with local NMDOH public health offices, involvement of public health staff varied greatly by county. The focus of detention center contact with public health is usually around testing and screening for sexually transmitted diseases. However, in cases where public health staff test inmates for HIV, TB, hepatitis B and C, gonorrhea, syphilis, and chlamydia, the detention centers did not always know how many cases were found at their facility and reported that tracking infectious disease information was done by NMDOH.

It is clear that some partnerships exist between detention centers and local public health offices. Identifying cases and reporting them is only half of the process. The other half involves analyzing, monitoring, and presenting the epidemiological data back to the detention center staff so that they can understand and make use of the information in their facilities. It is the action taken, in this case by detention centers, as a result of the surveillance data, that give the data purpose. The suggestion by participants that NMDOH assign a detention center liaison, provide directories of public health staff, and present surveillance information at detention center regional and statewide meetings are relatively simple steps that could be taken to bring the data back to detention centers and ultimately improve services.

The issue regarding the need for more public health physician, mid-level medical provider and/or nurse time at detention facilities is a decision often made in public health regions and subject to funding, staff, and other resource limitations. NMDOH detention center liaisons, if utilized, could be involved in the dialogue (and in some cases start the dialogue) between detention centers and regional public health staff. Assisting detention centers with demonstrating positive outcomes resulting from current public health clinical staff time in the detention center could be used to advocate for increased staff time.

It is clear from the survey responses that a lack of behavioral health and substance abuse treatment services for inmates is a concern of detention center health and administrative personnel. Participants noted a lack of in-house behavioral health services, long waits for referrals to behavioral health providers and not enough behavioral health beds in their communities. NMDOH can have a role in advocating for inmate behavioral health services by examining connections between repeated incarceration and behavioral health and substance abuse issues.

Loss of medical benefits while in a detention center is a serious problem. The facts about loss of benefits from Medicaid, Medicare, and the VA should be documented. The loss of medical benefits can lead to inmates not getting medication or services upon release. Depending on the inmates medical conditions, especially mental health conditions, lack of services and medication could foster a situation leading to repeated incarceration. NMDOH can advocate for change in benefit rules and regulations and, through the utilization of detention center liaisons, work to prevent loss of benefits and coordinate referral to appropriate community providers and services upon an inmate's release.

NMDOH needs to help address coordination and improvement of health services within and between detention facilities. Service capacity varies tremendously between facilities and the role of local and regional NMDOH public health staff involvement in detention center service provision also varies greatly. Unlike some states, NMDOH currently lacks any regulatory or advisory role over the extent or quality of care delivered in detention facilities. By comparison, North Carolina has adopted state regulations, commonly known as the North Carolina Jail Health Standards, that specify minimum jail health requirements and define specific state mandated policies and procedures, including yearly review of each facilities medical plan by the local health officer.

The level and extent of services available at any given county detention facility in New Mexico will always be dependent on a variety of factors, not the least of which are available funding and access to appropriate personnel. In rural counties in particular, these issues may always limit service provision. However, minimum services standards need to be developed that apply to all facilities, including integration with existing local and regional public health capacity. *Toward this goal, it is recommended that NMDOH lead the way in forming a Detention Center Health Task Force that would bring together representatives from NMDOH, detention centers and counties to begin the process of addressing a set of minimum standards for jail health statewide.*

A Local Model: Public Health at the Metropolitan Detention Center in Bernalillo County.

In New Mexico, collaboration between county detention facilities and NMDOH public health currently exists in a several locations. The collaboration between NMDOH Public Health Division Region 3 staff and the Metropolitan Detention Center (MDC) in Bernalillo County is an important example because it highlights how public resources can be utilized to provide needed services to inmates and simultaneously target at-risk members of our communities.

Since January 2004, NMDOH has had a “full service” public health office at the Bernalillo County Metropolitan Detention Center for specified services. The office is staffed by a nurse manager and clerk. A nurse practitioner and physician are at the jail three days a week for clinical services. Clinical programs provided by NMDOH include: family planning, sexually transmitted disease control program including partner notification services, HIV counseling and testing. Contract nurses from NMDOH Hepatitis Program provide immunizations and education, testing, and referrals for hepatitis C. The Department of Health also provides medications for HIV-positive patients whose care is coordinated by infectious disease nurses in consultation with the NMDOH HIV Medical Director. The program provides referrals to public health and primary care services after release. Community-based organizations funded by NMDOH provide harm reduction, HIV testing, and health education services at MDC. These include the South Valley Male Involvement Program, Healthcare for the Homeless, and NM AIDS Services.

A new program based at the NMDOH Stanford Public Health Office in Albuquerque recruits opiate addicted inmates while they are incarcerated and refers them to NMDOH for initiation of treatment with buprenorphine/naloxone (Suboxone) upon their release from jail. The goal is to start medication assisted treatment before the client relapses to heroin use. Once stabilized, the patient is referred to a primary care provider who will continue maintenance therapy with Suboxone, provide other medical care, and also help to arrange for counseling and other psychosocial support.

Since November 2004, a publicly-funded methadone maintenance program run by a publicly-funded private contractor has been providing methadone, counseling, case management, and medical consultation to inmates at MDC who were enrolled in a community methadone program before their arrest. Through this program, 40 to 60 inmates receive methadone doses seven days a week.

Conclusion

This survey initially set out to describe how border county detention centers were handling binational infectious disease cases. In the end, it demonstrated that binational infectious disease cases are apparently managed the same as all other infectious disease cases in county detention centers. Unfortunately, for many county detention centers, needed inmate services are sparse or non-existent. The recommendations above, although not specifically addressing binational cases, will benefit all inmates at detention centers and the communities in which they operate.