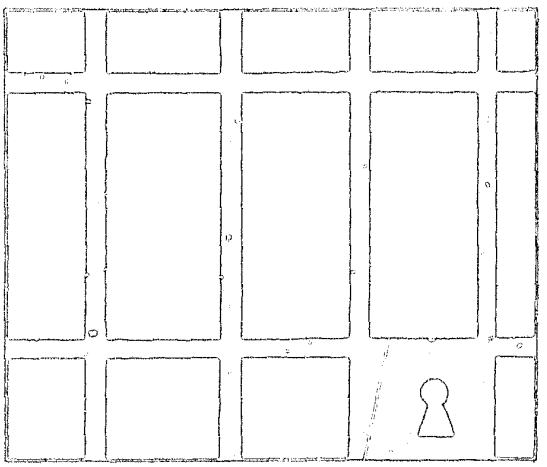
PROCEEDINGS

2nd National Conference on Medical Care and Health Services in Correctional Institutions



Palmer House Hotel
Chicago, Illinois
October 27-28, 1978

Sponsored by
American Medical Association

AMA Pilot Program To Improve Medical Care and Health Services in Correctional Institutions, supported by a grant from the Law Enforcement Assistance Administration, U.S. Department of Justice (Grant No. 78 ED-AX 0023) under the Omnibus Crime Control and Safe Streets Act of 1968.

SECOND NATIONAL CONFERENCE ON MEDICAL CARE AND HEALTH

SERVICES IN CORRECTIONAL INSTITUTIONS

The 1978 National Conference on Medical Care and Health Services in Correctional Institutions attracted 386 registered participants from 40 States, the District of Columbia, and Canada. The enthusiasm and unity expressed at the meeting were noteworthy.

These proceedings of the Conference are prepared as a service to the registrants and other individuals and organizations concerned with health care delivery in detention and correctional facilities. It was possible to use only those papers received prior to a deadline in order to facilitate publication.

The ideas and opinions advanced by all speakers except AMA officers and staff are not necessarily those of the AMA. Further, points of view and opinions stated in this publication do not necessarily represent the official position of the U.S. Department of Justice. Because the speakers have not had the opportunity to review this summarized material, any further reproduction or use should be cleared in advance with the individual concerned.

We wish to express sincere thanks to the speakers, panelists, and participants for their contributions in time and talent.

Joseph R. Rowan

Joseph R. Rowan
Conference Coordinator

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AMA PROJECT TO IMPROVE MEDICAL CARE IN CORRECTIONAL INSTITUTIONS: OVERVIEW*

For many years the American Medical Association has engaged actively in efforts to improve medical services for the nation's medically underserved. We have initiated programs, published papers and monographs, devised publicity and testified before Congressional committees in behalf of migrant workers, the American Indian, the center city poor, the mentally retarded, the alcoholic, the mentally ill. Consequently, when we were asked by representatives of the American Bar Association to demonstrate concern about the plight of the incarcerated, their request fell on receptive ears.

In 1971 the members of the Commission on Correctional Facilities of the American Bar Association voiced their concern to the AMA about the defective quality of medical services in correctional institutions, particularly in jails. In discussions with representatives of the National Sheriff's Association and the American Correctional Association, it became clear to us that conditions were lamentable. To obtain more exact data than were then available, the AMA composed a four-page questionnaire regarding medical services and sent it to 2,900 sheriffs. Surprisingly, over forty percent responded and they painted a dismal picture of health care accessibility in their respective institutions. Respondents variously expressed discouragement, concern, indignation and hope as they described outmoded facilities, inadequate staffs, limited funds and uninterested doctors.

Impressed by information the questionnaire disclosed, the AMA's Board of Trustees allocated $50,000 for preliminary study and planning of a program to improve medical care in correctional institutions. Central office staff were assigned to the project part-time, and an advisory committee was formed to represent not only medicine but also sheriffs, prisons, law, rehabilitation, government and inmates. It was decided to limit the initial corrective effort to jails, and the outline for a three-year project was presented to a number of potential funding sources. In 1974 the Law Enforcement Assistance Administration (LEAA) indicated definite interest; thus with the help of LEAA staff, a three-year pilot project was fashioned and refined; full-time staff with expertise in corrections was hired; and a new Advisory Committee was appointed. A grant request was submitted and approved for funding by LEAA. Day One of the project was November 1, 1975.

As finally approved by LEAA, the program was composed of three major subprograms: (1) the development of model health care delivery systems for jails; (2) the construction of minimal standards and the implementation of a national certification program; and (3) the establishment of a national clearinghouse of information on jail health. An independent organization, Blackstone Associates, was hired to monitor and evaluate the program as it proceeeded. This function was later transferred to Jaye Anno Associates.

Shortly after receiving the grant, the AMA sent a descriptive announcement to all state medical societies requesting each society interested to submit a plan for participating in the study, utilizing selected jails in its state. Because of limited funds, only six states were selected to serve as subgrantees for the pilot projects. The successful applicants included medical societies in three midwestern states (Indiana, Michigan and Wisconsin), one southern

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*Presented by Herbert C. Modlin, M.D., Chairman, AMA Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions.

(Georgia), one on the east coast (Maryland), and one on the west coast (Washington). Each of the selected state medical societies then appointed a medical advisory committee and hired a project director. They in turn selected four or five jails from urban and rural settings to serve as pilot sites. The next step was to develop a pre-profile of the jails and their existing health care delivery systems. That data collection was twofold in purpose. First, the information obtained would help the states identify deficiencies in their jails so that model health care delivery systems could be designed to correct them; second, the data would serve as the base line profile against which any subsequent changes evolving in the delivery systems could be measured.

The 30 jails surveyed included 10 small, 12 of medium size and eight large jails. Eighteen of the 30 served rural areas, seven suburban areas and five urban areas. The average daily population ranged from a low of four to 1,500, and the number of inmates received annually varied from 220 to a high of 68,000. In the survey of these jails, nearly one-third were found overcrowded, and there were many obvious and varying deficiencies in health services. Less than half of them provided a regular sick call, and only 17 percent had sick call on a daily basis. Twenty-seven percent lacked any emergency equipment, and in six percent there was not even a first aid kit. Less than one-third of the jails had any written policies regarding health care delivery to inmates. Sixty percent maintained no medical treatment records at all.

Our next step was to gather data concerning the inmate patient profile and to indicate medical services needed. Each of the states organized volunteer teams of physicians, nurses and medical technicians to evaluate a representative group of inmates. We were able to study 641 inmates in 28 pilot jails. The examination included a health history, physical examination, laboratory tests and each inmate's assessment of the current health care delivery system in the jail holding him.

Data collected from that part of the project replicated those collected in our 1972 survey. A significant number of inmates had never had a physical examination, had never been to a dentist, and had never had their eyes examined. Eighteen percent of the inmates reported using heroin on a daily basis prior to incarceration. Fifty percent reported the daily use of alcohol. Many of them described withdrawal symptoms during their first few days in jail.

The most striking finding concerned communicable diseases. Twelve and one-half percent of the 641 inmates were graded abnormal on tuberculosis tests and six percent positive on tests for syphilis. Findings of abnormal liver function in 30 percent suggested hepatitis, and in 12 percent urine abnormalities were observed.

To our surprise 90 percent of the 641 inmates presented at least one medical complaint, and in 60 percent of these cases some kind of follow-up medical care was recommended by the medical examiner. Physical examinations revealed about three abnormalities for each examinee, and of these one in every three was so severe that the examining physician recommended follow-up treatment. Most of these conditions had not been previously detected or treated by the jail staff.

Participants in the various state projects have demonstrated ingenuity

in discovering techniques to meet the manifest deficiencies in their pilot jails. Among the methods being tested are the maximal use of physicians' assistants, the assignment of nurse-practitioners to women inmates with gynecological problems, the training of correctional officers from small jails in health screening skills, and the devising of a uniform medical records system for all the jails in a state.

While the central office and state staffs were occupied with these activities, the Advisory Committee worked tirelessly to arrange a set of medical Standards for jails. These Standards were revised, field tested by the state committees, criticized by representatives of the National Sheriff's Association and the Commission on Accreditation for Corrections, refined by the central office staff, and revised again. In their twentieth edition, they serve as the current criteria in identifying jails eligible for a certification of accreditation. The certificate attests that a given jail meets at least 90 percent of the Standards. It was our pleasure to award the first certificates at the first national conference last year. A total of 24 jails have been accredited.

Meanwhile, back at the office, the clearinghouse component of the project has been accumulating medical and legal data including court decisions, preparing a comprehensive bibliography, and writing and publishing a total of 19 informative monographs on such diverse subjects as the role of state and local medical society jail advisory committees, the uses of volunteers in jails, the recognition of inmates with mental illness, constitutional issues of the prisoners' rights to health care and use of allied health personnel in jails. The staff has also produced a 22-minute award winning documentary film, "Out of Sight, Out of Mind."

As we approach the end of the third year of the project, we are gratified by how much has been accomplished. We have experienced the usual unpredictable delays, differences of opinion, false starts, dead-ends, changing regulations, and frustrating red tape. The most persistent problem, not necessarily the most difficult, has been constant attempts to nibble away at the number and quality of the Standards by a wide variety of well-meaning but unthinking persons. The Advisory Committee has been hard pressed at times to hold the line in the face of complaints that the Standards are too high, too unrealistic, too costly and too difficult to implement. We have, however, held the line and insisted that those Standards are indeed the minimal requirements the medical profession can sponsor. As the project progressed, our stand was buttressed by the number of jails, small, medium and large, urban and rural, that met the specified Standards and received certification.

All in all the difficulties have been manageable; steady progress has been maintained. Resultant to diligent efforts of the state medical society committees, 18 of the original 30 pilot jails have to date received certification of their medical programs. One of the least anticipated effects is that chronic and convalescent care is now provided in 21 of these jails. Adequate in-house medical clinics are provided by 20 jails. Complete health appraisals are given all inmates within 14 days of admission in 15 jails, and regular sick call is provided in 22 jails. A striking change is that detoxification for both alcohol and drug abusers is now supplied by 21 jails; the number was seven at the start of the project. Regular mental health services are now available

in 21 jails. Many other improvements have been made in institutions participating in the program.

So much for the past. What of present activities and future prospects? Currently we are actively engaged in four projects, the first of which is continuation of the jail project. Each of the six pilot states will evaluate and assist eight more jails to meet the Standards and achieve certification. Nine additional state medical societies have joined the project, have organized active committees, and are learning the ropes, each starting with five jails. We have conducted a training course in receiving screening and health education for personnel of small jails, including booking officers, nurses, LPN's, and medical technicians. The first such pilot program was presented in Seattle in 1978, and additional sessions were just completed in Houston, Texas and Evansville, Indiana. The curriculum for these training sessions has been experientially tested and revised and will be published for wide distribution by the National Institute of Corrections.

In 1974, the original AMA Advisory Committee expressed concern about medical services in jails, penitentiaries, women's prisons and juvenile institutions. The information available at that time indicated that jails were most in need of attention, and the full resources of the project were concentrated in that area. Now we are in a position to turn our attention to the other institutions. A new task force is concentrating on defining medical Standards for prisons. Using the Jails Standards as a point of departure, this task force has read, discussed, argued, revised and revised again. The tentative prison Standards are in their fifth edition following criticism and contructive input from medical and adminstrative personnel in penitentiaries in 20 states. The facilitating, coordinating and catalyzing functions of state medical societies will be exerted in encouraging prisons to adopt the Standards in order to achieve a level of excellence which will merit AMA certification.

Another committee is involved with determining appropriate medical Standards for juvenile institutions. The third draft of its proposal is being field tested in Michigan, Massachusetts and Wisconsin. After further criticism and revision the results will be published and submitted to relevant institutions.

Two special committees are paying particular attention to mental health problems in jails and prisons: such knotty issues as suicide prevention, substance abuse detoxification, and the proper use of psychotropic medication in a prison setting. They have circulated a training manual to assist correctional officers in recognizing and managing possible major psychiatric problems of inmates.

The task force of chemical dependence-drug abuse (including alcoholism) has tackled the complex problem of managing these serious difficulties in a prison or jail setting. They have composed a detailed description of an effective detoxification program and continued treatment of the dependent personality not only in the institution but after release.

In conclusion, after three years of experience, I am genuinely impressed by what has been accomplished, particularly since this project has not functioned as a bureaucratically organized, centrally controlled and led endeavor. The state committees have been granted considerable autonomy; the personnel are

mostly voluntary; the political and budgetary conditions in several states vary considerably. In addition we have necessarily close relationships with the National Sheriff's Association, the American Correctional Association and the American Public Health Association among others, all with varied interests and needs. Considering the complexity and diversity of all the people, agencies and pressure groups involved, the steady progress of the project is indeed remarkable. The devotion and hard work of the AMA staff is in no small part responsible for this success. But I must salute also the dedication and the belief by all participants, from the AMA Board of Trustees to the jailer in Podunk, that the incarcerated are members of our society with the same medical needs and civil rights as other citizens. At the risk of seeming naively enthusiastic, I wish to state without reservation that the future direction of this project is assuredly onward and upward.

ACCREDITATION -- A NEW PRIORITY
FOR THE NATION'S JAILS*

We are all familiar with the quotation, "Stone walls do not a prison make, nor iron bars a cage."

But not so familiar with Wordsworth's words, "Stone walls a prisoner make, but not a slave."

One may question Wordsworth. Did he mean man's spirit must still remain free, even if his physical being is restrained? Certainly, in many ways the prisoner is, in a physical sense, a "slave." But even there, the courts are moving away from the concept of total state control of the imprisoned person and asserting that there are constitutional rights which the incarcerated retain. He may lose his right to vote, his right to hold public office, and his right to be a juror and, in some jurisdictions, some of his civil rights; but the prisoner retains many of his civil rights and the right to basic needs and protections. In recent years, adequate medical care has been added to that list of basic needs to which the prisoner is entitled.

In the case of Fitzke V. Shappell, 468 F 2d 1072, decided in 1972, the Court of Appeals said:

"An individual incarcerated for a term of life for the commission of some heinous crime, or merely for the night to "dry out" in the local drunk tank, becomes both vulnerable and dependent upon the state to provide certain simple and basic human needs. Examples are food, shelter and sanitation. Facilities may be primitive, but they must be adequate. Medical care is another such need. Denial of necessary medical attention may well result in disabilities beyond that contemplated by the incarceration itself....Restrained by the authority of the state, the individual cannot himself seek medical aid or provide the other necessities for sustaining life and health."

We've come a long way since the beginning of the penal system in this country. But there is so far to go -- so far yet to go to change our thinking and adjust priorities so that the correctional system -- and most particularly the system on the local level -- receives the attention it needs.

The jail as a place of detention has existed in one name or another since man's recording of history. The more modern concept of the jail

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*Presented by Bernard P. Harrison, J.D., Group Vice President, American Medical Association.

began in the 12th century. The early prisons were collecting depots for accused persons, and jails then were solely to confine and not to punish.

Jails, as originally conceived, were places to detain suspected offenders until they could be tried. Later, in England, the House of Correction (or Bridewell) became the punishment institution. Still later the two -- The House of Correction and the jail -- gradually merged. The same vacility with the same keeper housed the suspected offender waiting trial and the convicted offender. In what were usually crowded quarters with little or no amenities, were the innocent and the guilty.

These jails then "traveled" to the new world. They were imported by the early settlers of our country who brought with them the institutions of the country which they had left. Whenever a settlement of some size was founded, there was soon to be found the colonial counterpart of the English jail.

The colonial jails were similar to each other. They often were in the settlement center, with the whipping post nearby.

Even in the more substantial buildings, there were no "cells." Instead there were small, separate rooms, each holding two dozen or more prisoners. The only heat was that which the prisoners could create themselves. Food was purchased from the jailor or contributed by the town folk. Medical care was virtually non-existent, except sometimes in the most severe cases.

The jail today is not unlike the jail of colonial times. It houses as punishment short term offenders and it is still a place to detain those charged and awaiting trial. And it still houses the alcoholic, the narcotic, the prostitute, the derelict, and the material witness. There are first offenders and the young, the frequent offender and the old.

A jail census conducted in 1970 by the U.S. Bureau of the Census under an agreement with LEAA, found 4037 jails meeting the definition of "any facility operated by a unit of local government for the detention or correction of adults suspected or convicted of a crime and which has authority to detain longer than 48 hours."

Typically, the jail is under the jurisdiction of the county government. It often houses a population that is more diverse than any other local institution. The 1970 census included 160,000 persons confined. Of these, 27,000 had not been arraigned, nearly 9,000 were awaiting some sort of post conviction legal action, 69,000 were serving sentences, and 8,000 were juveniles. So, once again we see those accused but not yet convicted, misdemeanents, and juveniles all together in the jail.

In addition to what one usually recognizes as the purpose of the jail,

that institution is called upon to handle a variety of tasks more social welfare in nature than correctional or penal. For example: the detention of the witness for his protection or to insure his presence, or the jailing of the alcoholic, drug addict, mentally disturbed person or family or social miscreant to ease a community problem.

The jail faces many problems today. One of the most apparent difficulties lies in the inadequacy of the physical facility. The national jail census found that 25% of the jails in use were more than fifty years old. And most of these institutions had had little or no modernization in all that time.

The problem of inadequate facilities was no greater than the need to upgrade the staff. The census data showed that too many of the jails had too few personnel; lack of funds meant inadequately trained people, and they were generally underpaid. From a report of the National Advisory Commission on Criminal Justice, Standard and Goals we learn that in 1970 there were 5-6 inmates per full-time equivalent employee. Considering three shifts per twenty-four hours, seven days a week, we have an average of 1-2/3 full time workers per shift, with an average of 40 inmates. As the Commission stated, "Given the nature of jail architecture and the numerous duties the employees must perform both inside and outside the facility, these staffing levels are simply too low to permit regular supervision of inmates.

In 1972 the AMA surveyed a sample of 1159 jails across the country to determine the level of medical care available or provided to inmates.

We asked what types of medical facilities are available in the institution. More than half replied "first aid only." Nearly 20% said none at all.

We asked if they had facilities for the mentally ill, the chronically ill, drug addicts, alcoholics? The most commonly available facilities within jails, we were informed, were those for slcoholics and mentally ill, but under 20% were affirmative.

We asked if inmates received physical examinations, and 85% said only if they had a medical complaint; another 10% said no inmates received physical examinations.

There were other pertinent questions and equally pertinent responses. In the main, they provided an indictment of our society's jails. And that AMA survey, with a consciousness for its obligation to society, led the AMA to develop standards for health care of jail inmates and to provide a lasting program to implement the standards in the nation's jails. The nub of the program is the concept of accreditation.

An accreditation system means a program whereby jails are evaluated upon an acceptable set of carefully developed standards and when found meeting such standards, are certified or accredited. Here's how it works in the AMA-state medical society program:

A jail enters the Accreditation Process when an Application for Accreditation from the person legally responsible for the jail is accepted by the American Medical Association, and the official is notified of his status as an applicant for Accreditation. The applying official may withdraw his application at any time.

Next, the self-evaluation questionnaire is reviewed by AMA's Accreditation Program staff. Should the questionnaire reflect that the jail is in sufficient compliance with the Standards to warrent accreditation, the jail is notified that its status in the accreditation process has been changed to that of Candidate for Accreditation. If, however, a questionnaire indicates that a jail's medical services system does not sufficiently meet the Standards, the areas for improvement will be communicated to the official responsible for the jail and technical assistance will be offered to assist the jail in reaching a higher level of compliance with the standards. A second self-evaluation questionnaire is provided within six months to hopefully place the jail in the status of Candidate for Accreditation.

During the period of Candidacy, an on-site field monitoring survey is conducted by the state medical association. The survey team, consisting of physician and non-physician members, interviews various levels of jail personnel, health care providers and inmates; they essentially review all aspects of jail operations and administration related to medical care. The field report from the on-site survey team, including any comments regarding accreditation, is then forwarded to the AMA National Advisory Committee for final action.

After reviewing the application, the self-evaluation questionnaire, on-site survey documents, and reports and comments of the state medical association, the AMA may grant or deny accreditation. The jail official applying for accreditation receives a full report regarding the action taken.

If accreditation is not granted, the official legally responsible for the jail may request a review of the decision.

In all facets of the accreditation process a confidential relationship is established between the jail and organized medicine, represented by AMA and the state medical society. This policy is based on the belief that criticism, if kept confidential, is more likely to be uninhibited and to promote needed improvements.

The American Medical Association has been involved with national accreditation programs for a number of years. Probably the best known accreditation program in which the AMA participates is the Joint Commission on Accreditation of Hospitals which has three other corporate sponsors in addition to the AMA: The American Hospital Association, The American College of Surgeons, and the American College of Physicians. The Joint Commission on Accreditation of Hospitals (JCAH) surveys, upon application, some 7,000 public and private hospitals across the country.

One may imagine that, at first, accreditation was a status symbol: to be accredited by the JCAH indicated to the medical and health professions and to the community and local government, that the hospital was "qualified." Subsequently, accreditation became such an integral part of the quality of care being provided that it was included in some state and federal laws as a requirement for participation in publicly funded programs -- most notably, the provision for JCAH accreditation for hospital participation in the Medicare program.

An accreditation system provides hope for continuity of program. Many good programs which seek to make major changes fail only because of the lack of continued funding. The JCAH and other successful accreditation programs have succeeded, and much of their success is due to their ability to generate funds to sustain the program -- to be self sustaining.

A good accreditation program will serve all who are part of the corrections system. For example, the sheriff whose jail has been accredited can defend his institution against attacks from the legislature, press, and public. The sheriff whose jail has not been accredited has "a handle" for his demands on the county board or state legislature for additional funds to meet the deficiencies found when he sought accreditation.

Accreditation also meets the needs of the public and governmental bodies. It encourages greater public support for the institutions because no community, no county board and no state legislature wants its correctional facility identified as inferior to other similar institutions in other counties or other states.

Continuity of the accreditation program is assured through funds from jails which apply for the survey accreditation process; for example, the county jail would include in its annual budget a sum sufficient to cover the accreditation process, that is, the application, the survey and the evaluation. These funds should allow the program (after the initial start-up years) to sustain itself and provide for growth.

An accreditation program needs to be honestly and fairly imple-

mented. Its credibility, initially, will be tested by the standards used to measure the jail. They need to be fairly, realistically and honestly developed, with the major voice in each group of standards being that of the profession to which the standards relate. Medical standards should be the province of the medical people.

A program of accreditation of qualified jails provides, I submit, the most promising way of upgrading the quality of jails. With standards developed by the professions, with support through self-generated funding, and with a spirit of dedication by all who have decided that the time has finally come to place some of our national priorities in this area, history may well relate that the correctional system has taken a giant step into the community of man.

Source Information

"Constitutional Issues of the Prisoner's Right to Health Care" - W.P. Isele, American Medical Association.

"Report of the President's Commission of Law Enforcement and Administration of Justice" - Corrections (1967).

"Medical Care in U.S. Jails" - A 1972 AMA survey.

"The County Jail" - New Horizons in Criminology (1967).

Reports of the AMA Board of Trustees to the House of Delegates: Report C, Winter 1976; Report M, Summer 1978.

"Local Adult Institutions" - National Advisory Commission on Criminal Justice, Standards and Goals (1973).

"Concept Paper for a Joint Effort to Improve Health and Living Conditions of Inmates of Jails and Prisons" - B.P. Harrison, August 1977.

"Accreditation of Medical Care and Health Services in Jails, 1978" - American Medical Association.

TENTATIVE STANDARDS FOR THE TREATMENT OF THE CHEMICALLY DEPENDENT IN OUR JAILS AND PRISONS*

I reviewed the charge given to the task force by the LEAA and the AMA, which basicly consists of developing standards for the care and treatment of chemically dependent inmates in jails or prisons. The charge is as follows:

> The nation's concerns about drug and alcohol abuse in the community are not diminished in jails and prisons. To date, there has been a plethora of articles and scientific papers dealing with almost every facet of chemical dependency. However, none to date has received unanimous acceptance by the persons ultimately responsible -- medical care providers. The AMA proposes to develop standards and models that are realistic and acceptable to both the medical profession and other concerned national groups.
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> The issues of the diagnosis of chemical abuse has been subject to controversy regarding the kinds and levels of clinical laboratory tests and clinical observations employed. As with diagnosis, the different treatment algorithms for chemical abuse have outnumbered those in actual operating systems. It is the intent of the AMA to review the area of actual operating systems and publish standards for the screening, diagnosis, referral and treatment of inmates in the community based programs, jails and correctional institutions. These standards will be universally applicable and will be of specific value to medical practitioners who have no extensive experience in the assessment and clinical treatment of chemically dependent patients. The Project will also analyze the drug/alcohol treatment requirements in Part E, Section 453 (9) of the Crime Control Act.
>
> There are many effective referral patterns for clinical and rehabilitative treatment of patients who are chemical abusers. Such referral systems have no proven effectiveness in regard to the incarcerated patient. Likewise, many self-help groups who have had great success in dealing with the problems of their members who come from the same social stratification have not been effective in dealing with groups from other social levels. It is the intent of the AMA to design model referral patterns to deal with the kind and time span for the effective referral of incarcerated patients who are dependent on chemicals.
>
> To accomplish the task of developing standards for the screening, diagnosis, treatment and referral of patients dependent on chemicals, the AMA will appoint a task force, which will be composed of a representative group of experienced providers of services to the chemically dependent, to study available information and develop standards. Physicians and others with extensive experience in providing detoxification and rehabilitation services

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*Presented by Edward C. Senay, M.D., Substance Abuse Services, Chicago, Illinois.

will be included in this task force. The existing AMA National Advisory Committee, which is multi-disciplinary in nature, will generally oversee the development of the standards and elicit feedback from the national organizations represented, in addition to approving the final product. Feedback will also be sought from the state pilot project directors, pilot jailers, inmate patients and jail physicians as well as other jailers and physicians around the country.

We agreed tentatively on the following points:

1. "The Physician has no restrictions imposed upon him by the facility administration regarding the practice of medicine; however, security regulations applicable to facility personnel also apply to the medical personnel."
2. "The task force should develop a standard for the accreditation or certification of the physician who is working in the correctional facility, spelling out regulations for employment, kind of person and on-the-job qualifications."
3. "It was the consensus of the group that arrest is more than a legal event; it is an event that has possible health hazards, including biological and psychological consequences. It was felt that this understanding should be incorporated into a jail affiliation agreement with some recognized agency that would be responsible for handling acute emergencies."
4. "Detoxification from alcohol, opiates, barbiturates and similar drugs, when not provided in a hospital or community detoxification center, is performed at the facility under medical supervision."
5. "Diagnosis is a complex clinical judgement; the results of laboratory tests do not substitute for clinical judgement."
6. "The use of urinalysis, if available, should be used as an adjunct to clinical diagnostic criteria for the detection of alcohol, other psychoactive drugs and opiates."
7. "The physician can request and must be provided with access to all information available on the subject, so that he can determine what portion of that information is relevant to the subject's health, i.e., nature of the drugs the subject has in his possession at the time of arrest, blood alcohol level, etc."
8. "The physician should review all admissions to the facility for evidence of alcohol, psychoactive drugs or opiates."
9. "Clinical diagnosis (or identification) of alcoholism is based on medically generated criteria and is carried out under medical supervision."

10. "The diagnosis of the drug abuser is clinical, massed on medically generated criteria and carried out under medical supervision."

11. "The diagnosis of the opiate abuser is clinical, is based on medically generated criteria and is carried out under medical supervision."

12. "The terminology 'alcohol, other psychoactive drugs and opiates' should be used in lieu of that used in the existing standard, 'alcohol, opiates, barbiturates and similar drugs.'"

13. "Acute medical care should preempt the demands of the criminal justice system."

14. "It is the responsibility of the physician to see that a treatment plan, including short-term treatment, is created and implemented."

15. "When clinically indicated, the treatment plan will provide inmates with (1) access to counseling, i.e., individual or group counseling or any self-help group, such as AA, NA or others that the medical director deem appropriate; (2) psychotropic medications; (3) nutritional support; and (4) referral to community resources."

16. "There must be medically supervised triage and this must be carried out by the physician or his designee, i.e., alcoholism counselor, nurse, physician's assistant, or nurse practitioner."

17. "A treatment plan must be individualized and based on assessment of individual client's needs."

18. "All treatment plans must fall within the accepted range of medical services in the community."

19. "There must be a written individual treatment plan with the roles and responsibilities of treatment personnel outlined."

20. "The patient chart should reflect the physician's responsibility for the disposition of the case."

21. "In circumstances where an individual is released and yet is in need of chronic care or treatment beyond the acute emergency, there should be a linkage with a treatment facility in the community."

22. "There must be a written policy reflecting the philosophy of general guidelines for management of alcohol, other psychoactive drug and opiate dependence. This philosophy should provide for extended periods of observation, i.e., in instances where there is dependence on long-acting opiates and/or sedative-hypnotics, and should provide for referral of extended care when appropriate."

23. "There must be a written standard of the goals that the treatment plan will achieve and methods by which these objectives will be achieved."

24. "In view of the fact that jails and prisons are not essentially medical facilities, treatment programs should make careful provision for appropriate referral outside of the institution."

25. "The treatment systems should provide for timely delivery of needed medications."

26. "An individual must be referred to an approved agency when released if the referral is necessary and indicated because of the nature of the chronic disease. The facility must have on hand a documented list of approved community resources."

27. "There should be a contract, when necessary, with an existing community resource to provide the necessary components of a particular treatment plan."

28. "For patients who enter a treatment program on a voluntary basis, there should be a schedule of random urinalysis for the drug of abuse as part of the evaluation process."

29. "The decision as to whether an individual suspected of having an acute alcohol problem can have non-pharmacologic detoxification or pharmacologic detoxification must be made by a physician."

30. "Detoxification, when indicated, must be done under medical support."

31. "On clinical grounds, when there is unquestionable evidence for substantial physiologic dependence on alcohol, psychoactive drugs or opiates, an appropriate pharmacologic regimen is indicated, and so-called cold turkey detoxification regimens are inhumane, lethal in some cases and inconsistent with the ethical practice of medicine."

32. "Detoxification that is allowed to proceed without an adequate supportive environment, including psychotropic medication when necessary, is not approved."

33. "Inmates with DT's or a severe barbiturate intoxification should not be detoxified in a jail or prison, unless there is a controlled infirmary setting."

34. "Standard operating procedures relating to management of patients undergoing withdrawal from addition to alcohol or other drugs shall assure that such patients shall receive whatever medical treatment and/or social/environmental support is necessary to maximize their physical comfort and human dignity throughout the withdrawal period."

35. "When there is unequivocal evidence of a physiological dependence and/or tolerance to a drug, a withdrawal regimen generally utilizing the drug that was abused or a drug drawn from the class that was abused, is the preferred method of treatment."

36. "Standard operating procedures describing the detoxification and long-term treatment of alcoholism or drug abuse should also address proper nutrition."

37. "There should be recognition of the fact that inmates may be nutritionally deficient, and provision should be made to correct that deficiency."

38. "The food served to the inmates must be approved by a qualified dietician."

39. "A model should be developed which will address the role played by parole and probation personnel. This should encourage involvement of parole and probation personnel who are charged with the responsibility of following and monitoring in connection with the crime. As a condition of release, the inmates must agree to such monitoring. The model should recommend that parole officers be involved in the monitoring of the referral process, but recognize that despite training of such personnel, their impact will be limited."

40. "There should be provision for the recognition of the population of drug and alcohol dependent persons with special needs, such as schizophrenic, depressive disorders, pregnancy, juvenile offenders, etc."

41. "A facility is required to have specific treatment plans for special populations."

42. "There should be provision for continued or extended care of cases involving complications of alcohol or drug dependence."

43. "There should be provision for continued treatment of drug dependent special populations, whether by direct service or by an outside contractual agreement."

44. "Patients with concurrent acute medical illnesses, surgical conditions and/or psychotic disorders, may require continuing observation, and chronic cases may preclude the immediate detoxification."

45. "There must be a written policy reflecting the fact that pregnancy poses a special risk as far as addiction is concerned, and detoxification of pregnant addicts should be carried out very cautiously, if at all."

46. "Pregnant women with substantial physiological dependence and/or demonstrated tolerance to alcohol or other drugs should

be detoxified in a medical setting; they should not be detoxified in a non-medical jail or prison setting."

47. "There should be a policy developed in the jail or prison with respect to dependence on nicotine, caffeine or over-the-counter medications that would involve an educational component, e.g., appraising the inmate regarding health consequences of these substances, providing a tobacco-free area, etc."

48. "Consideration should be given to screening procedures such as urine surveillance, if they are legally feasible."

49. "The results of urine surveillance must not be used in a punitive manner."

50. "The quarterly report will include monitoring the use of drugs in the jail or prison; the monitoring may include the use of urinalysis."

51. "The records of urinalysis testing may be used for clinical purposes only."

52. "A good chemical dependence program must provide for access to legal consulation in complex situations."

53. "There should be a written policy describing a continuing education program with respect to alcohol, other psychoactive drugs or opiates. This program should focus primarily on medical personnel, but it is desirable that it be institution-wide, if feasible."

54. "A continuing education program does not necessarily have to be in-house, but should utilize existing community resources."

55. "Training materials employed in the continuing education program should be approved by the medical director."

56. "A model should be developed for the following: The continuing education program should be an extension of existing health, drug and alcohol education programs in the community."

57. "There must be policies or procedures for disseminating information about the standards to all facility personnel with provisions made to assure implementation of these standards by all facility personnel."

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MENTAL HEALTH -- JAILS AND PRISONS*

The first thing I would like to do is make it quite clear that I do not consider myself an expert in the field of Mental Health in Jails and Prisons. The truth of the matter is that when I became director of the Pitt County Mental Health Center in Greenville, North Carolina, in January of 1960, there was an established policy that the psychiatrist from the center was not to set foot in the local jail. We were then under the Department of Health, and I have yet to figure out why we weren't supposed to have anything to do with the jail, but I followed orders and it was only when the community mental health centers were shifted from the Department of Health to the Department of Mental Health that this policy changed. My interest in this field began in June of 1975 when there was some disturbance at the Women's Correctional Institution in Raleigh, North Carolina, and then the president of the North Carolina Medical Society was asked by the Governor to form a committee to investigate medical services at the center in view of inmates' charges that they were not adequate. I was named chairman of that committee. One of our major recommendations was that more psychiatric services were obviously indicated for the center.

My interest in the psychiatric problems of prisoners increased, and in the spring of that year, Mr. Richard Kiel and I considered the possibility of a conference on the subject: "Mental Health for the Convicted Offender -- Patient and Prisoner." Such a conference took place in Raleigh from October 27-29, 1976, and was sponsored by the North Carolina Department of Correction and the North Carolina Medical Society.

At that conference I delivered a paper as part of a workshop entitled "Alternatives to Incarceration." I should like to outline for you some of the principles which I offered at that time:

1. Every defendant and every prisoner shall be treated equally without regard to race, color, creed, or social position. I pointed out that such was not then the case.

2. When the state deprives a citizen of his freedom, it ipso facto must assume the responsibility for his proper medical, including psychiatric, care.

3. It is recognized that the state cannot, on the basis of the record, forcibly rehabilitate those who come in conflict with the law, but once it has deprived a citizen of his liberty, it is bound to provide that person with an opportunity to, with proper help, rehabilitate himself.

4. The sentence a citizen receives after he has been convicted should be the least severe as it could be while still accomplishing the job of protecting society.

5. I also suggested that it was the responsibility of the state to see to it that the professionals doing rehabilitative work

*Presented by Philip G. Nelson, M.D., Chairman, Advisory Council, Health Care in Corrections, North Carolina Department of Corrections.

> in the prison system should at least meet the requirements of their own professional organizations. This would mean that a psychologist, a social worker, and a psychiatrist would be expected to meet the standards of their own societies.

There continued to be a communication between the Department of Correction and myself. Some time after the conference, I became a consultant to the Department of Correction, and I have been spending one-half day a week at the Maury prison unit. Here I see all the psychiatric patients in the Department of Correction in a 30-county area. This covers something like eight units. I don't know how many patients I am responsible for, but I do know that I see regularly any patient who is on a psychotropic drug. In addition, Mr. Amos Reed, secretary of the Department of Correction, formed an Advisory Council, Health Care in Corrections, and I was made chairman. One of my major interests since that time has been the problems which we are discussing today.

Over the years, it has been my very great pleasure to work closely with Mr. Richard A. Kiel, Chief of Health Services, North Carolina Division of Prisons, Raleigh, North Carolina. It was he who attacked this problem in the first national conference on Improved Medical Care and Health Services in Jails at the Milwaukee, Wisconsin meeting last year. Some of you may recall that he pointed out at the time that the prison system was probably the most negative therapeutic imprint in the world from a psychiatric point of view. It was also pointed out the U.S. Distric Court Judge Frank M. Johnson in the Alabama case had stated, "A state is not at liberty to afford its citizens only those constitutional rights which would fit comfortably within its budget." He also pointed out that the Fourth Circuit Court of Appeals in 1977 had stated, "No underlying distinction between the right to medical care for physical illness and its psychological or psychiatric counterpart exists." The court maintained that care was mandatory if a physician or other health provider exercising ordinary skill and care at the time of observation concluded with reasonable medical certainty:

1. That the prisoner's symptoms are evidence of serious disease or injury;

2. That such disease or injury is curable or may be substantially alleviated;

3. That the potential for harm to the prisoner by reason of delay or or denial of care would be substantial.

It was due in part to Mr. Kiel's interest that the Department of Correction in North Carolina established, or at least is establishing, minimum standards for mental health services. I cannot speak for the task force because our deliberations have not yet been completed, and as this paper is being written, we haven't even met for the second time. We have, however, gotten far enough to recognize that at the moment there are considerable differences of opinion on very grave issues. Permit me to bring one to the floor immediately. I am referring to the scope which mental health services would be expected to have. My own concept is far more conservative than that of Mr. Kiel. In discussing this by phone with Dr. Petrich recently, he referred to Mr. Kiel as an idealist, and I found myself wondering whether he was looking upon me as a hard-nosed realist. Mr. Kiel and his associates have done an extremely good job in preparing a set of minimum standards for mental health care of residents of the North Carolina

system. I would like to compare my own stance with that of North Carolina. The stand I take is that which was tentatively agreed upon at the first meeting of our task force in which we stated, "In these Standards, the term psychiatric services or psychiatric care has been used rather than the term mental health. It was felt that the term mental health is too broad and poorly defined." The modified Standards, it was agreed, could serve as the basic guide for the development of psychiatric standards. Hope was expressed that some of these modifications could eventually be incorporated into the original Standards so that they could apply to medical-psychiatric services. At one point, we stated, "Psychiatrically ill inmates are those who are suffering from a psychosis or a neurosis; sociopathic personalities are not included in the definition except from the standpoint of clinical management of their psychiatric problems." I personally feel very strongly that we can't possibly, under the present circumstances do an adequate job treating the very disturbed patient from a psychiatric point of view, and I am thoroughly opposed to the concept of setting standards which can't possibly be met in the foreseeable future. It is true that we psychiatrists might have something to offer to the treatment of a sociopath, but I think what we have to offer is very limited, and I would much rather see us spend our efforts on the psychotic patient as well as on the severely disturbed neurotic patient. I think it is obvious we are legally obligated to do so. I see man after man who is put into the prison system because he behaves in accordance with his mental illness. One such patient was 100 percent service connected for paranoid schizophrenia. He received a five-year sentence after he slapped his mother. His treatment is to be seen once every three months by someone like myself who sees him briefly and gives antipsychotic medication. Prior to his being sentenced, he had had five excellent psychiatric hospitalizations, but after each hospitalization, he stopped taking his medication. The law states in North Carolina that we cannot keep a patient who has been stabilized by medication. We have stressed individual rights to the point that medical rights of the patient are almost ignored. This is, in my opinion, an intolerable situation, and I doubt very much if the people of North Carolina have even a slight idea of what is happening. Until we can resolve this problem, I, for one, find it rather difficult to imagine why I should concern myself too much with the treatment of psychopaths. Such treatment of psychopaths would not likely be very helpful.

The North Carolina Standards provide for continuity of care both prior to entry into the prison system and after departure. This would mean a close relationship with the Department of Corrections and the Division of Mental Health Services. I am happy to say that these two organizations are working closer together than they ever have. For years in our state there was an almost incredible gap between the two.

As I read Standard 5 on confidentiality, I am not entirely certain I understand how confidential the record in North Carolina is going to be. Factor One states, "Each mental health program director shall insure confidentiality of inmate mental health records." It is stated, "Confidential information within an inmate's mental health record may be released without written consent to other individuals employed in the parent agency only when and to the extent that the performance of their duties requires that they have access to such information. If an individual is being considered for parole, a summary of the contents of his record would be made available, upon request, to a mental health professional assigned to the parole commission."

Factor Four states, "Confidential information shall be disclosed without the inmate's written authorization to the extent that the clinician reasonably determines that such disclosure is necessary to protect against clear and substantial risks of imminent serious injury, disease, or death being inflicted by the inmate, on himself or others, or a threat to the security of the unit."

It is obvious from the above statements that the status of confidentiality as proposed in North Carolina is not exactly crystal clear. In my own job as a consultant, the issue is of no great importance for the simple reason that I don't pretend to do any psychotherapy. I see patients with another staff member in a very small office, and I seldom see a patient for more than 15 minutes except after the initial evaluation. Too many patients have the mistaken concept that in seeing a psychiatrist, their promotion or parole or permission to have work release privileges may be endangered.

In conclusion, it seems to me that we should strive to give the best possible psychiatric care for the least possible cost to our residents in prisons and jails. Standards for such care should be realistic and attainable. If we can't give a patient proper care for his psychosis in the prison system, we have no right to take him as a resident. As a nation, we need to give serious thought to our present trend of making prisoners out of psychiatric patients, for "practical reasons." This fact is, I suspect, not now known to the public, and I would feel that many people in the prison system are hoping that this difficulty will just go away. It is not likely to. It is only folks such as you with the aid of organizations such as the American Medical Association who can bring this about. If you don't, the law may.

JAIL MEDICAL STANDARDS:
WHAT ARE THEY? WHAT DO THEY MEAN? HOW CAN THEY BE IMPROVED?*

Jail Standards: What are they? What do they mean? The medical Standards established by the American Medical Association are in reality guidelines to the provision of "community" medical care for inmates. These guidelines have been formulated into brief statements which we call Standards. At present they represent a type of medicine providing very adequate care, yet not providing care of elective procedures which could wait until incarceration is ended. The Standards provide a statement of conditions which the medical profession feels would assure adequate provision of medical care to jailed inmates. Standards reflect a type of care which we call realistic and which have been shown through actual practice to be practical. The initiation of a medical program in any jail which will satisfy the Standards of the American Medical Association will provide for the adequate detection of illness and disease on admission to jail; the care, treatment and detection of disease while in jail, the ongoing therapy for new problems. This medical program will also provide for dental and psychiatric evaluations and therapy which are an important part of the Standards, as is the preparation in the jail for medical emergencies. The Standards also reflect the environmental effects of the jail upon the mental and physical health of the inmates, and thus Standards referring to exercise, personal hygiene and diet are included.

How can the Standards be improved? These Standards will continue to be improved as more jails attempt to implement them. Through experience in using the Standards, certain areas, I am sure, will be found to have rough edges which will be capable of being smoothed. The practicality and effectiveness of the programs so initiated will then reflect any need for Standard change. At present, my recommendation for change occurs in Standard 1012 and 1023. Standard 1012 refers to a medical evaluation being done of all inmates within 14 days of admission to the jail and 1023 refers to dental evaluation and care given within 14 days and within three months of incarceration in the jail. It is my experience that receiving screening which is performed, if done properly, is very satisfactory for the detection of acute and chronic problems. Because the average stay of inmates in jail is three days, I believe it is not necessary to do a complete evaluation on every inmate who is booked into jail. This, in my opinion, would be a waste of medical personnel and time. The complete evaluation, rather, should be limited to those inmates who are going to be long-stay inmates in the jail. An inmate who is present for at least 14 days will probably be a long-stay inmate. Therefore, it is my opinion that those inmates staying more than 14 days should be the only ones who qualify for the routine complete evaluation both medically and dentally.

Lastly, the ultimate responsibility for the medical care of inmates rests with the governmental agency or county board which finances the care.

Jails cannot establish adequate medical care programs without adequate funding. However, the courts have mandated adequate medical care, and this will eventually force the issue with county boards.

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*Presented by Austin A. Aardema, M.D., Muskegon County Jail, Muskegon, Michigan.

A BROADER UNDERSTANDING OF

HEALTH CARE AND CRIMINAL JUSTICE*

Today I have been entrusted with not one, but two primary missions. The first is to discuss the AMA Jail Project in terms of public protection, efficiency and long-range economy or cost-effectiveness. I find this task eminently practical and thus relatively easy to fulfill. But my second mission is to explore the jail project in its philosophical dimensions, and I must confess that I find this task more difficult.

To begin with, I am a physician, not a philosopher. Also, the jail project is not the AMA's alone. It involves the participation and cooperation of several of our society's institutions and professions, both private and public. And here again, I am a physician rather than an expert on criminal justice, or human rights litigation, or on law enforcement and government. What I have done, however, is think long and hard about what I've been asked to do. And as a physician I can tell you this: through jail health programs, we can learn a great deal about the people in our charge, about one another and about the mutually beneficial coming together of our respective philosophies. Parenthetically, I found that in reaching these conclusions, the practical aspects naturally led to the philosophical aspects. So let's follow that same course right now.

In terms of public protection then, as well as health benefits for the individual patients involved, the jail project already has achieved considerable success. For example, there has been a fourfold increase in the detection of previously undiagnosed and untreated illnesses, including communicable diseases. Obviously such detection benefits not only the inmates themselves, but also the staffs of correctional facilities and the communities outside these facilities. So early health screening techniques followed up by comprehensive health and medical services where appropriate are very valuable in terms of protecting the public as well as inmates and staff.

Meanwhile, the jail project's development of health and medical program models adaptable to patient and community needs, along with the eventual accreditation of these programs according to a set of basic national standards, are adding badly-needed efficiency to the jail health system. This efficiency manifests itself in several ways. Fewer inmates need to be transported to the emergency rooms of community hospitals, for example. This is more efficient in itself, of course. But it becomes even more so when you consider that no discernible illness is detected in up to 50% of such emergency room visits. So, eliminating needless trips also eliminates the needless waste of hospital services, and of the valuable time of correctional staff, not to mention the needless expenditure of tax dollars.

In a larger sense, too, the jail health system is improved to the extent that "efficiency" means maximum production at minimum cost. For instance, previously untapped community health services can be more efficiently matched to previously unmet jail health needs. These needs and the community services which may be required are incidentally defined in the Accreditation Standards themselves, Standards which include not only medical, dental, and mental care, but special care ranging from detoxification to physical therapy,

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*Presented by Frank J. Jirka, M.D., Vice Chairman, AMA Board of Trustees

from personal hygiene to proper nutrition. The jail project also trains correctional staff, particularly those who process admissions, to recognize the symptoms of uncomplicated illnesses and health problems characteristic of jail populations. Thus the productivity of existing staff is increased and health services are improved at no additional cost in many jails.

Now, the foregoing developments have obvious implications in terms of cost-effectiveness and long-range economy. The economies of early detection, referral, diagnosis and treatment of incipient health problems are widely recognized, as are the economies of preventing the circulation of communicable diseases. And, of course, the very fact that a jail health program is a rational system for the provision of care is cost-effective, especially in comparison to the hit-or-miss (and all too common) non-system of care.

One other long-term economy should be mentioned -- namely that proficient jail health programs preclude the violation of inmates' constitutional rights and the subsequent filing of suits with judgments which can and, in fact, have reached well into six figures. In short, an effective jail health program does protect the inmate and the public, and it is both efficient and cost-effective.

To the extent that this can be called philosophy, it is an eminently practical one. But beyond the practical, beyond jail health standards and accreditation and beyond the program benefits that can be measured, I believe that a much more profound philosophy is at work -- a philosophy called humanism. Humanism recognizes that society is made up of real persons, of individuals who respect one another's individuality. So it is that the history and the practice of medicine are predicated on humanism, on the consideration of human beings as individuals, each with unique and changing wants, needs and capabilities. So it is, too, that the relationship between individual physician and individual patient is the living heart of medicine. The physician finds humanity in service to each patient and each patient is reassured as a human being through that service. Moreover, this kind of humanism can have a softening, even healing, impact on the harsh atmosphere which can pervade correctional institutions. For example, several sheriffs have described jail health programs as increasing the morale of inmates as well as staff and of positively influencing overall operations. I think this derives in large part from a simple fact: when one human being hurts or is in pain and another human being helps to ease this hurt or pain, a basic humanistic link is thereby established which would not otherwise exist. Both parties derive not only mutual satisfaction from this link, but also a heightened awareness of their mutual humanness.

In terms of the philosophy of humanism, then, health professionals have much to give. Conversely, jail health programs also provide important learning experiences for health professionals, including physicians. For example, added efficiency and cost-effectiveness in the delivery of care are being given a high priority by society at large and not just by the jail health project. At the same time, however, participation in jail health programs provides health professionals with one more opportunity to put theories into actual practice. To cite two cases in point, the programs serve to remind us that the early detection and treatment of health problems

are humane and cost-effective; and that the more efficient matching of community health resources to community health needs is effective in preserving health and dollars, most notably when the use of expensive hospital care is precluded. To put it another way, a basic philosophical approach to the incarceration of criminals today is to be "firm but fair." And society today also is asking health professionals to be fair to patients in terms of providing needed care, but to be firm, or firmer, in terms of moderating the costs of care.

So our respective philosophies are coming together to some extent and this coming together is beneficial for everyone concerned, including society at large. Apropos of that, and in closing these remarks, I should make one final point. Our institutional cooperation and participation in the jail health project have importatnt implications for the future. For instance, American medicine today has assumed important new social, economic and political dimensions. And in dealing with problems in these areas, medicine must respond as an institution and in concert with other institutions. As Rene Dubos, the prominent American physician and microbiologist, has said:

> "Physicians must learn to work with engineers, architects, and general biologists, as well as with city planners, lawyers...politicians (and others)...responsible for the management of our social life. Only through such collaboration can they help society ward off, insofar as possible, dangers to physical and mental health inherent in all technological and social changes, especially when these (changes) occur as rapidly as they do now."

Furthermore, and as Dr. Dubos emphasizes, what this collaboration leads to is a much "broader understanding of Man's nature." In both practical and philosophical terms, the AMA Jail Project helps further just such an understanding, a broader understanding of the inmate-patient, a broader understanding of ourselves and a broader understanding between us and society at large. So let's further extend the jail project--and this understanding--throughout the land.

"HOW DO YOU CHANGE HEALTH CARE SYSTEMS?"*

The topic presents a complex issue which is most difficult to place within neat and easily replicated categories. I can only speak for the Maryland Jail Project, and I am here to share some of these toughts with you.

Since 1976, I have found that changes toward a better health care delivery in a jail can only be achieved if the administrator/warden/sheriff (in short, the person in charge) is willing to make a total commitment toward betterment.

All jails that demonstrated positive changes since our project started were under the leadership of a strong individual who saw the need for improvement in the medical care delivery system.

The first visible indication of this commitment was their willingness to participate in the program - and from there to continue with their involvement throughout all project activities within their facilities as well as on a state level.

This provides us with the first variable in our step-wise progression describing changes toward betterment:

> An Informed Administrator Who is Willing to Address the Needs at Hand.

It becomes clear immediately that no change can be achieved without the necessary support from the local government. This gives us another ingredient toward achieving change:

> Availability of Local Government's Support (and Funding, if Needed.)

It has been found during the program years that changes can be affected without additional budgetary allocations in large amounts -- in some instances it may be possible to switch funds between line-items with resulting improvements in health care.

The Warden of Baltimore City Jail, for instance, was acutely aware of the dismal conditions in his medical unit. Here was a system which did not provide even minimal care. In order to address the issues, the Jail Board formed a task force to study existing conditions and recommend changes. Many hours were spent in meetings, papers were written, and consultants were asked for guidance. The project entered this ongoing effort and provided added support and assistance.

The following three areas were assigned top priority:

> There must be <u>availability</u> of care -- there must be speedy <u>access</u> to care -- and there must be a caring <u>attitude</u> by the providers toward the inmate patient.

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*Presented by Claire Evans, Jail Pilot Project Director, Medical and Chirurgical Faculty of Maryland

After review of various options, it was decided that the medical unit could be better managed under contract to a physician group having full responsibility for all aspects of the delivery system in the jail. This would provide physician time, support personnel time, and consultation capabilities in various medical specialties within the facility.

Heretofore, most of the inmates had to be transported to the Baltimore City Hospitals even for the most minor illness or injury, or for follow-up clinic visits. (As all of you know, this is the least desirable arrangement for a large jail since it places a burden on the entire administrative structure. Transportation of inmates means extra security, manpower, vehicle availability, and overtime pay.)

By eliminating the extensive use of the Baltimore City Hospitals as primary care provider and by offering this needed care in-house, line-item costs were shifted from security and transportation to medical care.

The end result was that for the first time the inmates at this jail receive medical care at a level complying with minimum Standards as defined by the American Medical Association. It must be remembered that the success at this facility was the end result of many hours of hard work by many concerned individuals on all levels of the City Jail - City Hospitals - and City Government.

Another areas of concern which had come to the attention of the Project Advisory Committee was the planning of new jails throughout the state by architects with very little information concerning the requirements for an adequate medical unit. For two years the members of the Committee worked to develop guidelines for physical facilities, and those recommendations are now in the hands of the Department of Public Safety and Correctional Services. It is hoped that this effort will result in better health care provided in new jails in Maryland for years to come.

But let me get back to changes which occurred at some of the Maryland pilot jails - changes which were not quite as drastic as those at Baltimore City Jail, but were just as important to the inmate population affected by them.

- In order to provide better intake screening and more prompt physical examinations to newly admitted detainees, Baltimore County Jail added a Physician's Assistant to the staff.

- At Anne Arundel County Jail the medication prescription pattern was altered and improved.

- Four medical units in the state are now preparing monthly summary reports reflecting their activities. This enables the administration to gauge staffing and prepare budgets for the next fiscal period.

This brings me to another MUST in defining betterment and change

There Must be Communication Between the Administration and the Health Care Providers.

Jails are tightly-knot communities; one area influences all others; changes in the medical unit impact the rest of the jail. It is therefore prudent to share the overall guidelines which govern the medical unit with the staff of other departments and as part of the training package for new officers and support staff.

During the second year of the project one of our detention centers developed an entirely new and detailed section of their Standard Operating Procedures (SOP's) for the medical facility. They were then incorporated into the correctional officers' manual and are used in training. As a result of better communications, the officers can function better when a medical emergency occurs.

Since that time two other jails have updated their manuals, providing more detailed guidelines covering the medical care delivery system. This means better informed correctional staff and, as a result, more efficient care when the situation calls for it.

We have here described some of the necessary components which can bring about change toward better health/medical care in jails. To recall, we have found that:

- It needs a strong administrator to take the lead;
- it takes an informed government to react to the needs;
- it takes a concerted effort between the administration and the medical provider to plan, develop, and implement a medical care system to benefit all.

In addition, it takes the medical profession on the national, state, and local level to be available for assistance and support whenever needed. Toward this end, the Standards, developed by the program of the American Medical Association have provided a tool that has had already a tremendous impact at the local jail level. The availability of published and tested standards encompassing all aspect of jail health care have assisted the jails in evaluating their own level of care. For the first time both administrators and health providers can compare what is in place at the jail and what must be developed to achieve compliance.

While many of the jails are for the first time developing the documentation describing their system, designing forms for use in the medical record, and establishing written contracts with health care providers, they are delineating an improved system - not yet ready to be accredited but already reflecting subtle changes for betterment.

HEALTH CARE PROVIDERS:

HOW DO YOU CHANGE HEALTH CARE SYSTEMS*

Changes need to occur if your present health services are inadequate, if progress is to be made, or if community standards for health care need to be adhered to and implemented. How change is accomplished is determined by:

1) The individual or groups who recognize the need for change, and
2) Their concern and determination in affecting it.

Change is extremely difficult in an environment where any deviation from standard operating procedure is regarded as suspect, where additional involvement with a client by health care staff is often misinterpreted or misconstrued, and where there are ambivalent feelings about the amount of service a client with an extensive criminal history and background is entitled to receive. The health care professionals, engaged in providing services to a group of unpopular clients (both in and out of our institutions) face these problems on a daily basis. Justifying, qualifying, supporting, explaining and protecting the services we provide in the day-to-day performance of our duties is time consuming, sometimes frustrating, and extremely upsetting. It is into this setting that we attempt to facilitate change. The physical plant does not readily lend itself to major changes, opposition from the institutional staff is openly voiced, department level officials are not trained to deliver health services and the legislature needs to be "sold" an expensive undertaking. In Minnesota we were faced with all the obstacles. In December of 1974, we opened our Security Unit in a community hospital. This month we will begin occupation of a Holding Unit adjacent to the Emergency Room in the same hospital. Both units are shared with the county. We have come a long way and effected some dramatic changes in the delivery of health care services to our Minnesota incarcerated clients.

There was no formula that guaranteed instant success or immediate solutions. The changes that occurred in Minnesota were a cumulation of efforts by several individuals and groups. There were many disappointments but there were also successes. The changes which occurred were not isolated to the infirmary or the hospital. We needed a commitment from the total institution and the Minnesota Department of Corrections. Deficiencies and inadequacies needed to be identified and workable solutions suggested. We did a great deal of sorting and asked many questions both of ourselves and the people with whom we came in contact. Would the changes we were suggesting work? Were the changes specific to all institutions or just to the main prison at Stillwater? Who would pay the bill? Would our new program be accepted by the custody element? Would there be transportation available to get the inmate to an outside facility? Would we have medical input on a department level? Were the new services we were describing designated to be "paper services" only? Who would make the final decision about the kind or amount of care the inmate was to receive--the physician, the nurse, or the custodial officer? In the new program would we utilize inmates as direct care providers? Would they administer medication? How would we handle our medical records? What system would we use for documenting information and for maintaining confidentiality? Would our unit be functional or would it just occupy physical space? What, if any, would be custody's role in making medical decisions? Who would call the doctor? Should we continue to operate as a

*Presented by Marquetta M. Origer, R.N., Medical Services Coordinator, Minnesota Department of Corrections.

hospital or change our classification to that of an infirmary? These are only a few of the questions we asked. We needed concrete answers before we could present our proposal for change to the legislature.

In 1965 when I arrived at the Minnesota State Prison to begin work as a surgical nurse I was surprised at what I found. Two civilian nurses were employed in the 45-bed hospital. They worked from 8 - 4 Monday through Friday. Their primary responsibility was medications. They prepared the medication for delivery to the population and administered a limited amount of medication in the prison hospital. Although a large number of medications were prepared by this team, the actual administration was either by inmate nurses in the hospital or correctional officers in the population. Major surgical procedures were performed by residents from the University of Minnesota surgical staff, and patient care was provided by inmates assigned to the hospital an "nurses." My job was to supervise the operating room where an inmate served at First Assistant to the surgeon. I soon discovered that this inmate was also "in charge" of the one-room surgical suite. Inmates requiring surgical procedures (either emergency or elective) were returned to the surgical ward following surgery, and the post-operative care was provided again by inmate nurses. I supervised the care but was not allowed to provide any direct service to the inmate/patient. This intervention was interpreted as fraternization and was subject to disciplinary action. The medical director, although on duty for eight hours a day, was physically ill and subject to violent outbursts of uncontrolled temper. Learning how to work in a foreign environment and trying to provide quality care without getting caught made this place of employment a major challenge.

In 1968 a new medical director arrived at MSP. It was with this man that we began to change. He was energetic, enthusiastic, and determined. He was an administrator. Under his direction the hospital changed. Nurses were employed around the clock. A full time pharmacist was secured. Consultant services in physical therapy, dietetics and administration were obtained. The need for consultant speciality services (i.e., surgery, medicine, neurology, dermatology, urology, etc.) was identified, and the consultants were brought to the prison to provide weekly consultant services. We were encouraged to attend educational workshops and seminars. A sick call process was developed, and patients with medical problems were seen systematically rather than at random. Complaints were followed with appropriate medical/surgical intervention. Inmate problems were heard rather than ignored. We thrived under the new system, despite the fact that our supplies, equipment and physical space was limited. We were an interesting operation. We operated a non-accredited hospital on a temporary license. We were, however, reasonably secure--for all practical purposes where could we go with a population of 1,000 inmates with varying health needs?

We ran our hospital, in the new pattern, for about two years. At this time David Fogel became Commissioner of Corrections in Minnesota. Many changes occurred in our institutions. We found ourselves answering inquiries from citizens' groups, legal organizations and the ombudsman for corrections. These inquiries were directed to the quality of care we were delivering to our inmate population. A team was formed that included a physician, nurse, pharmacist and systems analyst. We visited all of the DOC institutions in Minnesota and evaluated the medical services. A report on our findings was written and presented to the commissioner. A hospital administrator consultant was hired,

and other outside consultants were brought in to further evaluate the quality of care. It was difficult to extract information on either the cost or the amount of services we were and had been providing. Records were incomplete, oftentimes non-existent. Officers' salaries for escorting medical special duties could not be retrieved. Hospital records had been kept by inmates and the information was so drastically altered that it could not be considered factual. A class action lawsuit was filed by a group of inmates. It alleged inferior care. The consultant administrator worked long and hard, sifting, sorting and gathering information. Our temporary license to operate was denied by the Health Board. The progress we had made did not seem like any progress at all. It was time to make a move. We were spending a great deal of money and delivering a low quality of health care.

With help from a deputy commissioner, our consultant administrator and the prison physician, a proposal to improve the quality of health care services and make them equal to community standards was taken to the legislature. The combined efforts of a group with a purpose were successful. The Minnesota Legislature approved a request for 1-1/2 million dollars to (1) build a hospital unit at a community hospital, (2) provide a consultant full time physician for MSP, (3) hire a consultant psychiatric social worker, to be assigned to the MSP hospital at Stillwater, (4) hire a hospital administrator on a departmental level, and (5) provide the unit with 13 correctional officers to staff the unit.

We began researching the community to find a facility that would consent to the prison unit as part of their institution. Many hospitals were contacted. Finally, based on location, services available and its academic affiliations with the University of Minnesota, SPRH was selected.

In 1973 SPRH and the DOC entered into a contractual agreement. Renovation of one-half of a general surgical circle at SPRH was less expensive than constructing a new facility. A security-medical care committee was organized. Administrative security and policy making members from both City-County and the DOC met with representative physicians, nurses and administration and hospital board members from SPRH. The City-County correctional officials were included in the planning, since the county penal clients needing medical care have traditionally been treated at SPRH. The different elements of the committee cooperated fully, since it was important to the hospital and to the correctional units that the project succeed. Guidelines were established by the committee, and in the four years of operation of the unit very few changes have been needed. Important to the successful operation of the unit is the nurse coordinator, an employee of the DOC employed full time at SPRH. She is the communication link between the hospital and the correctional institutions.

We also implemented changes in our institutions. We began to systematically plan the care we offered our clients rather than to randomly treat them. Today the patient is initially seen by the institution physician. Using supportive laboratory and radiological findings, a diagnosis is made. If the problem needs further evaluation, the client is sent to the outside institution where the diagnosis is confirmed. Continued follow-up in the outpatient clinics or admission to the Security Unit is suggested. The patient is followed both at the sending institution and the outside facility until he is either discharged by the specialist or paroled by the institution. The provision of care is now a total program beneficial to the patient and the care provider. Positive communication between the custodial staff and the medical community assures a good working relationship

these two groups. Each is now aware of the other's responsibilities, and the program continues to thrive.

The program is expensive. Soaring hospital costs, physicians' fees, officers' salaries and transportation, nurses' salaries and administrative costs add up quickly.

Our emphasis is on the quality of the service. Our inmates in Minnesota receive a standard of care equal to that of the community. What we are paying medical services we are saving in lawsuits. Our populations seem satisfied with the services we are offering them. We have changed our method of delivering health care services and are far more confortable in our work environments.

PROMOTING CHANGE IN HEALTH CARE SYSTEMS*

Any jail or prison has an established system, or non-system in some cases, for providing health care to its inmates. In either case there are already certain ideas of how to operate, certain assumptions which actions are based on. Changing or developing a system, then, includes developing new or different assumptions.

To develop these new assumptions requires some impetus - a driving force or energy to overcome the inertia of the status quo. A goal must be defined, and those people affected must recognize the desirability of attaining that goal. There must be reasons they agree with, some incentive for changing the old and familiar, and in that sense comfortable, way of doing things. The incentives can be many: to have a more economic or efficient system; to develop a more routine and orderly way of handling problems, in order to move away from the chaos of a current non-system; a desire to reduce liability; a need to follow department or state guidelines or regulations; a desire to receive state or national recognition; a need to inject ethics and professionalism into the system; or perhaps the simple desire to do the right thing.

In any case, and in every situation, there must be something to move the current system towards a specific goal. Once the initial inertia has been overcome, there is an unlimited variety of ways to achieve the desired changes and over many periods of time. All involve developing concrete plans geared to the local facility and community resources.

The keys to both 1) overcoming this inertia and 2) shepherding through and actually attaining the changes is personal involvement. One's involvement will vary tremendously depending on the talents, energies, and goals one brings to bear on the problem at hand. It can be as extensive as it can be minimal; it will always be best when it is lasting. And the amount of time given is by no means indicative of how effective your particular contribution will be in the long run.

As "health care providers" you are doubly enriched with expertise and concerns about health care in correctional institutions. For while you are also trained professionals, you are first, last and always human beings and citizens. Most of you are taxpayers, and substantial ones, who want to be certain your dollars are being used appropriately. All of you are people, with the possibility of you, your friends, or your family being jailed and, I surely hope, with some feeling for those other people who are locked up, out of sight.

Your citizenship and humanity can combine with your professional training to look at a local or state situation and help you contribute to developing a system which is competent and professional in its operation as well as being practical and appropriate to the community in which it exists. You have to live in the community or state which has the correctional institutions; you can't pass it on.

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*Presented by Gregory M. Miller, Jail Pilot Project Director, Washington State Medical Association.

I would like to spend just a few minutes discussing what some health care professionals - mostly physicians - have done to spur or see through change in correctional health care in Washington State. A group of physicians has, since the early 1970's, made the personal commitment to help improve the health care services in the State's jails and prisons. They did not pursue comprehensive "jail reform," but limited their view to improving the health services, getting the providers that are needed together with the jails. A limited goal, it was deemed practical and part of the response to several recent investigations of local and state institutional health care.

The physicians chose as one of the primary tools to achieve their goal organizational involvement. Working through their professional organization, the State Medical Association, as a Subcommittee on Jail and Prison Health Care, these physicians involved the WSMA staff as well as other physicians, including the leadership and non-members of the Association, often bringing them into the organization. They were able to enlist the aid and support of other groups - the Bar Association, the Nurses Association, the Sheriffs Association, the Public Health Association, and local reform groups. They have also worked with state agencies, including the newly appointed State Jail Commission, and the Legislature in developing health care training programs for jail staff. The group has been active and effective on both broad and specific levels over the past several years.

Because most of the jails in Washington are small and without 24-hour nursing coverage, the physicians decided to concentrate on the role of jailers as an integral and essential part of the health care team and develop and support the concept of the "Medical Liaison Officer," who you saw in the film this morning. By working through training programs, both with the curriculum and in doing the training, physicians, nurses, and pharmacists have and continue to promote change in jails throughout the State.

Perhaps one of the most effective areas for a health provider's involvement, particularly of medium and large size facilities, is serving on or assisting with advisory committees to the jail health programs, or acting as a liaison between the jail and professional community. Here you bring both your professional and citizen concerns and, through a process which continues after the initial development of the jail system, can help insure that the problems of staffing and funding and professionalism are dealt with properly when they come up and, hopefully, see that they are dealt with before they adversely affect the quality of care in the jail.

In the Advisory Committee, the jail administration, health care workers, and, ideally, inmates have a body that they can turn to when problems or needs arise within the existing system.

Advisory committees are also important for keeping the jail door open to public scrutiny, keeping the quality of care high, and decreasing the isolation of those professionals in the institutions. They are particularly important in this last regard as a body to which health professionals currently working in the system can take their concerns regarding current practices and realistically hope for change.

It is also possible, and no less effective, to promote change on a smaller, more personal scale, as part of your everyday work and life, simply by touching those around you. Examples are: talking to students you teach and work with, casual conversations with colleagues, or the local county commissioner or health officer on the street or in a store, the president of the Kiwanas or Chamber of Commerce, your neighbor, your fellow worshiper. You can promote change effectively from any of these points of your professional and civic life. What is needed is a commitment and communicating that commitment to others.

58536

MIND-ALTERING DRUGS*

Drugs which alter mental states are by no means new to medicine. In fact, opiates were among the first of the effective medications available to the physicians of ancient times. Nevertheless, in the past 20 years we have seen the development of a cornucopia of psychotropic or mind-altering drugs. During the past five years in particular, there has been increasing recognition both within the medical profession and without that excessive use of such drugs has become a problem affecting all strata of our society. Certain of these mind-altering drugs, those which are called the minor tranquilizer or anti-anxiety drugs (e.g., Valium or Miltown) have become the most frequently prescribed drugs in the United States. Those of you who read the medical journals, especially those of a few years ago, will recall that tranquilizers were being sold as specifics for every sort of problem or stress from sexual inadequacy to mothers-in-law. This problem of inappropriate use of medically prescribed drugs has reached into the prisons and jails as do most community problems.

Another side of this same story of mind-altering drugs, is that of the development of the major tranquilizers or anti-psychotic medications. By their efficacy in controlling many of the symptoms of severe mental illness, they have been a major factor in bringing about a revolution in the care and treatment of the mentally ill. As you know, throughout the country the number of mental patients in hospitals has been declining steadily since the late 1950's, when these drugs came into general use. It is generally accepted that psychotropic drugs have been a major factor in enabling the mentally ill to be treated in the community rather than in hospitals.

Jails and prisons have participated in the same trends in usage of such medications as have existed outside. In fact, some of the conditions of imprisonment create special problems. If you have not had occasion to encounter problems with mind-altering drugs in a prison setting, you are fortunate. It has been my observation that the majority of physicians moving into prison practice from a private or clinic practice have to learn to handle these drugs in a different fashion. The frequent experience is that they over-prescribe the minor tranquilizers to the anxiety-ridden or pleasure-seeking people with personality disorders whom one finds in a prison population. At one time several years ago, it came to my attention that almost every one of the prisoners in one of our segregation units was on such medication. Generally, we have become aware in prison of the potential for abuse of new drugs before this potential is recognized in the general population. A fairly

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*Presented by Thomas L. Clanon, M.D., Superintendent, California Medical Facility, Vacaville, California

recent example of this is the drug Quaalude. This drug was introduced as a superior sedative, and we began to use it in place of Phenobarbital and older drugs. Very rapidly, however, it became evident that this drug had a potential for abuse, since all of the drug users in the population were shortly complaining of insomnia.

In this regard, I am reminded of one of my earlier experiences in prescribing the drug Miltown, which for a time was a highly regarded anti-anxiety agent. I had been prescribing it for a particular prisoner/patient, who appeared to be extremely nervous and anxious whenever I saw him on morning rounds or sick call. He emphasized to me that the Miltown was the only thing that kept him going without severe emotional problems. As time went on, and I became more and more concerned about his developing dependence, I eventually stopped the medication. After having done so, I discovered that in fact he had never taken any of the medication, but had been delivering it to a strong-arm cell mate. He did indeed have real anxiety when he came to see me to request medication. The anxiety consisted of his fear that the strong-arm cell mate would carry out his threat to beat the devil out of him if he did not come back with the drug. This kind of trafficking in desirable anti-anxiety drugs is one of the problems one encounters more in prison than on the outside.

At times it may seem to doctors and administrators, that such drugs would be useful in dealing with the anxiety and depression which many prisoners experience as a result of their incarceration and reducing disruptive behavior. One quickly learns as a psychiatrist in prison, however, that this is not a good treatment for these reactions to imprisonment, and the attempt carries with it the very real danger of promoting dependency. Furthermore, the prisoner who is intoxicated on minor tranquilizers is in fact not a well-controlled individual. It has been shown experimentally that these drugs tend to release aggression as does alcohol. I have myself observed that there is an increase in both self-directed aggression in a form such as wrist-slashing, and of attacks on other inmates and staff in units where these drugs have been used inappropriately.

Over the 20 years I have been practicing in prison, I have come to recognize several trends which combine to promote over-use of certain drugs. One of these is the fact that prisoners have often had much experience with such drugs and find ways to get them from physicians in order to make the time pass more rapidly, or with less anxiety and depression. Prisoners can find a variety of ways to pressure physicians, and this is so well recognized among physicians who work in institutions that they generally request that the more sought after drugs not be readily available for them to prescribe. In the institution where I have practiced, for a number of years we have placed certain drugs on a special restricted formulary, which requires that more than one physician

agrees to the need and then only for certain conditions, for limited time periods.

A second problem in prisons which contributes to the drug use is the lack of adequate space and personnel to provide reasonable living conditions. Excessive confinement and inaction create frustrations and mental problems which one is strongly tempted to treat with psychotropic drugs. This problem should be treated by improvements in living conditions, which will have additional benefits beyond controlled behavior rather than the problems which are created by excessive use of psychotropic drugs. The third trend which creates the problem of excessive use is the recurring hope in the minds of the drug companies, if not in the minds of many physicians, that a drug will be found which will be useful in altering disruptive patterns of behavior. Over the years it's been my observation that each new psychotropic drug as it comes out is tested for value in the treatment of sociopathy or antisocial behavior. This was true of Miltown at one time; it has been true of Artane and a variety of other drugs. Typically, these drugs are successful on one or two studies when tried, probably because of the general beneficial effect of any attention and in addition because the desirability of these drugs to some individuals motivates the subjects to cooperate. In the end, however, they prove either to be ineffective or dangerous. The tendency of Americans (physicians included) to look for a magic pill to cure everything is increasingly recognized and criticized.

The other side of the problem of the use of psychotropic drugs is that of getting appropriate drug use to prisoners. There are specific indications and appropriate occasions for use of most of the psychotropic drugs with prisoners. The more dramatic examples of problems coming from inability or unwillingness to provide needed drugs have come to my attention in cases of psychotic patients who require antipsychotic medication. For some time the institution where I work transferred prisoners as they neared their time of release to various prisons and release centers around the state. Some years ago we found that some of these centers had it as a matter of policy that no medications were given. In one case this came about because a prisoner had escaped, and in defending himself against the charge of escape, the prisoner brought up the fact that he was taking medication and alleged that this medication rendered him too incompetent and irresponsible to commit the crime of escaping. As a result of this single incident, the policy had been formulated that no medications would be given. A result of this was that any psychotic patients who were sent to this facility were withdrawn from their medications, and a certain portion of them would rapidly become mentally disturbed once again and have to be returned to the prison hospital.

It should be a well recognized fact that there are significant numbers of people receiving antipsychotic medication who should remain on such medication indefinitely if they are to minimize the likelihood of

future mental breakdowns. There are several factors which may make it difficult to meet these needs for prisoners, however. One of these may be a lack of physician and nursing staff required to make good diagnoses and properly administer drugs. The development of community mental health programs has been of help in this area, since most communities where prisons and jails are located now will have some level of service available to them.

There may be difficulty in getting across to budget and control agencies the fact that a significant portion of jail and prison populations are severely mentally ill and in need of treatment. Inability to get these ideas across will make it difficult to obtain the necessary medical and nursing resources. In fact, the incidence of mental illness in prison populations in our experience is at least four times the incidence in the population at large. Others have placed the incidence much higher than this.

In recent years, objections have come from various consumer groups in the media and in the political arena who resent all use of psychotropic drugs as a means of mind control by the state. Such drugs are of course especially suspect when used within prisons, and there is tendency on the part of some to feel that it is mandatory to prohibit the use of drugs in prisoners in order to prevent their abuse.

A further contributing factor is that the public is not well informed about anti-psychotic and other psychotropic drugs and tends to consider them as all sedative in nature. There is a tendency to believe that they all have a controlling effect when in fact the opposite may be true, and there is quite a broad spectrum of drugs producing different effects and requiring skillful handling by a physician.

Some of the things which must be considered in a program to achieve appropriate use of drugs include the following:

1. Well-trained and currently-trained psychiatrists and psychiatric nursing personnel need to be available to screen and follow prisoners who need their attention.

2. Such drugs should be prescribed initially and administered only in units which are medically administered with medical personnel on duty daily. The jail may be an exception to this, since medical administration of units in the jail may not be practical in terms of the size. In the case of long-term institutions with large populations, however, there is a need for the psychiatrist and medical personnel to have at least convalescent level units in which drug treatment can be started and monitored as necessary.

3. The general maintenance of a hygienic milieu in the prison is important to reduce the incidence of mental illness and the requirement for drug treatment. Programs of activity and exercise are important, especially for those prisoners who are in segregation or isolation. Visiting programs are extremely important as are other opportunities for communication with family and friends outside. One can see the benefit of these facets of living when a prisoner or prisoner/patient is released from the institution. It can be noted that the requirement of medication typically diminishes. Maintenance dose of medication arrived at in the institutional setting will frequently have to be cut in half once a person returns to more normal daily activities and interacting with family and friends.

Finally, a good working relationship between medical staff and the administration of the institution is essential to avoid abuse of drugs and insure their proper use when needed.

MIND ALTERING DRUGS FOR MASS CONTROL OF INMATE PATIENTS*

In the late 1950's and early 1960's, in our pre-trial and post-trial detention facility, we experienced a situation where the use of barbituric drugs was an indiscriminate practice for the control of inmates. It is estimated that in the Allen County Jail, 75% of the inmates were on some type of mind altering drug at this time.

Basically, the drugs that were used were Seconal, Nembutal, Amytal and liquid Paraldehyde. These drugs in many cases were indiscriminately dispatched by untrained personnel who had little information as to the effect of the drugs. The use of Paraldehyde in the control of alcohol withdrawal was a common everyday occurrence. Situations developed in the 1950's and 1960's where inmates actually became addicted to these particular drugs while being institutionalized. Cases where Paraldehyde was used indiscriminately causing the deaths of individuals and the indiscriminate use of aspirin and other drugs was commonplace.

These drugs were used for the purpose of placating the prisoner. They are often argumentative and demanding and it was an easy way for supervisors and physicians to maintain control. We also found that we had a lack of information and knowledge as to just what these drugs were and how they were to be used legitimately.

This brings to attention an incident that happened in this time frame where these drugs were often hoarded by the inmate and then traded off for cigarettes and other material things. They were also good pay for gambling debts created by inmates. One individual I knew personally hoarded Sodium Seconal which he then took all at once. I can remember to this day the stupor and overdose condition that the individual was in when I found him -- strictly as a result of abusing this drug.

As we progressed into the 1970's, the population increased in our institution. We had no programs for alcohol and drug detoxification. We had no R.O.R. Program. We had no weekend programs or Work Release Program. We found ourselves in a situation where our jail was becoming overpopulated. Tension was running high. Overcrowded conditions caused inmates to become nervous, anxious and on the verge of losing control. Again it was easy to placate the prisoner by sedation with mind altering drugs. And we continued that particular program. As we progressed out of the 1970's and got into the programs of detoxification, R.O.R. Programs and mandated court Standards for jails, we found that through these new Standards, proper medical attention for inmates incarcerated in pre-trial configurations was indeed a necessity. We found that by moving people into detoxification programs, we could eliminate in our county jail the use of many of the drugs for alcohol detoxification. We found also that physicians were becoming more conscious of the number, amount and kinds of medications they were dispensing to the inmate population. To break that particular syndrome was indeed in itself a very difficult thing.

We still have the inmate population. Although reduced in numbers, we have certain individuals who had been incarcerated through the 1960's and through recidivism have returned to pre-trial confinement and were demanding the same drugs that they had received prior to that time. With the insistence by the

*Presented by Charles Meeks, Sheriff, Allen County, Fort Wayne, Indiana.

physicians that this type of medication would no longer be used, we found in some cases a violent reaction on the part of the prisoner. Physicians were assaulted when denying the drug to them. And I must say, at this time, that the physicians we have in our facility were strong and remained strong and refused to succumb to their force and pressure to the use of the harder barbiturate drugs by the inmate population. We also found that through educating the officers on the abuse of certain control substances and mind altering drugs that they, too, were becoming consciously aware of exactly what some of the drugs can do to the individual.

From 1974 to the present, the Federal Court imposed Standards upon the county jail that made it mandatory for physicians and medical staff to be on sight constantly for proper supervision. We found in our statistics that we reduced the figure of 75% of inmate population on mind altering drugs to approximately 20% at present. We found that there were other drugs which could be used in specific situations that warranted them. So we left the use of heavy barbiturate drugs and went off to other drugs -- Valium, Librium and Thorazine. We saw a drastic reduction in the use of those particular drugs, even Thorazine dropping off from 1972 to 1978 -- a reduction of almost 35%.

There is definitely a need for the use of mind altering drugs in situations of pre-trial detention facilities. We must be very careful, however, that through the use of some of these drugs we do not cause addiction, overdose and the important introduction of the new abuser to the use of these particular drugs. We find it important that we should lay down specific situations by our medical staff whereby certain drugs will be used: situations of drug withdrawal, alcohol withdrawal, the alcoholic involved in the pre-trial facility, and foremost, the use by individuals who are known to have mental disorders. Without the use of mind altering drugs for pre-trial confinement, in certain situations, condition would be tenable for some individuals who are incarcerated in our jails. We find, however, that it is vitally important that a trained medical staff be available. We find it vitally important that we have nurses and properly trained personnel constantly on duty in our facilities to be able to control certain situations that develop. We find it important that they be trained in how to administer these drugs properly and in what amounts and in correct time, supervised adequately by our medical staff. For if we continue to give our inmate populations mind altering drugs and we continue to abuse the scattered effect of overuse -- the indiscriminate distribution of these drugs -- we will find situations developing where we will continue these individuals' problems with drug addition. We will find that we have introduced people to drug addition. We will find ourselves in situations where the inmate will be unable to defend himself, not only in the court of law, but also in the environment that he finds himself in. We find that we must continue to strive for better ways, better programs and more medical staff. We must continue to convince the legislative branches of our local government that it is their reponsibility and that of the communities to supply to the people locked up in county jails proper medical attention and demand that the proper medical supervision is there to dispense the control and mind altering drugs with restraint, using them only in carefully determined situations.

We have found in our facility that individuals coming through the pre-trial detention facilities in many cases have never had proper medical treatment. We have found people who have never seen a physician, who have social diseases, undetected cases of T.B. and hepatitis. Mental disorders by the score come

through our facility. We believe that the county jails are many times places where society has an opportunity to identify and then treat those individuals who are in our community who would never seek out help on their own.

I find it vitally important that these new programs including screening of the inmate population be increased, and that the staff there be properly trained in handling the problems that we face in the present judicial system and the individuals who we come into daily contact with. We have a continuing need to professionalize ourselves in the treatment of those who come to the county jail.

I thank you for the opportunity to address you and for visiting with you today.

58537

THE CARE OF MENTALLY ILL, SUSPECTED MENTALLY ILL AND RETARDED INMATES: WHO SHOULD DO THE TREATING?*

As I stand before a conference sponsored by the American Medical Association, it seems somewhat incongruous to be asking, "Who should do the treating?" As most of you are aware, medical practice today is characterized by a proliferation of specialists, sub-specialists and super-specialists. If you work in a major medical center, there is no question who should repair lacerated tendons in the hand--obviously the hand surgeon. The pediatric cardiologist undertakes the treatment of a child with a congenital heart defect, and the oncologist manages the patient with a tumor. Why, then, are we meeting here today to talk of mentally ill and retarded patients and questioning, "Who should do the treating?"

You and I, of course, both know the answers. The term "mental illness" means many things to many people, and the label of "mental illness" has been attached to many individuals in the past as the result not of judgments made on the basis of scientific medical practice, but rather because of social, cultural or legal biases. Psychiatrists themselves, in many cases, cannot agree on precisely what is meant by the term "mental illness," and the addition of other theoretical approaches by psychologists, social workers and other professionals has not helped to clear up the picture. The psychiatric profession is in an identity crisis, and for a great number of us psychiatrists, its only salvation is in the return to the so-called "medical model." We are seeing today the fruits of the explosive growth of the community psychiatry movement, which elevated psychiatrists and other mental health professionals into an unearned and unwarranted position as experts in education, racism, poverty and international relations, just to mention a few. I am not saying that psychiatrists may not have expertise in these areas; however, that expertise is not derived automatically by virtue of their M.D. degree, nor from the completion of a psychiatric training program. The psychiatrist who chooses to work in the criminal justice system, be it either in a courtroom, jail or prison, must recognize his limitations and fight off the cloak of omnipotence with which society tries at times to place on him. Contrary to what many may feel, psychiatrists are rarely prepared by virtue of their formal psychiatric training to deal with issues of public protection and criminal behavior. It is imperative that the psychiatrist very clearly defines his area of expertise and directs his time to the attention of those patients who can receive the needed services from no other source.

If you look at varieties of services that the mental health professional is called upon to render in jails and prisons, it becomes clear that they fall into two basic categories: (1) Public Protection Services and (2) Treatment Services. The category of Public Protection Services includes those activities not geared toward the needs of the patient but rather primarily to the needs of the criminal justice system and the institution in particular. Such activites might include initial classification studies, evaluations of inmates as the result of rules infractions, particularly if they involve violence or sexual misbehavior, probation, parole and pardon reports, etc. The second category, which I am calling "Human Needs Services," is directed toward the needs of the inmate and includes such items as crisis intervention, counseling, substance

*Presented by Dennis M. Jurczak, M.D., Chief Psychiatrist, Office of Health Care Services, Michigan Department of Corrections.

abuse services, programs oriented toward personality change in the inmate with hopes for resultant reversals of criminal behavior patterns and, last but not least, treatment of the mentally ill.

For the purposes of this discussion, I would like to restrict the term "mental illness" to the conditions known as schizophrenia, manic-depressive psychoses, organic brain disease and endogenous depression. It is these conditions that are known to have, or are presumed to have, an organic basis and, except in the most deteriorated states, respond best to the medical approach through the use of chemotherapeutic agents or other organic modalities. We do not know the cause of schizophrenia, nor do we know the cure; but we can--under proper medical supervision--ameliorate many of the symptoms through the use of medication and, with the support of nursing, psychological and social work services, provide the best hope for the patient. It is for this class of patient that management by a physician is mandatory, yet it is this very type of patient who by the nature of his chronicity has often been most ignored. At this point you may object that this is too narrow a definition and that there are other inmates in need: men suffering from guilt, loneliness, fear, despair, and all the other devastating effects of imprisonment. What about those inmates with serious drug problems, sexual problems, and marital problems? How about those inmates who just need somebody to listen to them or want in some way to find meaning to their lives? These needs, of course, must be answered, but I do not believe the criminal justice system should expect to find the resources or the expertise to satisfy these needs by turning to psychiatry. The impact of the criminal justice system on any individual involves medicine only to a small degree when compared to the importance of social, cultural educational, religious and legal issues.

If the psychiatrist backs out, who will take his place? Well, the very same people who have been doing it all along the line--the teachers, case workers, priests, ministers, correctional officers, wardens, work supervisors and correctional psychologists. It is my opinion that it is these individuals who are better trained and better equipped by virtue of their experience to assist the new inmate in adjusting to prison or in learning to deal with the threat of sexual assault or in developing the skills for getting along with others in an adult role.

This is not, as I see it, an abandonment of psychiatry's role but rather a re-definition of who the psychiatrist is and what his training is, thereby being able to utilize his resources most effectively. I firmly believe that the vast majority of the "Human Services Needs," exclusive of the treatment of the mentally ill, can be provided as effectively--if not more effectively--by a non-psychiatrist and, given the premium that the psychiatrist demands by virtue of his status as a physician, more economically. In these days of tax limitations, the wise use of tax dollars must be a priority with every public administrator. Another significant effect of the return of the psychiatrist to the medical model is that it, in effect, will strip away the mystique, the aura surrounding the practice of medicine which has been assumed by many non-medical professionals. The time has come for psychologists, social workers and other professionals to stand on their own and demonstrate the value of their disciplines independent of medicine and to rid their vocabulary of its medical terminology. In the practice of medicine we have no difficulty in understanding the word "treatment" and surely ought to, in most cases, be able

to predict the results of such treatment. Unfortunately, as they become applied outside medicine, the words "treatment," "therapist," "clinician" and "therapy" have lost their meanings.

What is treatment? I know what it means in reference to something I do to a person with a strep throat; I do not believe that same medical term should be applied to services provided to the individual who has violated the law by commission of an armed robbery, murder, rape or embezzlement. The term "treatment" has been used repeatedly in the correctional literature, yet more and more we realize that the use of the term has held out a promise, not only to the individual, but to the courts and the general public as well, that something was being done to "cure" the inmate. We cannot treat the criminal for his personality disorder, because treatment implies activity on the part of the treating person and, to a certain extent, inactivity on the part of the patient. The physician is responsible for treatment, while the patient, as in a surgical procedure for instance, may be a totally passive participant. There is no question in my mind that terms used in corrections such as "treatment teams," "treatment plans" and "treatment programs" ought to be replaced and that such services be defined more clearly as psychological, counseling or guidance services. If we do away with the term "treatment" for the vast majority of services provided to inmates, we should also, of course, do away with those time-honored and prestigious but ill-defined terms such as "clinician" and "therapist." I frankly do not know what a clinician is or what a therapist is. I do know what a social worker is; I do know what a psychologist is; I do know what a prison counselor is; and, more important, I know and other responsible individuals in the criminal justice system know what psychologists, social workers and prison counselors do and are expected to do.

As an ethical issue, it is even more important for psychiatrists and the psychiatric profession to divest itself of what I consider an over-involvement in the management of the offender. Classification studies, parole board reports, pardon hearings and the like are not issues directed toward the welfare of the patient. They do involve the protection of the public and unless the individual is mentally ill, they should not concern the practice of medicine. This is especially true in view of the growing realization that psychiatrists are in general poor predictors of violence and dangerous behavior. Because of the weight given to a psychiatric report by various decision-making bodies, the potential for harm to an individual who is the subject of such a report is great. Physicians should avoid being drawn into such activities, particularly when the individual is not mentally ill and the issues can be addressed by a non-medical professional. Most certainly psychologists by virtue of their training are often far better equipped to speak of the concept of personality assessment and development.

My answers, then, may sound simplistic but let's be realistic. Psychiatric resources are extremely limited, and it is the rare state or county correctional system which has adequate psychiatrists available. The psychiatrist as a physician has a responsibility to the treatment of the schizophrenic, the manic-depressive, the individual with organic brain disease or with severe depression. He has a responsibility to these patients because no one else can take his place, and until these patients are receiving adequate services, he ought not to be involved in other albeit more stimulating endeavors.

The psychiatrist must closely align himself with the medical staff at the institution and assist them in the diagnosis and management of those complaints which have a very strong psychological component. He must at the same time encourage the medical staff to refrain from an over-dependency on medications where the problems are basically of a psychological nature. The psychiatrist must work collaboratively with other institutional staff, keeping in the forefront the realization that his time and talents are limited and will be rapidly over-extended of he attempts to take on responsibilities which in reality belong to others.

The delivery of human services programs should be under the supervision of psychologists or social workers and divorced from the medical department. Their clients should be recognized as individuals who are not mentally ill and whose crimes are the result of the interaction of many forces. We have heard again and again that the medical model does not work. On the contrary, the "medical model" does work but only when applied to medicine. The "medical model" will not work when applied to social, education, cultural or legal problems. The failure is not in the "medical model" but in its application outside of medicine. The "Mental Health Marching and Chowder Society" bandwagon has gone too far. It has confused our language, misdirected our goals and promised the moon, but delivered much less, except for high costs to the taxpayer and disappointments to many.

THE CARE OF THE MENTALLY ILL, SUSPECTED MENTALLY ILL AND RETARDED INMATE PATIENTS: WHO SHOULD DO THE TREATING?*

Three and a half years ago, the Oregon Legislature in its regular biennial meeting, provided funds and a legislative mandate to develop a Mental Health Program within Corrections. In granting the funds to the State Mental Health Division, the Legislature stated its expectations to 1) increase the cooperation between Mental Health and Corrections Divisions; 2) develop a correctional facility based treatment program for alcohol and drug dependent clients; 3) establish a hospital treatment program for alcohol and drug clients at the state hospital and 4) develop needs assessments of offenders in the institutions and in the communities.

Before launching into the specific argument of this address, I would like to define some terms. In Oregon, the agency responsible for mental health is the Mental Health Division. It is part of an umbrella agency of the Human Resources Division, which also includes the Corrections Division as well as other human service agencies. The state Mental Health Division carries out programs aimed at persons with mental health problems in both hospital and community settings. The mental health program network includes mental health program authorities in every county of the State. These programs are operated as semi-autonomous county agencies. The funding in most cases is 50% state funds and 50% local. The range of problems addressed by the Mental Health Division according to statute include alcohol and/or drug dependency problems, mental and emotional disturbances, and mental retardation and/or developmental disabilities.

Until three years ago, when the Mental Health Programs in Correction was started, the Mental Health Division did, in fact, treat offender clients as part of local specialized alcohol or drug treatment programs. In addition, offenders have been treated at several of the state hospitals, either as mentally ill patients or as persons specifically committed as "not responsible" for a criminal offense because of mental disease or defect. Prior to three years ago, the Mental Health Division's involvement in the three felony prisons in the State of Oregon was minimal.

It is my thesis, and I am not an impartial observer, that the delivery of treatment services by the Mental Health Division has resulted in an increase of the quality of services being delivered and has also increased the quantity of services available to offender clients.

First of all, we have found it relatively easy to recruit a competent and well-qualified staff. This includes persons at the professional and pre-professional level of counseling and psychotherapy. It includes psychiatrists, psychologists, professionally certified social workers, as well as a master's level psychologist. We have also successfully recruited several persons with treatment expertise in alcohol and/or drug treatment who are pre-BA.

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*Presented by David A. Francis, Coordinator, Mental Health Program in Corrections, Oregon Department of Human Resources.

Our success in recruiting competent staff is partly because we are a Mental Health Division, not a Corrections Agency, and partly because of our practice of hiring part-time consultants rather than hiring regular full time state employees.

Many mental health professionals will simply not respond to a job announcement published by a correctional agency. We have had some resistance from mental health professionals who, after inquiring about a position and discovering that it involved working in a prison, indicated their lack of interest. In one instance, we recruited and hired a psychiatrist who found within a short period of time that he was not interested or capable of working in a prison setting. However, by in large, we have been able to recruit and maintain a competent treatment staff.

The obvious benefit to quality treatment of starting with quality staff is without argument. Quality of services is also increased by our ability to provide competent and knowledgeable supervision of this professional staff. In each of our three felony institutions, the prison superintendent still has on his direct staff a psychiatrist position and other mental health personnel. He or she is responsible for the supervision of these employees. These superintendents have all expressed to me their concern about the lack of their ability to supervise the work of a professional whose special training takes them out of the area of the superintendent's direct knowledge or experience. Superintendents at times have had difficult employees, but have not been able to determine whether quality services are being delivered or the services are being delivered according to generally accepted treatment standards.

I am pleased to see the focus of this conference on the preparation of Standards for mental health care for jails and prisons. The publication of these Standards will, of course, increase the correctional administrator's ability to supervise professional staff. I am even delighted to see this argument weakened by the focus of this conference.

Nevertheless, our experience in Oregon has been that we have been able to increase the quality of services compared to the quality of services delivered by correctional personnel by providing competent supervision. That supervision includes Peer Utilization Review for our licensed clinical staff and clinical supervision of those persons who are not presently licensed. Clinical supervision is carried out only by licensed clinical staff.

The third way in which the delivery of services in the mental health authority increases the quality of services is that by recruiting staff and providing competent supervision of this staff, we, in effect, increase the credibility of the service being delivered.

In Oregon, the credibility of the service was first extended to the Mental Health Division by the Legislature. Secondly, as we began to go into the prisons and meet with inmate clients, our credibility within increased, and finally, as we planned programs with correctional administrators and began to work side by side with correctional staff, our credibility within has increased.

Although credibility of service may not appear at first to be a quality issue, the absence of credibility in the service agency and the service provider does in fact reduce service quality.

It is obvious, I am sure, to any of you who work in correctional settings that the correctional inmates would extend at least lip service credibility to persons who come in from the outside. It's all part of the "conning" game. However, it is our experience and judgment that some clients have been moved into a deeper experience of therapy than they had imagined and felt free to do so because we represent an independent outside agency working with them. It is not secret that we work cooperatively with Corrections Division. However, the perception of the inmate is that they see us sufficiently separate to feel freer to be more honest. We think this increases quality services.

The fact that the Mental Health Division is an independent agency makes our consultative services much more credible than if they were, in fact, in-house consultative services. This is true of both case consultation, where the focus is a particular client and his or her problems, and even more true of system consultation. System consultation is where the correctional facility superintendent or some other person on his staff requests that we look at any area of institutional program or at some kind of institutional problem area and make recommendations to him or her as to how these problems may be addressed or how the effectiveness of the institution could be increased. The effectiveness and quality of this consultative service is, I think, directly related to our status.

The Mental Health Division in Oregon is currently providing services with special funds earmarked for offender clinets -- that is, clients within the State's Corrections Division in the three prisons in hospital treatment units which serve inmate clients, and also in community mental health programs. But let me, for this argument, separate the program into the institutional phase and the community phase.

First of all, in the institutional phase, the quantity of service was markedly increased in the first year of our program's operation. Beginning in 1975 when we started, the prisons had the capability of treating somewhere around 25 or 30 alcohol and drug clients during any given time. At the end of our first year of operation, we had a static treatment caseload of 140 alcohol and drug clients. We increased by nearly five times the amount of treatment services available to alcohol and drug clients in the prison.

Secondly from a dollar standpoint, it is difficult to isolate the dollars committed to the treatment of alcohol and drug clients in the prison prior to 1975. However, the initial two-year budget for the program was $363,000. It is inconceivable to me, at least in Oregon, that the Corrections Division would have been successful in getting an additional $363,000 from the State Legislature to provide treatment services in the prison. However, in a partnership between the Corrections Division and the Mental Health Division, we did get that amount of money from the State Legislature.

The treatment budgets within the three state correctional facilities

have been level with moderate increases because of inflation over the past number of years. The start of this new program made a surprising increase in the dollars committed to treatment of prisoners.

When we went back to the State Legislature in January 1977, we had a budget from the previous two years of about $1.1 million. The Legislature appropriated $5.5 million for the next two-year period. This includes the establishment of new hospital treatment wards for mentally and emotionally disturbed sex offenders and mentally retarded offenders, and also expanded our prison treatment programs to include not only clients with alcohol and drug problems, but also those with mental and emotional disturbance and sex offenses.

There are a number of reasons why in partnership using the external mental health authority we were successful in increasing the quantity of services.

First of all, resources are limited and mental health treatment is not the highest priority. Budget requests within the correctional facilities for these additional monies for mental health treatment simply have little chance. Any responsible superintendent faced with a choice between increasing safety and security or increasing treatment resources must decide to increase safety and security. Consequently, most treatment within correctional facilities is limited by budgets to first aid and evaluations for administrative purposes.

Our success in Oregon is that we had the cooperation of two agencies going in with a unified budget plan and request to the Legislature, rather than one coming in alone. The Legislature had instructed us to study and document the needs within the correctional facilities. We did that, and we were rewarded with a greatly expanded program.

Treatment services to offenders have also increased in quality and quantity in the community. By providing treatment services within the mental health systems the community resources, in effect, are really multiplied. In 1975 the program was started with no funds for treatment in the community for offenders. It is true that some of our treatment programs, particularly alcohol and drug programs, carry caseloads that were heavily weighed with offender clients. However, there were no funds specifically dedicated to the treatment of offenders within the community.

The 1977 Legislature did appropriate $1.5 million for the treatment of offender clients in the community. These funds were divided county by county with each county getting a pro-rata share. By the time $1.5 million is divided 35 ways, no one county gets very much in the way of resources. However, what we are finding is that the flow of special funds to the counties has, in fact, opened the doors of community mental health programs to offender clients. Once inside the door, these clients are receiving a much wider range of services than those simply provided by the specific funds allocated for them.

Let me give you an example of this. Let's assume we have a client whose

major problem in the past has been drug dependence. That client has been referred to a county mental health program for treatment of his drug dependence and is assigned a counselor. In this county, the amount of dollars was sufficient to enable the county to hire an alcohol and drug treatment specialist who deals exclusively with a caseload of offender clients. In the course of treating this person with drug dependency, the counselor notices there are severe problems in the client's marriage. A therapist in the next office has a marital counseling group. In addition to this regular treatment with the drug counselor, the client is assigned to the marital counseling group. The benefits of the treatment are in fact multiplied.

Let's imagine another county, whose funds are limited and are already treating 20 offender clients. Twenty is their contract caseload. They are technically full. However, in order to work with that 20 caseload, the counselor in charge of that caseload has developed a working relationship with the parole and probation officer in his county. The parole officer has a brand new parolee who seems in need of treatment. He calls up his contact in the mental health program who says, "Well, you know I'm full, but why don't you send him by and I'll see what we can do." This situation multiplies the effect of these special dollars.

Our community system is still in the process of being implemented, but we fully expect that the benefits of providing services through mental health programs will multiply the effect of the benefits and increase the quantity of service beyond the quantity that $1.5 million would be expected to buy.

There is a third argument for the delivery of treatment of services by the mental health authority: that it provides better continuity of care. Continuity of care is medical jargon which means that the quality and type of service delivered in one setting will have some continuity with the quality and type of service provided in another setting. We refer specifically to the continuity between institutional treatment and community treatment.

In contrast to this, I would like to hold up an ideal model. Because the State Mental Health Division is the treating agent's agent in both the institution and in the community, there is a greater possibility that the care will be of similar quality and type from the institution to the community. It is also more likely that communication between the treating agents will precede the client's arrival at a community treatment program. The fact of the matter is that community treatment resources for people like the sex offender simply do not exist in any great quantity in Oregon. The morning I was writing this speech in my office, I got a phone call from a parole officer in the Portland Metropolitan area describing a case of such a person and asking me where treatment could be secured. Since the client lived in a county which has not implemented such a community treatment plan for offenders, I was stuck to provide him with a resource. There are only two private practitioners in Portland that I know of who have specific expertise in this area: one is a psychiatrist, the second, a psychologist. Both of these gentlemen are in private practice and need to receive fees for most of the treatment they do. However, when the community treatment program is fully implemented in the Portland area, I will be able to suggest a specific resource.

Finally, I have argued the case for treatment services being delivered by

mental health authority rather than by other means because it is our experience that this plan has increased the quality of services as well as the quantity of services available to offender clients. Before I finish, however, I have to recognize that there are problems with the involvement of a mental health agency.

First of all, considering that treatment programs are being run within prisons, there is the problem of administrative control. The superintendents of the prison facilities we work within do not control us in the same manner that they may control a person who is directly their employee. Some superintendents were uneasy about this relationship. It is a problem to be faced. We have faced it by combining top administrative people--including the superintendents--from the Mental Health and Corrections Divisions into a policy-making board, which is called the Policy Board. This group is delegated the authority by each agency administrator to develop policies which govern the operation of our treatment programs in the prisons, hospitals and communities. This Board has served as an important bridge between the two divisions and has provided a forum for us to discuss our sometimes differing points of view on philosophy and our judgment as to what clients need.

Another problem is that of coordinating the efforts of mental health treatment personnel working in a prison with those people who develop the total correctional plan for that client. We have approached this problem by initiating contact with a variety of personnel within the prisons, mostly in our case the correctional counselors who act as case managers in charge of developing correctional programs.

A third problem that we have faced is "burnout." Anyone who works for any period of time with offender clients will become extremely weary, perhaps even cynical and depressed. This is "burnout." We haven't solved this issue, and it is one of the reasons mental health people are very reluctant to work with offender clients. Our approach has included the use of part-time consultants. Our treatment staff who work in the prisons work for us no more than half-time. Most work one day a week. This has reduced "burnout." The promise of learning new skills specifically designed to treat offender clients will also reduce "burnout."

A fourth and final problems we have faced and are still facing is the lack of interest by mental health people in the offender client. This is rooted in the prejudice that offenders cannot be treated.

It is partially true that many offender clients are "cons." Many, even though psychotic, may be sociopathic. The debate within mental health circles in Oregon as to whether offenders are "mad" or "bad" rages on. We have found that many of the clients within the prisons are, in fact, capable of responding to treatment and want treatment. They may not exhibit this motivation in the first interview, but within a reasonable period of time they become motivated and begin to cooperate in their treatment.

The final problem we face is really the basic question. What are we doing and how can it be measured? Some would expect that we are treating persons to change their criminal patterns. We carefully avoided promising the Legislature a "cure" for criminal behavior. What we told them is that we

would treat many of the symptoms that seemed related to criminal behavior and that we expected this to reduce their criminal acts.

Certainly we cannot expect to change all our clients into fully functioning human beings. We probably cannot make most of these people less troublesome. We can perhaps make them less troubled. But is that enough? I am personally not satisfied that it is enough. More and more I am coming to believe that the offender is caught up in a whole pattern of thinking and behaving which must be totally changed. I've been moved to this belief by my treatment experience with narcotic addicts, and more recently by the work of Doctors Yochelson and Sammenow in the "Criminal Personality." We haven't yet solved the problem of appropriate ends and goals. We do have some programs in place.

In Oregon, thanks largely to the Legislature, a sympathetic governor, and two mostly willing state divisions, the Mental Health Division is involved in the treatment of offenders in a big way. I think it is the preferred approach because it has produced increases in treatment quality and quantity, and has brought two disparate agencies into a close--not always comfortable--working relationship.

58538

FORMALIZING HEALTH CARE SYSTEMS*

This monograph is devoted to the formalization of the health care system based upon the individual standards contained in Standards for the Accreditation of Medical Care and Health Services in Jails.

WHAT AND WHY

WHAT

Standard operating procedures are statements regarding and describing the structure (people, equipment and supplies) and processes (how the structure works) of medical care made available to the inmates. These statements will, by necessity, describe--but not be limited to--the following:

1. Medical authority and responsibility.
2. The patient flow starting at the point of request for care to final disposition.
3. Identified referral sources (clinicians and/or institutions in the community).
4. Identify clinicians by title within the jail (i.e.: Staff physician, infirmary nurse, etc.)
5. Orders regarding jailer roles in the delivery of health care.

Standards operating procedures identify the goals of the health delivery system and guide the personnel "toward these goals through realistic and attainable objectives." [2]

Standard operating procedures should be used to provide:

1. A basis for training programs to enable new personnel to acquire knowledge and skills.

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1 American Medical Association Program To Improve Medical Care and Health Services in Correctional Institutions, Chicago.

2 Accreditation Manual for Hospitals, 1979 Edition, Joint Commission on Accreditation of Hospitals, Chicago.

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*Presented by Myron P. Nidetz, Associate Director, Health Care in Correctional Institutions, American Medical Association.

2. A ready reference on procedures.
3. Standardized procedures and equipment.
4. A basis for evaluation and study to insure continued improvement.[3]

WHY

"Private" care need not necessarily require the formalization of policy and procedures. Institutional care does because it is based on a system of multiple providers of medical care and a revolving patient population.

Legal considerations: The documentation of written procedures and the compliance thereof make it difficult to prove deliberate indifference; a phase used by the United States Supreme Court in the famous case: Estelle v. Gamble.

Finally, and certainly not the least, is the adoption of horse sense: written standard operating procedures are simply good professional and business practice.

WHO

The standard operating procedures are developed by both the sheriff and/or his staff and the responsible physician. The standard operating procedures are periodically reviewed and revised as necessary by both and are approved-in-writing by the responsible physician.

COST

The cost of writing down these standard operating procedures is dependent upon the time spent by the sheriff and physician and that of a typist whose salary is relative to the individual jail.

IMPLEMENTING THE FORMALIZATION OF THE HEALTH CARE SYSTEM

The present delivery system is assessed including who does what and where they do it.

The second step is the comparison with the Standards requirements to see where the delivery system fits and where it doesn't.

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3 Ibid.

The following are some of the standard operating procedures and policies required by Standards:

1004 Written standard operating procedures approved by the responsible physician exist for the following:

Receiving screening;
Health appraisal data collection;
Non-emergency medical services;
Emergency medical and dental services;
Deciding the emergency nature of illness or injury;
Provision of medical and dental prostheses;
First aid;
Notification of next of kin or legal guardian in case of serious illness, injury or death;
Chronic care;
Convalescent care;
Medical preventive maintenance;
Screening, referral and care of mentally ill and retarded inmates;
Implementing the special medical program;
Delousing;
Detoxification; and,
Pharmaceuticals.

CASE STUDIES

The following case presentations demonstrate how each of the individual standards can be used to construct the required standard operating procedures.

Case No. 1 - The Standards require a standard operating procedure implementing the special medical program:

1026 A special program exists for inmates requiring close medical supervision. A written individual treatment plan for each of these patients is developed by a physician which includes directions to medical and non-medical personnel regarding their roles in the care and supervision of these patients.

This is easily translated into:

When the physician prescribes closed medical supervision for an inmate, the physician will construct and individual treatment plan which may include special orders and instructions to the jail staff. The staff, in turn, is responsible for carrying out these orders. The general

overall program for inmates who require special medical supervision is directed by Dr. Kildare.

Case No. 2 - The standards require quite a bit of written documentation regarding routine-type dentistry:

Dental care is provided to each inmate under the direction and supervision of a dentist licensed in the state as follows:

> Dental screening within 14 days of admission;
> Dental hygiene services within 14 days of admission;
> Dental examinations within three months of admissions; and
> Dental treatment, not limited to extractions, within three months of admission when the health of the inmate would otherwise be adversely affected."

This in turn relates to:

> Each inmate will receive a dental screening within 14 days after admission to the facility. This screening will include the charting of decayed, missing, and filled teeth and the taking of a dental history. The screening will be performed in conjunction with the health appraisal data collection and will be performed by the medically trained corrections officer.
>
> Each inmate will receive dental hygiene services within 14 days of admission to the facility. The hygiene services will include instructions in brushing and flossing teeth and will employ the procedures developed by the Illinois State Dental Association. The responsibility for this service is that of the shift commander.

(The following is a standard operating procedure which does not reflect the specific requirements of the individual standard but a statement thereto is still a mandatory requirement for accreditation:)

> Dental examinations are performed by the dentist during the office visit in which dental treatment occurs. (This does not meet the requirements of the standards; i.e.: Not all inmates are given dental examinations.)
>
> Inmates will receive dental treatment within three months of admission to the facility when the health of the inmate would otherwise be adversely affected. Dental treatment is not limited to extractions.

Case No. 3 - The control of prescriptions of medications--The standards require a policy which addresses the following:

1028 "The facility's standard operating procedures for the proper management of pharmaceuticals include:

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A policy regarding the prescription of all medications with particular attention to behavior modifying medications and those subject to abuse;"

The Standard Operating Procedures:

The prescription of all inmate medications--both those requiring a written prescription and those not--is controlled by Dr. Kildare. This does not preclude the delegation of this control by Dr. Kildare to other physicians of his choice. The names of these delegate physicians are on file at the jail. All prescriptions written by other than Dr. Kildare and his delegates must be cleared by Dr. Kildare before their administration to the inmate.

All prescriptions of behavior modifying medications and those subject to abuse is controlled by Dr. Kildare via his personal approval of each of these prescriptions or by the delegate physicians of Dr. Kildare's choosing.

OTHER RESOURCES

The Practical Guide to the American Medical Association Standards for the Accreditation of Medical Care and Health Services in Jails contains examples of standard operating procedures for the following subjects:

administrative structure
health appraisal date collection
non-emergency medical care
emergency medical care
chronic and convalescent care
medical preventative maintenance

The national program staff of the American Medical Association Program to Improve Medical Care and Health Services in Correctional Institutions, Chicago, and the participating state medical societies can provide limited technical assistance to persons interested in formalizing health care systems.

CHEMICAL DEPENDENCY -- JAILS AND PRISONS*

There are a number of available data sources that indicate the need for identification and treatment of the chemically dependent inmate in jails or prisons. In 1976, LEAA and the Bureau of Census published the National Prisoner Statistics which included a drug abuse survey of 10,000 inmates in state prisons in 1974. The sample was representative of 194,000 inmates in state prisons in 1974. The survey revealed that 61% or 118,340 inmates had abused illicit drugs; 30 to 33% or 64,020 had abused heroin at one time, and less than 15% or 100,589 of those who had abused drugs had ever received treatment.

In order to determine what resources were available for the chemically dependent inmate in local jails, the National Jail Resources Study, conducted by researchers of the Pennsylvania State University (funded by LEAA) examined the service network of a national sample of 118 jails offering some drug abuse treatment programming. Services examined included screening, detoxification, social services, and psychological counseling. This study found that most jails lacked a formal screening process to identify the substance abuser. Even though 80% of the jails surveyed reported some form of detoxification service, methods for detoxification of the chemically dependent inmate appeared to be inconsistent and widely diverse. The study found that most jails treated withdrawal symptomatically, often utilizing tranquilizers, antispasmodics, antihistamines and other drugs. In addition, most jails in the study had no provision for methadone administration and/or methadone maintenance, but instead had a policy of detoxification only.

In March 1978, the Office of Drug Abuse Policy in the White House identified the treatment of the incarcerated chemically dependent individual as a problem area, and included in the yellow paper on Drug Abuse recommendations to encourage alternatives to incarceration, to improve treatment during incarceration, and to strengthen linkages between the drug abuse treatment system and the criminal justice system. One of the recommendations included a provision for detoxification of the chemically dependent inmate "by the most appropriate and humane methods of drug withdrawal."

Recognizing that detoxification services to chemically dependent individuals are often provided in a haphazard manner, if at all, the National Institute on Drug Abuse has developed a treatment manual which includes procedures and guidance for detoxification of the chemically dependent individual who may present the need of treatment in a variety of situations such as hospitals, clinics, correctional institutions, or psychiatric facilities.

In addition, the National Institute on Drug Abuse is working together with the States to develop or expand linkages between criminal justice

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*Presented by Dorynne J. Czechowicz, M.D., Special Assistant to Director, Scientific and Medical Affairs, National Institute on Drug Abuse.

systems and drug abuse treatment programs. Involvement of the chemically dependent individual with the criminal justice system has a potentially therapeutic value which should be exploited -- it is often the catalyst which sets the treatment rehabilitation cycle into motion.

58539

JAIL AND PRISON DEATHS: *

A FIVE-YEAR STATEWIDE SURVEY OF 223 DEATHS IN POLICE CUSTODY

NORTH CAROLINA 1972-1976

One goal of the North Carolina Medical Examiner System is reduction of homicides, suicides, accidental deaths, and untimely natural deaths. To this end we directed an analysis and evaluation of deaths in custody. We assumed we might not only demonstrat specific problems but also identify characteristics among the victims and the circumstances of their deaths that would facilitate problem solution. This is a short report of our project.

By statute and by custom all deaths in police custody in North Carolina are investigated by medical examiners. Policy requires autopsy for each victim. Our data are derived from medical examiner, autopsy and toxicology reports plus information from jail and prison authorities whom we found interested and cooperative. During the five year scope of the study, 1972 through 1976, the North Carolina population was approximately 5.4 million persons living in small cities and towns and on small farms. The racial proportions were about 75% white, 24% black and 1% American Indian.

We distinguished between deaths of inmates or patients in the jails and those in the prison system in several categories. The approximately 110 jails are primarily county and municipal facilities and house new arrestees, prisoners awaiting trial and those serving misdemeanor sentences of usually less than six months. This system had about 200,000 admissions per year with an average daily census of about 28,000. Although the daily census indicates approximately equal numbers of whites and non-whites, the admission rate is about 3:2, white:non-white. The state's Department of Corrections operates over 80 prison units comprising a variety of facilities including Central Prison with its hospital which provides definitive medical and surgical care for the entire prison system and jails. The prison inmates are convicted persons serving sentences for felonies and the more serious misdemeanors. They number about 12,000 including about 1200 at Central Prison. The sex and race proportions are as illustrated.

So called natural disease processes accounted for nearly one-half (102) of the 223 deaths. Seventy suicides were a third of the total. Accidents and homicides comprised a tenth each, but nearly half of the latter resulted

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*Presented by Page Hudson, M.D., Chief Medical Examiner, Department of Human Resources, State of North Carolina.

from a single act of arson. In four instances, less than two percent, the manner remained obscure although the causes were evident.

In the natural category, we attributed death to that common but medically poorly understood process, alcohol withdrawal syndrome in 30 prisoners, typically middle aged alcoholics. "Fatty liver" and "DT's" are terms also frequently used for this entity. Most of these deaths occurred within the first three days of incarceration. It was clear in our review that several known alcoholics were jailed on public drunk charges when their problem was alcohol withdrawal or delerium tremens, not intoxication. Various manifestations of arteriosclerotic coronary heart disease accounted for thirty-five deaths. The period of incarceration varied from hours to many years. A wide variety of other diseases accounted for death in the remaining one-third of the natural deaths.

Three types of accidents accounted for 18 of the 25 fatal accidents. The five acute drug abuse deaths involved pentazocine (Talwin) in Central Prison, barbiturate in prison camp, Freon (antiperspirant) and tetrachlorethane (Nu-Type) in prison youth centers and heroin in a county jail. The five falls were alcohol and/or seizure-disorder related and closely followed admission to county jails. Acute alcohol poisoning killed eight. Each of these victims had been incarcerated a few hours before death on public drunk charges. They continued to absorb recently ingested alcohol from their stomachs and reached fatal alcohol concentrations while their jailors and fellow prisoners assumed they were "sleeping if off." Seven had recently ingested at least a fifth of a gallon of whiskey, one had been drinking methanol. All but one were white and their average age was 60 years (two were 73). The mean blood alcohol concentration of the seven whiskey drinkers was 420 mg/dl or 0.42% by weight.

Suicide was the manner of death for 70 prisoners, a grimly impressive one-third of all deaths in custody. A disproportionate 54 of the 70 suicide victims were white males, predominantly under age 40. Not only were the suicides concentrated in the first day, but more than half of the total suicides occurred in the first twelve hours of incarceration. Twenty-one percent took place in the first three hours! "Post-alcoholic depression," to which some have attributed this phenomenon, appears to be a poor explanation. Of the 34 taking their own lives in the first 12 hours, 85% were intoxicated at the time of death. Their average or mean BAC was 190 mg/dl. The majority of the suicide victims had been booked on alcohol related charges such as "public drunk" and "DUI". It is estimated that over one-half of confinements to jails in North Carolina involve intoxicated persons. Sixty-five of the seventy suicide victims hanged themselves. Twenty-seven of these used a belt. It is still not standard procedure to deprive even the intoxicated jailee of his belt in many of our facilities. One of our jails had in four years five hangings, four of which involved belts. In the two years since policy changed and belts were routinely removed, there have been no successful suicides, despite at least five unsuccessful efforts, four of which were hanging attempts.

Sufficient time was consumed and commotion created in the attempts with non-belt material that the efforts were discovered and thwarted. Not one of those would-be victims has subsequently taken his or her life.

Homicide is a miscellaneous group that includes, in addition to prisoners killing prisoners, one or two receiving a subsequently fatal injury from "friends" prior to arrest, one shot escaping, a shooting by a deputy during booking, one still under investigation wherein the arresting officer may have inflicted the fatal beating, and nine victims of an arson event in a prison camp.

Four deaths were classified "undetermined" manner. One died in renal failure a few days after a DUI arrest with what may have been rhabdomyolytic myoglobinopathy. A delayed death with a barbiturate may as well have been suicide as accidental drug abuse overdose. The victim had been in a prison unit for months. The injury, if any, causing peritonitis in a prisoner soon after jailing was not discovered. A prisoner died with a subdural hematoma of several days development after being in jail less than 24 hours. Origin of the head trauma was not determined.

The next figure refers to the three, possibly four, deaths that occurred during escape or otherwise at the hands of captors.

Only four of the 223 were female. This figure relates their terminal problems.

We note that 97 of the fatalities occurred within the first 24 hours of custody. Most of these victims were arrested on charges directly related to alcohol. Regardless of the arrest, at least 51 of the 97 were intoxicated at the time of death. Among those dying after more than one but less than 30 days in custody, there was strikingly positive correlation between alcohol related arrest and fatty change in the liver, a good marker for alcohol abuse detectable at autopsy.

In conclusion, we strongly believe the toll of avoidable and untimely deaths in our jails and prisons, and yours, can be significantly reduced. Changes can be made that would not only be humanitarian but cost effective. We have identified four problems which not only represent the highest risk to prisoners but which may be those most easily remediable. These are:

1) deaths in jail due to alcohol withdrawal syndrome ("DT's").

2) failure to distinguish features of alcohol withdrawal from intoxication.

3) fatal alcohol overdose.

4) suicide in an obviously high risk group: relatively young, typically white, intoxicated males who have just been jailed.

It is our impression that the community, the citizenry, is generally concerned about investigation of deaths in custody only relative to so-called police brutality. This is ironical as the faults may more fairly be laid upon the community, the citizens, county officials and the medical profession. It is these who provide the handicaps, the guidelines, the constraints with which those who have custody of prisoners must work. Despite the progress of the past, there is great need for change.

JUVENILE FACILITIES -- SHORT AND LONG TERM*

It's difficult to focus on just one or two problems in health service delivery since any given problem seems to be interrelated with all the others, and what is a problem in one system or institution is perhaps much improved somewhere else. However, there certainly are some overall problems that are probably shared by all of us and from which flow many of our day-to-day difficulties.

Most states do not have a statewide health care administrator whose responsibility is to develop programs for recruitment and training, secure space and equipment, prepare and defend an annual budget, monitor quality of care, control costs, handle complaints, and communicate with other agencies and professional societies. This lack of central organization stems from a time when each correctional facility was essentially a fiefdom -- and everyone, including health care personnel, answered to the superintendent. This still exists in many places. In fact, I understand that in one state health care budget items were submitted as "repair and maintenance equipment" and promptly got cut out of the budget. Underfunding is certainly not a problem only for health care delivery systems, but for correctional systems as a whole. As a result, the context in which health care is provided is abysmal in most facilities.

As a psychiatrist, I would like to make a few comments with respect to mental health care, particularly in longer-term juvenile facilities. It has long been recognized that there is little clinical difference between most juveniles confined in correctional institutions and those confined in mental hospitals. However, in recent years increasingly stringent civil commitment criteria, and inconsistent screening procedures, have resulted in more and more seriously emotionally disturbed youngsters being committed to the criminal justice system. Highly specialized clinical and educational staff are necessary to perform diagnostic assessments and to formulate and monitor individual treatment plans.

Staff at Wisconsin's correctional facilities have not been able to effectively manage and treat this disturbed segment of the population. Many reasons have been offered as to why this is so:

1. The security needs of the more traditional delinquents result in a relative de-emphasis, by comparison to mental health facilities, on treatment and rehabilitation. Specialized and individualized programming becomes very difficult.

2. The staff/resident ratios at the counselor level required to both control and, at the same time, treat highly disturbed youngsters have never been accorded corrections.

3. Recruitment of highly specialized clinical staff, even on a part-time basis, has always been a major problem because of the nature of correctional settings and the low consultant fee schedules.

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*Presented by Kent S. Mannis, M.D., Chief Psychiatrist, Bureau of Program Resources, Wisonsin Division of Corrections.

4. When a highly disturbed youngster temporarily loses contact with reality and a genuine emergency requires the administration of psychotropic medication, treatment in a correctional facility can continue only so long as the acute emergency exists. Once the emergency situation abates, statutory restrictions forbid the prophylactic administration of medication on a continuing involuntary basis unless: a) due process is observed -- probably requiring civil commitment proceedings and, b) a treatment unit is available that meets rather rigid standards as an "approved treatment facility."

5. The Division of Corrections in Wisconsin has been frustrated at times in its attempts to transfer even the most disturbed youngsters to the mental hospitals even if the criteria for involuntary commitment are met and/or the admission would be voluntary. Inordinate periods of time sometimes elapse from the point that a youngster is defined as being in need, and transfer is accomplished. One major problem is that hospitals also suffer from staff shortages and have limited bed capacity. However, the over-riding issue is that transfer is often sought for youngsters who are borderline, not overtly, psychotic. The courts are reluctant to commit, and the hospitals tend to resist voluntary transfers.

A survey of need for psychiatric hospital care among institutionalized juveniles was recently accomplished by Wisconsin's Division of Corrections. The findings suggested that there is a core of both seriously emotionally disturbed and agressive youngsters in need of hospital psychiatric care. However, these youngsters meet the criteria for involuntary commitment only intermittently and for relatively brief periods of time. They can generally be characterized as being borderline psychotic and assaultive and/or self-destructive and/or mildly mentally retarded. Hysteroid features are commonly seen, i.e., emotional liability, depressive dysphoria, impulsivity, a high degree of sensitivity to rejection, low frustration tolerance, aggressive or suicidal behavior, and a proneness to quasi-dissociative episodes. Other youngsters evidence a pseudo-sociopathic facade, with considerable underlying depression. There is evidence that many of these youngsters also have previously undiagnosed speech and hearing disorders, learning disabilities, or minimal brain dysfunction syndrome. External events, such as change in institutional placement, often seem to have a dramatically positive and immediate effect on the individual's mental status. On the other hand, transfer to another closed setting at times results in a continuation of the acting out because of fears of passivity and helplessness. The experience to date has been that while the youngsters may willingly accept transfer initially, their mental set is very capricious, and treatment may be refused on a whim. If the youngster does not meet the criteria for involuntary commitment at that point, treatment cannot be continued and transfer back to the correctional institution is the only alternative. The staff at the hospitals is understandably reluctant to receive these youngsters and seek to discharge them back to the correctional institution as soon as possible. Thus, a ping-pong game ensues.

In my view, what is needed is a range of security and treatment programs within a given correctional facility and ready access to psychiatric units within the mental hospital system for those youngsters who meet the criteria for commit-

ment. Intensive treatment units for the more obviously disturbed youngsters are necessary within a correctional system but, for the above reasons, they should not be designated as psychiatric (medical) units. Rather, psychiatric consultation should be readily available, and the psychiatrists should be part of a multidisciplinary team. Transfer to a psychiatric hospital should be on a case-by-case basis when it is in the best interest of the youngster. Close communication between clinicians at both the correctional facility and the hospital is essential.

The challenge of this conference and of the AMA Task Force on Juvenile Treatment is to suggest accreditation standards that will finally effect change. At least a half dozen associations, commissions and academies have, over the past five years, developed standards for the delivery of medical care and health services in both adult and juvenile facilities. Many are very comprehensive, beautifully organized and well written. They reflect the most enlightened insights into the problems faced by those in correctional health care and reiterate the principles of good medical care which we all learned in medical school -- or nursing school -- or wherever. These various documents are, however, largely tucked away on shelves, their contents and messages venerated but ignored. Their value, despite all the effort, is essentially negligible except to occasionally tweak the conscience of all of us who know better.

The hope in restating once again the standards in operational terms, and holding accreditation out as the carrot, is that leverage can be brought to bear both organizationally and monetarily so that the goal of adequate medical care can be achieved.

PROJECT ON LEGAL AND ETHICAL ISSUES IN THE DELIVERY OF HEALTH CARE WITHIN DETENTION AND CORRECTIONAL INSTITUTIONS*

The objectives of this Project are: (a) to sensitize health professionals, correction officers, students, trainees and inmates to the legal, ethical and social issues inherent in the provision of health services to incarcerated patients: (b) to provide both health professionals and inmates with methods for identifying and articulating legal and ethical conflicts in actual care situations; (c) to develop with participants, staff and inmates, strategies for conflict resolution within prison health care; and (d) to develop and disseminate teaching methodologies and materials which permit the extension of this work to all correctional institutions, their health services and their inmate populations.

It is the intent of this program to bring the legal and ethical dimensions of prison health care under the same scrutiny as the clinical care itself, because ignoring these issues directly compromises the quality of the clinical care and because the constitutional right of prison inmates to adequate medical care demands it.

The Project is based in three major locations working out of Montefiore Hospital. They are the Rikers Island Correctional Complex, the major detention and short-term sentence institution for the City of New York; Spofford Juvenile Center, the maximum security short-term and remand facility for juvenile offenders in New York City, and Woodbourne Correctional Facility a New York State medium security institution. At Rikers Island and at Spofford the Project conducts a regular series of Law and Ethics Rounds which examine individual instances of patient care from the perspective of legal and ethical issues. The topics covered in these rounds at Rikers Island include: 1) The right of an inmate to refuse treatment; (2) Access to care; (3) Confidentiality: the doctor-patient relationship; (4) Medical records; (5) Sexual attack, rape and violence in the prison--the health perspective and health care responsibilities; (6) Rights of detainees to continuation of methadone, birth control medication and sex change hormones; (7) Provision of special diets for inmates with medical problems (e.g. diabetes and hypertension); (8) The disposition of children born to women at correctional institutions.

The Rounds at the Spofford Juvenile Center focus on the rights, responsibilities and duties of a health care staff in a juvenile facility. Rounds held at Spofford have considered the following issues: (1) Right of a detainee who is a minor to refuse treatment; (2) Responsibilities of a medical staff for security arrangements which affect their ability

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*Presented by Nancy Dubler, L.L.B., Montefiore Hospital and Medical Center, Bronx, New York.

to deliver care in a confidential setting; (3) Sexual contact, violence and assault as it affects the adolescent in a detention setting; (4) Question of racial identification on the admission form; (5) Information on the admission form (does knowledge of the charge affect the quality of care?); (6) Foster care, adoption and placement as it affects medical decisions.

Both sets of rounds are being edited into curriculum materials which will be available to health care staff in correctional and detention institutions.

In addition to the formal rounds at Rikers Island and the Spofford Juvenile Center the Project is producing a monthly series of articles on prison health care for the Fortune Society's publication Fortune News, and is working with inmates, health care staff and correctional officers at the New York State Woodbourne Correctional Facility to develop a new program for all three groups which addresses the legal, ethical and perceptual problems in negotiating quality prison health care. This program includes (1) the development of a curriculum and teaching program for inmates about health and self-care in prison; (2) training of a small group of inmates who will act as trainers for the larger general population and as organizers of a health fair at the prison; (3) negotiating with inmates, correction and health care staff to clarify differences in perception about health care, its use and possible misuse by all groups.

PRISON HEALTH AND MEDICAL EDUCATION*

Prison health has long been neglected as an area of service by organized medicine and a site for clinical education by health science centers. Yet the dire health needs and richness of pathology among prisoners suggest that prisons could be a favorable site for clinical education and community service.

For the past three years the University of New Mexico Health Science Center has offered an elective, weekly clinical experience for pre-clinical medical students, senior nursing students and senior pharmacy students at a prison facility in need of medical services. Students' clinical preparation and subsequent health care delivery was closely supervised by faculty. After three years of operation, 45 students have served in the prison clinic. Thirty-one students submitted a detailed evaluation of their experience; 25 inmates evaluated the student service; and a survey was conducted of the impact of the student clinic on the prison health care system.

Students' reaction to the prison experience was strongly positive. They saw a wide variety of medical problems and learned clinical skills rapidly. Most developed empathy toward the inmates and a greater understanding of prison health problems. Over time, the students paid increasing attention to the psychosocial concomitants of their patient's illnesses and gained valuable counseling skills. Fears of learning on a captive population subsided with students' growing confidence in the value of their services. The great majority felt the experience enhanced their academic performance, appreciation of basic science and didactic coursework.

The great majority of inmates rated the student service as "very good" to "excellent," better than other service they received in the prison system, and similar to that they received in the community prior to incarceration. Prison administrators, favorably impressed with the University-prison health alliance, hired a full-time prison medical director recruited by and simultaneously given a faculty appointment to the medical school. Health science students' participation has increased, and now two residents in Family Medicine and six mid-level health practitioners are working in the system.

This community health education experience has provided a non-contractual model of a University-prison health alliance. In this model, the educational needs of health science students are served through provision of voluntary health care to the prison, as permanent, professional health services are obtained.

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*Presented by Arthur Kaufman, M.D., Department of Family, Community and Emergency Medicine, University of New Mexico School of Medicine.

58340

PRISON HEALTH CARE -- MEDICAL STUDENT OPPORTUNITIES*

I've been invited here today to talk about the role medical and other health science students can play in prison and jail health care systems.

Prison and jail populations remain one of the most medically underserved groups in the United States. I do not need to repeat the results of numerous studies which have demonstrated the high incidence of drug addiction, mental and emotional disorders, alcoholism, T.B., veneral disease and physical trauma in our country's jails and prisons.

This situation results from the life histories of inmates - many being poor and coming from minority, inner city and other medically neglected groups -- as well as from the often overcrowded and unhealthy conditions present in correctional institutions. This situation is further complicated by the lack of adequate health facilities and personnel.

The 1972 study by the AMA and AMA found that 17% of jails had no medical facilities, 31% had no arrangements by which a prisoner could see a doctor and only 38% had doctors available on a regularly scheduled basis.

In recent years there have been several court cases which have established the right of prisoners to adequate health care. Prison authorities have the legal responsibility to provide health care including the maintenance of an environment which will reasonably safeguard the overall health of the prison or jail population.

There has also been recent interest by the medical profession and the federal government in improving the standards of health care in jails and prisons. The AMA project, support by LEAA, is an example of this interest. These efforts are much needed. However, the majority of these efforts are aimed at health care facilities. The next area which needs attention is that which relates to adequate health care personnel.

The unattractiveness of prison health care to health practitioners remains a major obstacle which prevents improvement in prison health care. This lack of appeal often leads to situations where the competence of prison physicians may be of concern. Many states allow physicians who are not fully licensed to be employed in state institutions such as prisons and mental hospitals.

One of the major problems which must be addressed in order to change this situation is the lack of exposure to, and resulting lack of understanding about, prison health care among health science students. The mention of prison health care often brings to mind experimentation and cruel and inhumane treatment and is reacted to negatively by idealistic students.

It is my belief that all people deserve the best possible health care.

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*Presented by Douglas Outcalt, Past President, American Medical Student Association, College of Medicine, University of Arizona.

It is also my belief that medical schools should assume some of the responsibility for addressing the problems relating to medically underserved populations. I think it is quite appropriate for medical schools and correctional facilities to work together to improve the health service available and to offer learning experiences for medical and other health science students and housestaff physicians inside jails and prisons.

If medical and other health science students could experience model prison health care systems and work with concerned, competent practitioners it would allow them to see that prison health care can be provided in a humane manner while at the same time exposing them to the harsh realities of institutional care. When students realize that positive change is possible and that creating such change can be a rewarding professional experience, the possibility of a future career in the field of prison health will be greatly enhanced. The AMSA has been placing health science students in underserved areas around the country for over 10 years. Through these experiences we've learned that an early exposure to the needs existing in such areas helps develop understanding and a commitment to return and serve. This approach has worked in rural and urban underserved areas, in Appalachia and on Indian reservations. There is no reason why it can't work in prisons as well.

What do I mean when I talk about learning experiences inside prisons and jails? I am referring to clinical externships, where students can spend an extended period of time, four to eight weeks, inside a prison or jail setting, working with and being taught by prison health practictioners. Optimally, housestaff physicians would also be able to participate in similar experiences. The learning opportunities should include both the clinical and non-clinical aspects of prison health care. Non-clinical aspects -- how a prison is run, the logistics of prison health services, prison financing, lines of authority, the role of the prison environment in disease, etc. -- are essential to help students understand and feel comfortable with institutional health care.

Such a cooperative arrangement between medical schools and correctional facilities can benefit all those involved. For those who are prison or jail administrators such an arrangement offers the following:

1. An enthusiastic, energetic and free work force.
   Students can help out with the clinical tasks as well as conduct special projects such as screening for T.B., V.D., drug abuse; establishing links to community agencies for released inmates; and determining the need for patient education.

2. Links to medical school faculty and housestaff programs.
   Teaching will not only stimulate prison physicians to provide better medical care (nothing helps to learn medicine better than to teach it) but will also prove to be a challenging and welcome activity. It will decrease the isolation often felt by practictioners inside prisons. The medical school faculty can also

serve as a resource for research on the prison health services.

3. The creation of a future pool of prison practitioners.

4. Increased medical professional awareness of health problems inside prisons.
   The medical profession can be a powerful political ally when going to funding sources for support. Even if not all students who experience prison health care return to practice, they will become aware of the problems and needs of health departments in correctional settings and will contribute to an involved awareness in the profession.

For medical schools prison externships offer:

1. A population group with an immense amount of physical and social pathology.
   The diseases seen frequently in prisons (drug abuse, V.D., alcoholism) are often neglected in medical school, yet are some of the most common diseases in society.

2. For altruistic academicians, a chance to become involved in a pressing social need.

For medical students prison externships offer a change to become involved in social issues, see first hand the role played by environment on health, learn about common communicable diseases and to experience first hand the practical aspects of applied idealism.

Inmates will gain improved medical care. It has been my experience that when medical and other health science students are involved in learning and providing health services with proper supervision, the level of the care provided is generally higher than if they were not involved.

Prison externships should not be undertaken by every medical school, every person or every medical student. There are requirements which must be met in every learning situation in order for it to be a positive experience. The facilities should be adequate, there must be appropriate supervision by competent practitioners, students should be taught and allowed to learn and should not be used as simply a cheap source of labor, clinical and non-clinical learning should be available.

For those interested in establishing prison or jail externships, what resources are available? Almost all medical schools have departments of family and community medicine. They will probably be the faculty most interested in working to establish a link to a prison or jail.

The American Medical Association is attempting to establish a national program which will involve working with medical schools and correctional

facilities to establish prison/jail externships. We are currently seeking funding for this program. AMSA also has chapters at almost every medical school, allopathic and osteopathic, in the country. We can probably get you in touch with active students.

Finally, there are those who have already established such programs. Dr. Kaufman, Dr. Jay Harness and others are very willing to assist anyone in establishing these types of externships.

I would like to conclude by saying that I believe the improvement of health care in prisons and jails involves two aspects. One is the improvement of facilities, the other is the attainment of competent medical personnel. One cannot be addressed without the other if success is to be the result. One way to address the personnel issue is to expose health science students to positive learning experiences inside prisons during their medical training.

58541

RECEIVING SCREENING - AN ADMINISTRATIVE AND OPERATIONAL VIEW *

When we first think of receiving screening as part of the reception processing of an inmate committed to our institutions, we must assuredly think of the benefits related to such a process.

The benefits to the inmate are obvious:

1. He has an opportunity to make known his medical complaints to a staff that has the ability to act on them.
2. He is exposed to a source for beginning to realistically solve the medical problems he is experiencing.
3. He feels more comfortable and in control of his "personal being", therefore contributing to an improved environment at the institution.

The benefits to the jail are less obvious (especially to the custodial staff) but surely not less important.

1. You have a complete profile of an inmate.
2. You can experience the option of being able to plan a treatment process for the inmate rather than having to react to a "crisis" medical situation.
3. You can often have the time necessary to consider more appropriate and usually less expensive treatment modes for the inmates individual problems.

Administratively and operationally, though, there are advantages and disadvantages associated with the implementation of any treatment program or part of a treatment program in a correctional setting. Some of the most obvious area effected would be in staffing (both medical personnel and security staff), in budgeting, in the medico-legal area, and in possessing the resources to act upon the medical needs of inmates that are uncovered during the receiving screening.

These are some of the areas that I would like to speak to you about, presenting the problems, and I hope, some solutions and then having the benefit of your discussion and questions afterward. In my presentation, I will have to ask your indulgence and understanding, in that in my experience, I will be relating to a viewpoint from administering a correctional institution that houses, at present, over 600 inmates, both felons and misdeameanants, both pre-trial detainers and convicted prisoners, both men and women, and that has a medical staff of 9 licensed nursing personnel and 4 administrative and security personnel. Also, to achieve a proper prespective, I must say that in Richmond we experience no lack of resources in that we are located less than 2 miles from the Medical College of Virginia, certainly one of the Virginia State Penitentiary Hospital and its medical clinics and that, at worst, I'm sure our position is enviable to some of you seated here.

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*Presented by Andrew Winston, Sheriff, City Jail, Richmond, Virginia.

Now, moving along to the first area of receiving screening that I would like to present to you, staffing and budget. Our screening program has been in effect now for over 2 years. When we initiated the program we found that in extra staffing only 1 additional nursing position and 1 extra security officer were necessary to do the 125 to 150 screenings weekly, without placing too much of a burden on the existing medical staff. The majority of the screening are performed in the evening. The staff sees all newly committed inmates of that day before they are moved from the classification area. An extensive medical history is taken from the inmate, a PPD Tuberculin Test is given, and his blood pressure and weight is taken, as well as notes made as to whether the inmate wears glasses, and any other pertinent information that may be necessary in the future medical treatment of the inmate. All of this information is collected within 8 hours of the inmates commitment to the institution. Of course, the single most important budgeting factor in this type program is the staffing requirements. In jails without a medical staff, space, equipment, and other factors will greatly increase the cost of a screening program and this should be taken into consideration, but in the Richmond Jail our overall cost of slightly less than $2.00 per day per inmate increased only slightly. Training for a "lay-staff", which will be doing a screening, should also be taken into consideration in the budgetary requirements for a program. An excellent resource for this might be State Departments of Correction or, as in Ms. Parker's case, the state or local medical society. Other organizations that might be of help, although not specifically targeted a correctional setting, may be your local Red Cross or some of the local organizations, such as Rescue Squads or other volunteer groups that can offer any training input in a medical context. Still though, the jail supervisory staff will have to see that any medical knowledge gained from outside sources is put to the best possible use in the correctional setting.

After the receiving screening has been performed, you must be prepared to act on the information gained from the screening. This leads us to the area of resources. Ill or injured inmates must be transported to a place where immediate medical attention can be given. This may be an emergency room or the local physician that provides medical care for the jail inmates. Inmates with medical problems of a less serious nature will have to be referred to the jail physician on his next visit, to a clinic or whatever medical authority is used by the jail. A guideline for the time-delay factor would be that it must be generally the same amount of time that it would normally take for a member of the community to make available to himself the same service. This has been an accepted practical "rule-of-thumb" to both the Courts and to local medical authorities. By my experience, acquiring the utilization of resources outside of the jail usually presents no serious problems. The services are present because they have been established for the uses of the community. There may be considerable "leg work" necessary in contacting the persons responsible for the services and in convincing these persons that, indeed, inmates incarcerated in your jail are members of the community too. But these are minor problems that time and a little effort can overcome. The real problem lies in getting the local physicians to participate in the jail "in-house" medical program. We have solved this

problem by contracting with the local hospital to have senior medical residents in internal medicine do a rotation at our jail as part of their residency requirement. In areas where there is no teaching hospitals, or isolated rural areas where there are only a couple of general medical practioners serving the entire community, the problem could be drastically critical. The community physicians will probably have little available time to contribute to a jail medical program, even though they will recognize the need and make an effort to help. It is in this area that our State Medical Societies can be so valuabe. Through these organizations, some physicians may be contacted who has some available time and an interest to help in your need for medical care for your inmates. This will definately help if there are populous areas within commuting distance of the institutions then, with several visits per week and a local physician who will take care of emergency situations, you will have the realistic beginnings of a medical service program. I might add that the beginning steps are the hardest. Once you have established your institution and have the basis for medical care, future contacts will be easier and, if the need arises for more medical coverage, the physicians that are providing services presently will make the pathway to more resources less resistive to you.

In discussing resources for medical service programs, both for in-house or outside of the institution, and especially in establishing a medical program or a receiving screening program, you must have both a receptive and interested local government to provide the most necessary factor involved: funding. No amount of need on your part can place the funds necessary into the municipal or county budget. You must successfully communicate these needs to both the governing body and to the community in general. Without community support and the influences this brings to bear on the locally elected officials, it is increasingly diffifult to initiate new medical programs in the correctional setting, especially jails and more specifically in jails where no court decisions have been handed down against the jail. Initially, the generation of community support must begin with the volunteer organizations involved in the institution. These may be offender aid groups or local clergy organizations. Making these groups aware of your problems, being frank and honest with them and sincerely asking for their help will be the initial impetus for vocalizing of these problems whenever the opportunity arises place the burdens of providing funds for jail programs where they belong and certainly where the action to provide these funds must begin.

In starting a receiving screening program and thereby accumulating medical data on your inmates, there are certain <u>legal aspects</u> to be considered. In respect to the screening itself the fact that you are aware that an inmate has a medical problem is important. Once you possess that

knowledge, you are bound legally, to take action on it. Although I feel ignorance has never been an accepted excuse for neglect, some rational relaxing of court decisions against jails have evolved from this. This cannot and will not be the case if the jail staff has foreknowledge of the medical situation and fails to initiate action to solve this problem within a reasonable time frame. There is also the problem of confidentiality of the medical information you possess. Even though no doctor may be involved in the receiving screening process, the information obtained, whether by a correctional officer or licensed medical personnel, carries the same confidentiality. This information must not be revealed except as is needed in administering the proper care and/or in the best interest of the inmate. This includes making proper housing assignments of inmates, carrying out treatment plans for the inmate, and then only the minimal information necessary to carry out the needed operation must be released. Also, certain individuals or agencies may be requesting the medical information you have obtained. Attorney, caseworkers, probation officers and the local health departments may be among these. When this information is released, it should only be with the receipt of a release form signed by the inmate and the form should clearly indicate that the release is for medical information.

In conclusion, the receiving screening of inmates is certainly a beneficial program for improved jail operation. It aids both the inmate and the jail staff. In jails with an existing medical service program it can be implemented with little additional cost or increased work load for the staff. Where no medical service program is in effect, the custodial staff can easily carry out the gathering of a medical history and the basics of a physical exam, although extra personnel may be needed for this task and surely the space and equipment requirements will have to be considered. So there are no severe or drastic problems related to initiating a receiving screening program. However, this process, as with any treatment program in corrections, carries responsibilities. It places us in a position of acting on the information we possess. It requires us to seek out ways to solve the problems we encounter with regard to what is proper and adequate medical care. It places those persons responsible for funding our institutions in the position of having to accept the cost of reasonable medical care that is comparable to that which other members of the community have access to.

Certainly all of these things must be considered and dealt with. But, none of the advantages or disadvantages can cloud the issue of the fact that we must know, and have knowledge, and carry out our responsibilities to the persons that have been placed in our institutions and, at the same time, carry out our responsibility to the communities that we serve.

58542

RECEIVING SCREENING*

Sheriff Winston has given you the administrative viewpoint of receiving screening and the example of how receiving screening is done in his jail. I agree with the Sheriff, as do the AMA and others, that especially important is the concept of responsibility, the responsibility to know the medical health situation of the inmate at in-take and to act on that knowledge in the most appropriate manner. Based on the need of this knowledge, we at the Medical Association of Georgia have developed a training program in receiving screening for jailors and particularly for booking officers. Not every jail is blessed with the resources of Sheriff Winston's jail, and many must use deputies and correctional officers to perform receiving screening duties. To answer this need, our training program has been designed to develop skills for these officers.

In this part of the program we will be doing several things. We are handing out a specially designed receiving screening form which is keyed to the manual we use in our training sessions. The manual is based on the outline which we are also handing out. We will be showing you some videotape segments of actual training sessions. We will also show you some special cases that will test your observational skills and perhaps help you to become more aware of the need for receiving screening. I will talk to you later about the course content. First, however, I would like to introduce my assistant in the AMA Jail Health Care Project in Georgia, Day Ann Doak. Day Ann is a medical records administrator and has been working in jail health care for over a year now. Day Ann has worked very closely with the receiving screening training and co-presented two receiving screening workshops in Georgia. She will describe the development of our training program.

DESCRIPTION OF RECEIVING SCREENING WORKSHOPS

Two workshops on Receiving Health Screening for Jail Personnel have been conducted by the MAG as part of the AMA Jail Health Project to date, one in November, 1977, and the second in February, 1978. A total of 26 jailors attended, representing eight pilot jails that were participating at the time in the AMA Jail Project. Inivitations were extended to only those jails that were participating in our Project, and we encouraged the actual booking officers, or jailors who perform the book-in duties, rather than the Sheriff or jail administrator, to come. This course is a detailed "how-to" approach to the subject material, and we wanted to teach directly those persons on the jail staff who would actually be performing receiving health screening.

Both workshops were taught by two people: a physician who has worked as a full-time jail physician and who also wrote the course, and a correctional officer who has had experience doing receiving screening. The course was designed to be taught by two people of such backgrounds: one, a medical professional (though not necessarily a physician) who has some experience in jail health care, and two, a correctional officer experienced in receiving health screening.

The course content of the two workshops was the same, with the exception that teaching how to take blood pressure was included in the first one but omitted from the course after that. This followed the decision by the course

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*Presented by Dorothy Parker, Jail Pilot Project Director, Medical Association of Georgia.

authors that blood pressure screening is a luxurious but not essential component of routine screening of incoming inmates for their appropriateness to be admitted into the jail population. It was a time-consuming exercise that was not altogether successful anyway. Even with this omission, the second workshop lasted about as long as the first, approximately a day and a half.

Both MAG workshops were conducted at local universities in Atlanta. An upcoming workshop is being planned for December in Savannah and is being sponsored by a local state college there for any interested jails in Georgia and neighboring states. An important feature of the course is that it was designed to be replicable on a local level, with the sponsoring agency supplying the teachers and some equipment and MAG providing the teaching materials and audiovisual aids. A videotape playback unit and monitor are required for the A-V's, so the community must at least have these resources, as well as qualified individuals willing to teach (unless someone is imported and therefor paid). We suggest that the local medical society be approached to identify the medical member of the teaching team.

A teaching manual was developed for the course, and this is used by the participants afterwards in their jails as a companion reference manual in the use of the unique receiving screening form that was designed for this course. A manual for instructors was also written to guide future teachers and organizations or institutions wishing to put on the workshop. MAG has a limited supply of both of these manuals that will be provided while they last to groups sponsoring the workshop for their participants. These are also available upon written request to other interested individuals or agencies. We have brought with us today the form that is used in the course, as well as a course outline for your information.

Audiovisual aids are videocassettes that were produced especially for this course. A 20-minute film, "Recognizing Abnormal Behavior," show a series of six fictitious inmates present at book-in. Participants are asked to identify as many unusual or even abnormal characteristics about each of these persons as they can; they are then discussed, as are the alternatives of disposition of the "inmates", i.e., whether to admit to general population, qualified admission to isolation or special observation, seek medical clearance, or refer straight to the doctor or hospital. We will show segments of this tape to you today and seek your participation as well. In addition to this single tape, we have six one-hour videocassettes of most of the second workshop. This is available to be used in portions of future workshops or viewed prior to conducting one as preparation for teaching the course.

Although there is a good deal of lecture, group discussion and questions are a vital part of the course. In our two workshops the instructors relied on the participants themselves to share their experiences and even come up with answers to questions that were raised. Role-playing is also used as a practice mechanism to familiarize the participants with the form and its use. These samples and other examples to illustrate points are all included in the Instructors Manual.

COURSE CONTENT

Before we discuss the use of the forms and the receiving screening procedure, I want first to focus on the goals of receiving screening. From the medical viewpoint, after being able to cover emergencies, most experts on jail

health care agree that receiving health screening is the next most important thing for the jails to do. The AMA Standard #1011 which is also an Essential Standard, in respect to receiving screening, states the following:

> "Receiving screening is performed on all inmates upon admission to the facility before being placed in the general population or housing area with the findings recorded on a printed receiving screening from approved by the responsible physician. The screening includes inquiry into: current illnesses and health problems including those specific to women; medications taken and special health requirements; screening of other health problems designated by the responsible physician; behavioral observation including state of consciousness and mental status, notation of body deformities, trauma markings, bruises, lesions, ease of movement; jaundice, etc,; condition of skin and body orifices including rashes and infestations; and dispositions or referral of the inmate to qualified medical personnel on an emergency basis."

The following discussion in support of the Standard defines receiving screening as "a system of structured observation/initial health assessment designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population and to rapidly get them to medical care. The receiving screening can be performed by allied health personnel or by a trained correctional officer at the time of booking." The discussion further states that the "initial assessment of health needs and the general condition of the inmate at this crucial point may prevent further complications such as communicable disease epidemics, rapid states of health regression, suicides, and assaults. The welfare of the inmate, other inmates, the correctional staff, and the community can be protected."

In addition to trained personnel, to implement a receiving screening program within a jail a policy statement, set of procedures and a form are a basic minimum. To be effective the form should survey by question and observation these potential health problems and also show disposition. To administer the procedure, the booking officer will need to understand the need for receiving health screening; he will need to be thoroughly familiar with the general principles for performing the screening and understand how to use a receiving screening form. The officer should be ready to ask questions indicated on the form and, with training in the MAG course, be able to ask further appropriate questions indicated by the response to the initial question. The officer should also learn to perform a general physical assessment, including a description of general appearance such as consciousness, walking and gait; detection of breathing difficulties; recording pulse and temperature; be able to describe skin appearance and behavior, and to recognize signs of drug and alcohol use and withdrawal. He should also be able to perform a urine dipstick test for sugar. Further, the officer should be able to develop skills in using this information obtained in the form to make appropriate decisions concerning the need for medical clearance, detoxification, special housing needs, or to admit to the general population.

Consequently, receiving screening is not the same as first aid. All

officers should have first aid training before taking this training. Possessing these skills does not replace health personnel and is performed by the officer or health personnel under the authority and direction of the jail's physician. Health personnel or the physician will need to be contacted for cases requiring medical clearance or other medical decisions. Also, screening does not substitute for general health assessment or physical examinations which are more appropriate for long term prisoners.

One the skills are developed and practiced, the receiving screening process can be accomplished in a relatively short period of time and become a component of the regular booking process. Let us look briefly at the receiving screening form which was handed out earlier. This form was designed to be used with a manual. When the booking officer has a positive response to questions or observations made, he is then referred to the appropriate place in the manual, and when appropriate, follow-up questions which help to make decisions regarding disposition can then be asked. At this point, we will show you a short segment of one of the training programs that Dr. Tim Wolbert conducted in Atlanta. Dr. Wolbert was consultant to our project and helped to develop the training materials. He will be discussing decision making during receiving screening in this videotape segment. (Videotape segment shown.)

For those of you who are making notes, I wish to reiterate at this time the six decisions that are likely to be the outcome of the receiving screening process. The first is to admit to the jail; this of course is the most common disposition. The second is to seek medical clearance, in which case medical clearance is usually defined by the physician in authority. Third, the decision may be to put into a separate cell until the inmate can be seen by the jail's health workers or the physician. A forth disposition could be to refer to the infirmary, and a sixth could be to place the inmate in a special location for closer mental observation.

In order for receiving health screening to work effectively, several principles should be emphasized. These principles are as important to the screening process as the health data collection and the decision maing. First, the information collected during receiving screening is health data. Health data must not be used as evidence against the prisoner. It should be explained to the prisoner at the outset that the information that is being gathered for the receiving screening is for the prisoner's benefit and may not be used as evidence. There is a statement to this effect on the screening form and it can be shown to the prisoner. It is helpful if the sheet also contains a brief statement of the purpose for doing the receiving screening. Second, all health data collected are confidential. The only people with whom this information should be shared are health workers associated with the jail or the jail's physician and the duty commander <u>if</u> special attention is required. This confidential information should not be discussed with other officers or prisoners. Third, the receiving screening form must be filled in completely. Each question in the form has been chosen to meet an important need to determine if someone may be safely admitted to the jail. Omitting a question may result in a critical error in judgement. If any question is unable to be completed, one should write in the reason why. Fourth, the officer must assume the inmate is telling the truth. It is the responsibility of the health personnel associated with the jail or the physician to determine the validity of the prisoner's

health complaints. Fifth, the officer's role is deciding whether or not the prisoner is healthy enough to be admitted to the general population in the jail; it is not to make a diagnosis. And last, whenever there are any doubts about admitting a prisoner, call the jail's physician.

As Day Ann described earlier, to develop skills in using the form and manual and to follow up with the appropriate questions and disposition, role playing and other techniques were used extensively in our earlier workshops. You may refer now to the handout in section 4 which lists the various medical problems which need to be recognized before admittance to the jail. The use of the manual helps to assess the extent of each problem if it exists and especially to learn of the current status of that problem so an appropriate disposition can be made.

Still referring to section 4 of the handout, I wish now to move to part C, Physical Assessment. Notice that each of these items will require some very special skills to be developed. Many booking officers are certainly aware of many of them from general experience with hundreds of prisoners. However, this course teaches the officer to focus on making particular and structured observations so that no medical problem is likely to be overlooked. The development of these skills is perhaps the most vital part of the receiving screening process because when other communications fail or are invalid, focused observation will likely communicate to the officer the existence of medical problems requiring attention.

We have another short segment of videotape to show you now in which Dr. Wolbert emphasizes the critical importance of the development of these observational skills for making physical assessments. After this segment we will show you three fictitious cases of inmates being booked into a jail and let you practice making some physical assessments on your own. (Videotape segment shown.)

A PHILOSOPHY FOR DENTAL CARE IN JAILS *

The unique nature of dental care delivery, with its vast instrumentation requirements, precludes definitive treatment at most Michigan Jail Facilities. Only the very largest jails may elect to equip a dental room which would be staffed by a resident dentist.

Emergency dental care should be palliative in nature until an appropriate referral can be made.

Routine cursory admission oral examinations should be part of a total medical record.

Accepted dental care and hygiene includes biannual dental prophylaxis (cleaning) and detailed toothbrush and gingival care instruction.

All dental care will ultimately be administered or directed by a licensed dentist in the State of Michigan.

SUGGESTED DENTAL REFERRAL MECHANISMS

A) When possible, all definitive dental care should be provided by the inmate's personal local dentist. His/her personal dentist will have past records and x-rays of the patient and will insure a more orderly and appropriate treatment in instances of urgent or sub-urgent dental problems.

B) A dentist in the community, upon recommendations of the local dental society, should be identified to serve either contractually or by a fee for service method as the jail dentist.

C) Many dental societies have an emergency dental call list or referral system which will provide emergency dental care.

D) Emergency room physicians and nurses are able to treat many emergency dental problems on a palliative basis until an appropriate dental referral can be made.

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*Presented by Jerry Booth, DDS, MS Consultant, Michigan Department of Corrections.

EMERGENCY DENTAL CONDITIONS

Emergency dental conditions are those which must be treated within a 12 hour period. Jail personnel may provide first aid relief by appropriate standing orders until a dental referral can be made. Emergency dental conditions include:

1. Post-extraction hemorrhage
2. Post-extraction osteotis (dry socket)
3. Dental-alveolar abcess with or without suppuration (pus)
4. Maxillo-facial alveolar fractures
5. Traumatically avulsed teeth

Post extraction hemorrhage may occur either immediately after or as long as seven days following an extraction. This is characterized by an insidious unrelenting bleeding from the extraction site and usually accompanied by the presence of a very large fragile clot which tends to build up in and about the extraction site. The bleeding is usually bright red characterized by an arterial type bleed.

First aid treatment as with any hemorrhage includes the application of a 2X2 gauze between the teeth in such a fashion that pressure from the opposite jaw or opposite ridge can be applied against the gum and extraction site. This gauze should be placed and maintained for no less than ½ hour off the face. If pressure treatment is not successful dental referral is indicated.

Professional treatment would include the introduction of a local anesthesic in adjacent soft tissue and addition of sutures across the mucosa in such a way as to aid in controlling the bleeding. The appropriate local anesthesic would be 2% xylocaine with 1:100,000 epinephrine, and an effective suture material is 4-0 silk. Often times these two mechanisms will not suffice, and it will be necessary to place a hemostatic agent in the extraction site. Novocell pellets which are a thrombinized cellulose work very nicely in this particular field. Surgical and some of the other hemostatic preparations are usually too flimsy and become too softened to use effectively in a dental extraction field.

Post extraction osteotis (dry socket) occurs routinely within one to seven days following an extraction. It is characterized by the rather grayish appearance of the extraction site with no evidence of a viable clot. Often times the patient complains of a marked odor from the extraction site

and there is evidence of some early superficial necrosis in the area. Clinically the patient will complain of pain not only in the extraction site, but also pain that radiates toward the ear. The pain of a dry socket is unrelenting and excrutiating.

A dry socket is appropriately treated by a 1½ inch length of ¼ inch Nu-gauze dressing that has been saturated in a Dentalone ointment solution. This is tucked into the extraction site in such a fashion as to fully fill the bony defect. The dressing serves not only to protect the wound from food, saliva, and other contaminates, but it also carries to the exposed and denuded bony wall the local anesthesic effect with the dentalone ointment. Classically these dressings are changed every 24 hours for a period of approximately seven to ten days.

A Dental-alveolar abcess is usually characterized by marked swelling lateral to the tooth involved and characteristically involves surrounding soft tissues. Upper teeth including the canines, lateral incisors, and central incisors will classically cause swelling that presents itself in the upper lip, the lateral aspect of the nose, and the lower eye lid. The remaining posterior teeth manifest themselves with marked swelling in the lateral aspect of the upper cheek and will tend to involve much of the side of the face. Lower teeth which are involved with an abcess will most often have swelling not only lateral to but inferior to the tooth involved such that the cheek and neck just below the involved tooth will be markedly swollen. Very often one can inspect intraorally and see evidence of pus presenting itself either from the gum agove the tooth or actually present itself from the gum tissue around the neck of the tooth. Quite often a dental alveolar abcess which is produ ing pus in the mouth is not exquisitely tender, however the patient becomes extremely concerned because of the large amount of swelling and redness of the skin overlying the area. It must be noted at this point that this kind of an abcess can involve the adjacent soft tissues of the mouth in such a way that the airway and its patency can be compromised and should be treated immediately.

Dental-alveolar abcesses must be actively treated with broad spectrum antibiotics; most appropriately, Penicillin would be considered in those instances where the patient shows no allergic history. The medication should be given at a rate of 500 mg. four times a day and continued until professional help is available. The patient will also be instructed to apply warm moist compresses to the involved side of the face on an intermittent basis six times a day. Because of the marked discomfort with this situation an analgesic appropriate to the level of pain should be administered.

Fractures of the alveolar process usually occur because of a blow from

a blunt instrument such as a pipe, bottle, or fist. Classically when the fracture occurs all of the teeth that were included in that particular alveolar segment will be displaced from their normal position. One can often see a laceration of the gum adjacent to the fracture indicating a tear in the mucosa because of the displacement. The patient will also complain of an inability to bite his teeth together properly because of the displacement of the teeth and this will readily be seen when one will inspect the mouth and check the relative positions of the teeth when the patient is asked to close his teeth together.

The repositioning of teeth which have been moved from position with their alveolar segment is of the utmost importance. This repositioning should be treated by a dentist only and one who has had experience in surgical trauma. No attempt should be made at treating this particular problem in a jail environment.

It is important, when teeth have been avulsed, that the entire tooth has been accounted for. A complete tooth with no evidence of root fracture can be successfully reimplanted in the patients mouth with a high incidence of success. A tooth, however, that has been grossly crushed or has a fractured root as a result of the avulsion probably presents a slim margin of success when considering reimplantation.

The avulsed tooth should immediately be placed in a normal saline solution which is kept at approximately body temperature or 37 degrees centigrade. A simple way of accomplishing this would be to place the tooth in a tumbler filled with water to which ½ teaspoon salt has been added. It is best to place this in an open oven set at warm or near an appropriate heater opening to keep the water warm until such time as a dental specialist can be contacted for the surgical reimplantation and stabilization of the avulsed tooth. At no time should a jail person make the decision that a tooth is not worthy of this particular form of treatment.

URGENT DENTAL CONDITIONS

Urgent dental conditions are those which need attention or treatment within a 72 hour period. Urgent problems include:

1. Acute necrotizing gingivitis (trench mouth)
2. Acute pulpitis (tooth ache)
3. Temporomandibular joint arthritis
4. Traumatically subtotal avulsion or mobilized teeth
5. Pericoronitis associated with partially erupted wisdom teeth
6. Sharp cusps or crown fragments associated with broken teeth

Palliative or first aid treatment should be instituted by jail personnel, and professional referrals can be made after proper processing of the prisoner has been completed.

1. Acute necrotizing gingivitis (trench mouth) is a non-contagious disease characterized by a fetid (foul) mouth odor, exquisitely tender gums which bleed spontaneously and appear very reddened around the teeth. Very often the gingiva between the teeth will have a grayish and/or punched out appearance.

Jail personnel should encourage the inmate to vigorously rinse his mouth with equal parts of 3% H_2O_2 and Listerine four times daily. It may become necessary to provide analgesics if the pain is severe.

Dental treatment will include dental prophylaxis and proper tooth and gingival hygiene instruction. The condition is usually easy to bring under control.

2. Acute pulpitis (tooth ache) is characterized by excrutiating or sharp lancinating pain in and about an involved tooth. Many times the pain is caused by either eating hot or cold foods, or foods containing high contents of sugar. The tooth may become painful simply in the act of chewing. Pulpitis may also occur with no provocation when extensive dental decay exists. It is sometimes difficult to judge which tooth is involved in a patient because he may have difficulty localizing the pain which may seem to involve many adjacent teeth and can even be referred to teeth in an opposite dental arch.

Jail personnel should change the diet of the patient so that it would contain only those foods which are tepid (warm) in temperature and contain

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1 OF 2

very few pure sugars. A full liquid diet is suggested to reduce the amount of chewing that is required by the inmate. Analgesics appropriate to the level of pain should be administered to the patient, and it is well to begin prophylactic antibiotics to abort a developing dental abcess. On occasion ice applied to the involved side of the face will offer the patient some relief. Over the counter dental troches or lozenges usually offer little in the way of relief.

Dental treatment will usually include removal of the decay in the involved tooth and the placement of temporary dressing or fillings. Many times root canal therapy will be the ultimate treatment of a tooth which is dying. Occasionally pulpitis can simply be treated by the proper adjusting of a dental filling or a tooth which is not in proper occlusion or bite relationship.

3. Temporomandibular joint arthritis (jaw point pain) usually occurs on one side of the face just in front of the ear. It is usually aggravated by chewing, yawning, or vigorous movement of the jaw. This pain is usually dull and annoying in nature and is often times most severe immediately after meals or during sleep. The causes of temporomandibular joint arthritis are numerous and no attempt will be made to describe the many reasons for the occurence of this condition.

Palliative treatment by jail personnel should include offering the patient a full liquid diet. A warm moist heat source applied to the involved side of the face on an intermittent basis will often times provide relief for the inmate. It is advisable to offer the patient one capsule of Valium 5 mg. to be taken ½ hour before bedtime to insure sound sleep. It is usually well to add Nembutol or Seconal 100 mg. as part of the H.S. medication. As these patients will frequently complain of earache type pain, it is often well to make sure that a medical examination prior to the referral to a dentist includes a thorough othologic examination.

Definitive dental treatment, depending on the nature of the patient's complaint, his dentition, and his past history will be varied, and no attempt will be made to describe the many diagnostic tests that must be performed.

4. Traumatically subtotally avulsed or mobilized teeth occur after the patient has suffered an injury whereby teeth were moved short distances but there is no threat of the imminent loss of the tooth. This is often characterized by misalignment of the teeth in their dental arch and will often exhibit minor amounts of hemorrhage around the gingiva adjacent to the neck of the tooth. Many times the tooth will be also in misalignment when the patient is asked to bring his teeth together.

Jail personnel should encourage the patient to gently reposition the tooth into what is felt to be a satisfactory position, but under no

circumstances should this repositioning maneuver be attempted by jail personnel. Bleeding is usually minimal, and only minor gauze pressure is necessary to control the associated hemorrhage. Analgesics appropriate to the level of pain should be administered, and a full liquid diet is recommended so that further displacement of the tooth will not occur. Since the tooth rests physiologically in its own socket, urgency of treatment is minor.

Professional treatment will include anatomic repositioning and stabilization of these teeth. Often times teeth which have been moved even small distances will later require root canal therapy to complete their treatment.

5. Pericoronitis associated with partially erupted wisdom teeth occurs most frequently with patients between the ages of 15 to 25. This situation occurs when wisdom teeth are partially erupted and have a skin flap serves as a reservoir for food and bacteria and frequently can become extremely inflamed and uncomfortable. Because of the inflamation and edema, swelling occurs in such a way that the opposing teeth will often times bite against the skin flap causing sharp pain and discomfort. The low grade infection may also manifest itself with swelling on the involved side of the face as well as swelling into the throat.

Jail personnel should encourage the patient to gargle with warm salt water on the involved side at least four times a day. A full liquid diet will aid the patient avoiding additional injury to the inflamed tissue caused by chewing motion. Analgesics appropriate to the level of pain should be administered to the patient; because of the threat of a formulating infection, it is well to provide a prophylactic antibiotic regimen.

Dental treatment will most often involve the surgical removal of the involved wisdom tooth; however, occasionally wisdom teeth will be retained and a simple surgical exposure or window will be made for the partially erupted tooth.

6. Sharp cusps or crown fragments associated with broken teeth are usually a result of gross dental caries or fractured fillings. Most often sharp cusps will cause soft tissue injury to either the tongue or adjacent cheek tissues. If these have been long standing situations a large ulcer in the involved soft tissue may be present.

Jail personnel may offer the patient dental boxing wax which may be applied over the top of the involved tooth or in the lost filling site. If boxing wax is not available chewing gum or a cotton pellet may suffice until professional treatment can be instituted.

Professional treatment will probably include either the removal of the involved tooth or repair of the broken filling and/or crown segment.

58543

DENTAL CARE -- WHAT IS REALISTIC? *

This paper will focus on conditions as they are today after studies and on-site surveys in Michigan jails. It is hoped that the topic "Dental Care -- What is Realistic?" may be answered in more certain terms during this program. It may be that the topic of our discussion ought to be followed by the question, "What is Achievable?" today and in the foreseeable future.

Reliable data have not yet been assembled to give us answers, but we can at least discuss what we have learned so far.

After two years and many hours of discussions, debates and consultations, the AMA National Advisory Committee evolved an approach to jail dental care which is now being tested by incorporating this type of care into the Standards. Credit must be given to the Advisory Committee for their foresight in recognizing the importance of including adequate dental care as an integral, connecting segment to any good medical care system.

The Michigan Project Group, as one of the original pilot project states, developed a philosophic framework, expressed in the Michigan Manual for Health Care in Jails. I quote: "Society has the responsibility to provide adequate medical, dental and mental health care to inmates in county jails just as society has the responsibility to protect the health of any citizen."

The Michigan Project Group was fortunate in having Doctor Jerry Booth, DDS, MS, as a consultant. He provided vital input on the clinical aspects of dental services in county facilities. Doctor Booth has 10 years of experience as consultant at the Southeastern Michigan Prison -- better known as Jackson Prison.

When you study the 42 AMA Standards you will note the many references to dental observation, treatment, care and education throughout the document. You will not be surprised to learn that 22 of the 42 Standards refer in varying degrees to dental care and treatment.

To pursue this thought, I'd like to underline two points. One, too many believe that dental care is a minor or secondary part of the total

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*Presented by Herbert Mehler, Jail Pilot Project Director, Michigan State Medical Society.

health system. Two, to emphasize this recognition of dental care in jails, let me take a few minutes to quickly summarize these dental standards for a better perspective.

Because these Standards all begin with the numerical 1000, I'll refer to them by citing the last two digits.

Standards 01, 03, 04 and 05 require physician approval of dental services; quarterly and annual statistical reports; receiving screening; hygiene; examination and treatment; and that dentists be licensed in the state in which they practice.

Standards 06, 07, 10, 11, 12 and 14 deal with written job descriptions; written or standing orders for allied health personnel; contents of first aid kits; the receiving screening form and a health appraisal data collection to be completed by the 14th day of stay.

Standards 14, 15, 16, 18, 19, and 21 requires a written communication on how inmates gain access to dental care; medical complaints; sick call; the availability of 24-hour emergency care; insuring that trained personnel are capable of rendering first aid; and an explanation of chronic and convalescent care and medical preventive maintenance as part of any educational effort.

Standards 22, 23, 28, 29, 30 and 38 relate to protheses; a dental examination on or before the 90th day of stay; management of pharmaceuticals; passing medications; medical records; inmate transfers and personal hygiene.

Despite the fact that dental care plays an important role in the accreditation process, it is my observation that some sheriffs, jail administrators and medical people still do not yet fully appreciate this kind of care in jails.

These Standards are not as awesome as you may think.

I want to give you approaches that some of our Michigan jails use to comply with these Standards. Obviously, these may not be appropriate for all jails -- depending on personnel and funding.

One of the Standards requires that there be 24-hour emergency dental care. Let's use the example that an inmate has a severe toothache at 3:00 in the morning and the dentist can't be reached until 8:00 a.m. Even the smallest jail can see to it that the inmate gets a couple of aspirin or Tylenol for relief until the dentist is contacted. Or, if the ache is severe enough, the inmate can be sent to the hospital emergency room.

A tooth extraction may result in a dry socket within one to seven days.

If that occurs, it can be handled by a medically trained jailor by following the written standing orders of the physician or dentist.

In the area of personal hygiene, our jails provide a toothbrush and toothpaste to indigent inmates. The cost for both the brush and paste comes to 67¢ -- a cost that almost any jail ought to be able to cover.

Another Standard requires that inmates receive a dental examination on or before the 90th day of stay. Our records show that only 5% of inmates sentenced to the county jail stay on or beyond the 90th day. Most of the others completed their sentence and/or had seen a dentist. A simple procedure is to flag the inmate who will be incarcerated 90 days and more at the 80th or 85th day for a timely examination.

These are just a few examples to show what a jail can do to provide adequate dental care and treatment in any jail. I know that both Doctors Booth and Rawlins will elaborate on their more extensive experiences.

Returning to my previous comment that some do not appreciate or understand why medical and dental care is provided inmates, let me give a personal anecdote. My dentist asked what I was now doing at the Medical Society. When I told him about the Jails Project, he replied, "Herb, it's a shame these people who violate our laws are receiving better medical and dental care than I get." I suspect this attitude is fairly prevalent in our general population. A question -- is a public educational effort needed?

Let me conclude by giving some notes, comments and observations in my role as Michigan Pilot Project Director:

1. The size of a jail determines the scope of dental care given. Larger jails provide more in-house services.

2. All jails can provide emergency treatment in the form of first aid or other relief measures until the dentist is contacted. This emergency care can be given by a trained jail employee.

3. Routine cursory oral examinations should be made soon after the inmate is booked.

4. It is important that inmates know how to get emergency care -- including written and oral instructions on the way to properly brush teeth and care of the gums.

5. You will find that county boards are reluctant to appropriate funds for medical and dental services. Some

method must be found to break through this barrier.

6. Most dentists prefer to use their own equipment in their own offices. A variety of contractual arrangements can be made so that inmates are not denied this care.

Finally, I'm pleased to announce that the Michigan Department of Corrections, with whom the Michigan Project Group and staff maintains close liaison and communication, proposes to include the AMA Standards, with minor variations, in the Michigan jail rule revisions.

58544

PATIENT EDUCATION - A GOLDEN OPPORTUNITY*

Everyone of us in this room shares a common desire. Now you're probably saying to yourself, "How can that be? We all come from different states, we all have different jobs, and more importantly, we all are individuals." Yes, we all are individuals with different backgrounds, different lifestyles and different goals. Even with these considerations, I still maintain that you and I share one common desire: to get through life with as few problems as possible.

This desire is reflected both in our personal and occupational life. Whenever possible, most of us try to prevent accidents or any other type of crisis from arising, either at home or on the job.

People who work in the correctional system are no exception. The entire operation of a correctional institution is geared toward the prevention of problems. The rules enforced and the procedures followed are for the purpose of having a smooth running organization that has the best interest of all at its foundation.

The Standards for Accreditation exemplify how this basic desire fits into the professional world. The Standards not only provide guidelines for medical and health care in the correctional setting, but also guidelines to prevent some problems from occurring within the correctional institution.

Standard 1021 is one such standard. It states, "Chronic care, convalescent care and medical preventive maintenance are provided to inmates of the facility." Under the discussion section, medical preventive maintenance is defined as "...health education and medical services provided to take advance measures against disease and instruction in self-care for chronic conditions." This Standard gives those associated with the correctional institution the opportunity to prevent a medical crisis from arising and to encourage the incarcerated to develop positive health habits. Positive health habits are those which enhance the quality of one's life.

So now you're probably wondering where I fit in with the prevention of problems and, even more so, with the Standards for Accreditation. Last spring the State Medical Society of Wisconsin contacted the Community Health Education program at the University of Wisconsin-LaCrosse. One of the requirements of the program is to do an internship, where the student has the chance for practical application of his or her knowledge. The State Medical Society was interested in having a Community Health Education intern work with the Jail Health Project. The intern would develop a health education program to be conducted in a pilot jail. I was that intern.

For ten weeks this past summer I planned, implemented and evaluated a health education program for the inmates at the Eau Claire County Jail. Eau Claire County Jail had expressed an interest in this particular type of program and, therefore, was chosen as the pilot state. The pilot program that I developed was entitled "Getting a Handle on Stress."

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*Presented by Virginia Beth Jones, Community Health Coordinator, State Medical Society of Wisconsin.

In developing a program there is a planning process that should be followed. This process includes these essential components:

1. Problem Identification
2. Resource Identification
3. Methodology for Problem-Solving
4. Evaluation of the Program

Problem Identification is when you, or the person who is working on the program, determines what the health education or patient education needs of the incarcerated are. Some examples of these needs are: nutrition education, personal hygiene education or education regarding the management of a chronic illness.

For my program I determined the health education needs by way of:

1. Health Interest Survey
2. Interviews

The Health Interest Survey was sent to jail personnel to find out what they perceived the health needs of the inmates to be.

For a more personal approach, I conducted interviews with the inmates and jail personnel. In the interviews I asked them which one of the following did they see as being most useful to them:

1. Drug Education
2. Exercise Education
3. Nutrition Education
4. Relaxation Techniques for Stress Reduction
5. Personal Hygiene Education

I also asked for any suggestions they might have regarding the programming.

The results from these types of needs analyses were that the incarcerated wanted and needed to learn ways of dealing with stress and tension in the jail setting.

Step two in the planning process is Resource Identification. A resource is anyone or anything that will facilitate, directly or indirectly, in meeting the identified health needs of the target group, which in this case was the inmates. The resources that you will want to consider are:

1. Human
2. Financial
3. Material

In the case of my program John Berg, the jail counselor; Dick Detert, an instructor from the University of Wisconsin-LaCrosse and I were the prime human resources. The human resources that you may want to consider are:

1. People already working within the correctional institution.

2. Official agency personnel - University Extension and your Public Health Department.
3. Private agency personnel - YMCA or a counseling center.
4. Voluntary agency personnel - American Cancer Society, American Heart Association, Mental Health Association, etc.
5. Professional Organization Interns - State Medical Society.
6. Interns from a university system that offers degrees in health-related occupations.

Financially speaking, since I was an intern with the State Medical Society, the only cost to the jail was time -- time that it took the jailers to move the inmates in and out of their cells and time spent by jail personnel in helping plan the program. The cost you or your institution may incur will all depend upon who you choose to conduct the program and what materials they may need.

The materials used in the Stress Program were handouts, a film and a film projector. As far as materials used in a program in your institution, it all depends upon the human resource you choose to use and the topic or topics that are covered.

The next step of the planning process is the Methodology of Problem-Solving. These are the actual program and the techniques used to meet the health needs of the target group.

The following were included in the three two-hour sessions of the program at the Eau Claire County Jail:

I. First Session
   A. Short lecture on the topic of stress - what it is, how it helps you and how it hurts you.
   B. Holmes Life Stress Measure
   C. Rap Session for the inmates regarding their stress in the jail setting.

II. Second Session
   Dick Detert teaches the inmates Relaxation Skills.

III. Third Session
   A. Discussion concerning Relaxation Skills taught during the second session.
   B. Film "Your Own Worst Enemy"
   C. Handout given to the inmates called "Strategies to Beat Stress"

The methodology your program contains will all depend upon the individuals who conduct the program and the topic chosen.

At this time I'd like to let you all experience a few relaxation skills. After all, conferences involve a lot of sitting, listening and interaction with people. All three of these activities can produce a certain amount of tension. Because of the time factor and the setting here, we will not be doing the same activities that were taught to the inmates. However, we will do some other

exercises that are just as effective. They are as follows: neck roll, arm and hands press, hands on hands, heel and toe stretch and deep breathing.

The fourth and final step in the planning process is Evaluation of the Program. In order to continue having programs that are truly useful, you must evaluate your program in some matter to see if it achieved its goal. If your program successfully meets the health needs of the inmates, and they appear to be using some of the information that was taught to them, then you can assume that your program has been effective.

There are various ways to evaluate. I will share with you the methods of evaluation that I used:

1. Pre and Post Test
2. Interviews with all participants of the program

The Pre and Post Test consisted of twenty identical questions given to the inmates before they started the program and after the final session.

There were an average of ten individuals at each session. However, only five attended all three sessions and were present when both the Pre and Post Test were issued. Three out of the five showed an increase in knowledge about stress and handling stress.

The interviews were much more indicative of the success of the program. The interview provided a time when I could ask them questions about their use of the relaxation techniques and their overall impression of the program. I also asked the inmates for any suggestions that they may have had for future programs. This is something that is crucial when planning for future programs.

I strongly urge you to have some sort of evaluation, no matter how formal or informal. You or the person conducting the program can choose whatever method seems most appropriate for your program.

To summarize, here are the four essential steps in the planning process: Problem Identification, Resource Identification, Methodology of Problem-Solving and Evaluation. Whatever the health needs of the inmates in your institution are, that will determine what type of program you develop. Handling stress was the topic that the inmates of the Eau Claire County Jail seemed to feel was the most important to them. If the inmates have learned from my program ways to deal with stress, then that entire correctional institution will benefit.

In conclusion, correctional institutions can provide the setting for professional medical care and health education. Utilize this setting to its full potential. The care you provide in your correctional institution is a means by which you can prevent a crisis from developing. Prevention is the name of the game when you want to get through life with as few problems as possible.

REFERENCES

1. "Standards for the Accreditation of Medical Care and Health Services in Jails."

2. "Guide to Self Incorporated," Agency for Instructional Television, Box A, Bloominton, Indiana.

PATIENT EDUCATION - A GOLDEN OPPORTUNITY *

Patient education reveals inclination not only in the betterment of the patient as a whole but also as a stimulating economical impact.

Initially, as we well know, a substantial percentage of diagnosed illnesses or tentative diagnoses requires some type of medical workup to establish the exact status of the nature of the condition. Once determination of that status has been rendered by the physician and the treatment plan devised, it is then of paramount importance to approach the inmate with the diagnosis and an explanation of the expectations of the inmate towards supportive and self-care measures.

Before we attempt to relate this information we definitely have to consider the mentality of the individual as a whole. We must be assured that the measurements utilized to explain the condition: (1) give a vivid picture regardless of the level of mental conception; (2) project some time factor as to the course of resolution and (3) tell what is or what is not expected of the individual throughout the course of his illness and treatment as related to self care.

There are numerous ways of attempting to project the nature of an illness, but it is basically dependent on the categorization of the inmate being evaluated and/or treated. There are those who are capable of verbalizing the nature of their condition. These persons may even pose outstanding questions which show they understand their own condition and have a concrete interest in improving their medical status. Then there are those who understand the conversation but, as an outlet for legal bargaining, choose not to do what they are told. This particular categorization accounts for only a minimal portion of the overall penal institution's population; nevertheless, if medical compliment is not met in a reasonable and appropriate period of time, protective measures should be instituted and annotations made of all pertinent data. Probably the largest and foremost group consist of those who have only a partial understanding of their overall condition. These are the ones whose needs demand immediate attention, no matter what the extent of their condition, in order that they be treated as early as possible. For this reason, these are the inmates whom I will basically speak. However, these means can also be used when dealing with the other two categories of persons and may, in some instances, lend to more clarity.

One of the simplest means of relating to the average inmate is the utilization of medical leaflets and brochures. Obviously, the promoters of these "teaching documents" are aware of the needs of the general public, whether free or incarcerated because the literature is basically simple.

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*Presented by B. K. Morris, Medical Technician, Prince George's County Jail, Upper Marlboro, Maryland.

This type literature can be obtained from your local Red Cross office, free of charge.

If further information is needed, we would, of course, probably be dealing with a more complicated condition and anatomical diagrammatic mechanisms may be employed. General health and anatomy books lend greatly to the presentation of ideal illustratrations of the human body and its physiology. Of course, by this time more medical interpretation is probably needed and the staff should donate more to this purpose.

Perhaps, at this time, I should pause and make you aware that I am not employed in an institution of medical fantasy. This is to say that I am very much aware of the fact that it is very difficult to find time during any functional day to devote primarily to basic patient education. With the number of incoming physicals, large number of persons evaluated per sick call, the number of persons who receive daily or twice daily in-unit therapy, the number of demands of medical administration, the number of calls you receive per day from administration inquiring about one thing or another and probably centered around financial affairs, it sometimes becomes difficult to maintain reasonable security; nevertheless, we are obligated through our medical involvement to assure the best possible health care delivery system.

With the shortage of time available for patient education, another means of auxiliary aid in obtaining teaching materials is yiur local health department. We have been quite fortunate in the coordination of different teaching assistants with their system. They are equipped with the patient education section which also can be the source of pamphlets, brochures, films, slides, etc., which deal generally with all phases of illnesses and treatments. The subject of Diabetes also lends problems to patient education either because of the "patient's" inability to render self help or because of his irresponsiveness to the seriousness of his condition. Nevertheless, films available through the Health Department give great assistance in defining the conditions and aspects of the patient as a Diabetic.

With the prominence of drug and alcohol habituation in the incoming population and the high rate of recidivism in respect to those two categories, we approached the State Narcotic Treatment Agency located in the Health Department and were temporarily able to obtain a part-time drug counselor until our own system could be devised and somewhat more perfected.

With the female population in mind, we were able to not only provide the inmate with an initial and follow-up Pap smear, but also we scheduled periodic visitations by the Health Department nurses and coordinators. They delivered information on numerous topics inclusive of personal hygiene, cervical cancer, the importance of Pap smears, contraception techniques, birth control, etc. Always with these teaching sessions, numerous brochures and pamphlets are made available on basically all discussed topics and more. The nurses and coordinators are quite able persons who, hopefully, will be found to be almost ready, willing, and able to accommodate inmates' needs.

58545

HEALTH CARE NEEDS OF WOMEN*

Are female prisoners different from male prisoners? If so, how? And what are the implications of such differences for developing programs, including health care?

If these questions have been addressed by researchers, their findings are not revealed in the available literature. Those of us who work with incarcerated women operate on the assumption that there are differences; however, in the absence of documentation of needs, approaches to program development tend to be based on experience, hunch and/or personal bias. As a result, health care services most often evolve haphazardly with minimal planning. Evolution can, all too easily, result in health care which is expensive and inefficient. Perhaps our sharing of information here today can produce some guidelines for planning.

There are some pitfalls in seeking or emphasizing differences between men and women. In a correctional system women represent a small group in comparison with the number of men for whom the system is responsible. Historically, and understandably, attention and available resources have gone to the significantly larger group. Also historically, there has been an attitude that women are so different from men that programming for them is a whole separate exercise. Actually, men and women prisoners are much more alike than they are different: differences are far more often in degree than in kind.

The insistence upon difference is both good news and bad news from the point of view of the women affected. It has been good when it has produced more liveable, less severe facilities for women than for men. It has been bad when it has relegated women to the also-ran position in the race for attention and resources. It has been good when it has resulted in programming for women which is less formal, less militaristic, less security dominated. It has been bad when it has failed to recognize and provide for similarity of needs. A non-medical example of the latter relates to vocational training. This has been seen as highly desirable for men and has been provided, sometimes with almost spectacular diversity, while women have been, long and often, restricted to exposure to housekeeping, clerical or other "women's work" techniques. If greater emphasis had been placed on identifying the samenesses of needs, women could have participated in the attention and resource allocation much more and much longer ago.

A danger in emphasizing <u>special</u> health care needs of women is that it becomes too easy to ignore the fact that <u>most</u> of the health care needs of women are not special but are the same as those of men. The <u>standards</u> for health care are the same for both men and women. If we too often withdraw into separate groups to discuss the needs of women, we can raise the implication that the standards somehow don't apply equally and that would be bad news. We can make a great contribution by defining what, if any, real differences exist.

As a person not medically trained, I am not qualified to speak authoritatively on the question of medical differences between men and women. I can speak from the point of view of a woman experienced in management of correctional institutions for both men and women. On the basis of that experience, I am convinced that the only real differences are those related to reproductive

*Presented by Martha E. Wheeler, Member of AMA Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions.

functions.

For some years, when my day-to-day contacts were with women prisoners, I was of the opinion that women used health care services differently than men, tending more often to act out various problems through complaints of illness. Later, my work brought me into greatly increased contact with male prisoners, and I discovered that the differences were slight, if they existed at all. Men also overburden sick call, complain of bad nerves, change symptoms while walking down the hall from one medical person to another, bad-mouth staff, demand medicine they don't need and fail to take medicine they do need, conceal real illnesses and threaten to sue as much as women do.

What, then, are the special needs which bring us together in a separate workshop? I am sure my fellow panelists, both physicians, will discuss health care needs from the point of view of the medically trained; I have already declared my lack of expertise in this area. I would like, therefore, to discuss some of the management issues in which health care personnel ought to participate.

POLICY MAKING

In order that health care services meet the needs of patients with a high level of cost effectiveness, it is necessary that written policies be developed cooperatively among the managers of the system, the institution and the health care providers. Such policies would include statements as to the kinds of services to be provided, by whom and where. In general, the same kind of statement should be developed for men; however, this is an example of a situation in which the needs of women, usually, are separate, although not greatly different, from those of men. In a correctional system, there are usually several facilities for men while there is rarely more than one for women. A system might decide to designate one of the facilities as a medical center or elect to deliver various specialties at various facilities; I don't know of any system which has established within itself a coeducational medical center. The institution for women must be all things to its people.

There is no universal model for the structure by which health care can be effectively and economically delivered. It is only possible to point out some of the possible options which can be considered. For example, who is going to serve as the medical authority for the institution? A full-time physician employed by the institution? A hospital administrator employed by the system? A group of physicians (a corporation?) under contract? A part-time physician who also has a private practice? A general practitioner or a specialist?

What kinds of services will be delivered? Clearly, the institution for women must be prepared to cope with any kind of health situation which may arise. It goes without saying that facilities must be provided for OB-GYN. Will there also be need for infant care? Pediatrics? What about elective surgery? Plastic surgery? Dental care? Mental health care?

Where will the services be delivered? Will the institution operate a hospital? An infirmary? Or will it be limited to an out-patient clinic with in-patient care elsewhere? If elsewhere, can women be incorporated into facilities provided for male prisoners? Will arrangements be made with a nearby hospital? Wil there be a ward set aside as a prison ward for women,

or will they be admitted as if private patients? What will be the need for providing guards for hospitalized women?

The staffing of health care services needs to be determined with consideration of the level of services to be delivered. Decisions need to be made assigning responsibility for and authority over the budget; clear lines of supervision and authority need to be drawn in relation to non-medical personnel assigned to health care functions.

It should be obvious that this kind of cooperative planning should be carried out for both male and female prisoners. The processes are not really different but need to be separate, partly because of the OB-GYN needs of women but mostly because of the separated nature of the system. It is urged that careful thought be given to the integration of services where it is possible. For example, could both male and female patients be economically and efficiently served by the same laboratory or cardiologist or orthopedist? Once again, sameness should be identified and dealt with as such.

Neither health care personnel nor correctional management should finalize the kind of planning just described without close consultation and agreement with each other. Unless all parties subscribe to an understanding of what is to be done, where, how and by whom, the result can be sabotage, frustration and disillusionment to the special detriment of the patients.

SERVICE DELIVERY PROCEDURES

This, too, is an area which is not fundamentally different for women than for men. In both cases, it is necessary to agree on the procedures by which prisoners gain access to health care services; differences in the procedures themselves may arise because facilities for women are usually much smaller than those for men and provide for more informality of communication. In a very small facility with trained health care personnel available around the clock (e.g., a nurse on duty), it might be possible to provide attention on demand. Usually, however, it is necessary to establish clear procedures for sick calls, "triage," referrals for follow-up or special care and the like. The establishment of these procedures requires close cooperation between health care and other institution staff to be sure that the interests of all concerned are being appropriately served. It is an intricate juggling act to maintain unimpeded access of prisoners to needed health care while preserving the orderly operation of the total institution community and protecting the health care services from misuse. Here, again, there is no universal model for proper procedures. The Standards issued by the AMA for health care in jails and being developed for prisons speak to the subject, especially in terms of frequency of availability and kinds of services mandated, but leaves the specific procedures in the hands of the persons responsible for the facility.

It is essential that procedures be developed cooperatively by persons who have clear understanding of the purposes and functions of the total institution as well as health care services. Unless everyone involved can live reasonably comfortably with the procedures, they will not work. A fundamental requirement is that the custodial functions of the institution shall not prevent the proper practice of medicine. A corollary is that health care personnel shall know enough about the functioning of the total institution

not to require the impossible. Mutual respect, knowledge, compassion, flexibility and a sense of humor are all helpful qualities in those who get together to work out the routines.

One of the knottiest problems in the prison setting is the control of medications. Certainly there are purely medical decisions to be made as to the appropriate prescription of various kinds of substances; there are also some serious custodial implications. In the "free world" most patients are expected to get their prescriptions filled and take the medicine as instructed. If they don't do it, that's their problem. In prison, we see a whole different sense of responsibility, from both medical and custodial points of view. It is incumbent upon us to get together and take a good, hard look at why we do what we do. For most of us a trip to the doctor or an emergency room is a fairly occasional thing. If we have a minor cut or a cold or a headache or the cramps, we don't go to the doctor -- we go to the medicine cabinet or the drug store. Are there some ways we could simplify everyone's life by making it easier to do likewise in prison? I'm not answering this question; I'm just asking that you, with your medical and custodial colleagues, consider it. This, again, is not a problem peculiar to women, but the smaller, less regimented facility might permit some different procedures than the larger, male facility.

Another problem relating to medication is that of the availability of a registered pharmacist for the small institution for women. The part of the system which deals with males is usually large enough to convince the purse string-holders that the expense of a pharmacist is justified; the small institution for women may have a problem. Health care personnel should insist that some arrangement be made, whether by sharing with another institution, a part-time employee, a contractor or whatever.

PREGNANCY

Obviously, provision must be made for caring for women through pregnancy, delivery and the post-natal period; the medical aspects will, I am sure, be addressed by the other panelists. Some management decisions around this must be made, however. Where will the baby be delivered? At the institution? Elsewhere? By whom - the institution physician or a specialist in obstetrics? Will the staff regularly include an OB-GYN specialist or will it be on a referral or contractual basis?

Will the baby be cared for in the institution? If so, where, by whom and for how long? To what kind of care will the baby be released and who makes the decision that the release plan is acceptable? These questions, while not purely medical in nature, certainly have implications for the health care personnel. If the institution is to assume responsibility for infants, health care services must be prepared. I confess to a personal bias for minimal involvement of the institution in the care of children. I would prefer to see an extra-institutional agency involved with the expectant mother in planning for the care of the child after birth, delivery at a hospital away from the institution and placement of the child in its setting by an appropriate agency without returning to the institution.

Within the past few years, termination of pregnancy by abortion has become

a reality to be faced by correctional institutions for women. Health care personnel need to be closely involved with institution managers in developing the policies and procedures in this area. The situation may differ markedly from one jurisdiction to another, depending on budgetary provisions or local laws affecting the expenditure of public funds for abortion. All personnel need to be thoroughly informed as to the legal position of the prison. Can abortions be arranged on demand? Financed how? Can referrals be made to other, community agencies? How is the whole question affected by legislation, departmental policy, institutional operation? Policies and procedures should be clearly defined, written and known to all employees and prisoners.

Similar consideration needs to be given to the question of prevention of pregnancy. Does the institution provide birth control information and equipment? What kind? To whom? By whom? When? Again, policies and procedures must be clearly defined, written and known to all employees and prisoners.

EDUCATION

Are health education needs for women different from those for men? Perhaps not ideally but, realistically, I think so. For one thing, women continue to be the primary nurturers of children, and it is more important that they be informed about the maintenance of health. Both men and women are ill-informed about their bodies and how they operate, and both can benefit from education; however, women are in a better position to use their knowledge to benefit their children as well as themselves. They are also more likely to be able to provide better nutrition for the family and to use any home nursing skills they may acquire. It is certainly important for women to understand the perils of drug use at any time but particularly during pregnancy. Menstruation and self-examination, especially of breasts, are clearly subjects for health education for women.

Health care professionals ought to be active in promoting health education programs in the institution. This is not necessarily an instructional activity reserved to health care personnel; non-medical persons may develop, coordinate or teach such subjects. Health care personnel ought actively to support the program, however, and participate to the extent that primary duties permit.

I have another personal hobby horse to which I would like to refer, in passing. This relates to the intake function of the institution. Very often, the admissions unit is close to - or even a part of - the health care area of the institution. It may even, to a considerable extent, be administered by health care personnel. I think this is a mistake. Most women committed to us have the potential, at least, for being reasonably healthy, not sick, persons. I think it is an error to establish the implication that they have been admitted to a facility for the sick. It would be better if we established that it is a total community, including the capability to maintain health and cope with illness.

As you have seen, the thrust of this paper has been to point out some of the management areas which call for the closest possible cooperation among health care providers and those responsible for the system and the institution. Health care does not stand along but functions within the institutional community which

is, most usually, part of a system of such communities. All of these must learn to identify and dovetail more closely their relationships to each other as well as to the larger community, the "free world." If health care personnel find that they are not being consulted about matters which affect them, they must be energetic about insisting that they be made a part of the policy making or procedure designing. By the same token, health care personnel must be knowledgable about the total institution and be sensitive to the impacts which their practices make upon it and all its inhabitants. There are many occasions on which cross-purposes can develop. Only a close, warm, mutually respectful and understanding relationship can minimize conflicts and ensure the delivery of high grade health care.

58546

WHAT ARE THE HEALTH NEEDS OF JUVENILES AND WOMEN IN CORRECTIONAL INSTITUTIONS?*

Young people who find themselves in juvenile court facilities display many health problems. Their medical care has been episodic and crisis-oriented at best. These is no doubt that some of the medical problems, such as physical handicaps and neglect of acute and chronic disease, are contributing factors to the youths' poor self-image and delinquent behavior.

In a study conducted by Litt and Cohen[1] in New York City, out of 31,323 incarcerated, presumably healthy teenagers, 46% were found to have medical problems, excluding those of a dental or emotional nature. Nearly half of the health disorders were detected by simple screening tests. Another study[2] of female adolescents in a Wisconsin institution for delinquent youth showed a fairly consistent incidence of infection with Neisseria Gonorrhoeae of 11 to 13%. The prevalence of Trichomonas vaginalis[3] was determined to be 35.2% in a series of 338 consecutive admissions to the institution. The following diagnostic tests should be regularly performed on all residents of a juvenile correctional institution:[4] hematocrit, urinalysis, urine culture in females, tuberculin skin test, serological test for syphilis, gonorrhea cultures for sexually active males and females, vaginal wet-mount preparation for Trichomonas vaginalis, hemophilus vaginalis and yeast infection and Papanicoloau (PAP) test for cancer of the cervix. Screening for sickle cell anemia and trait should also be done for black residents. Those who give a history of drug abuse should also be screened for liver disease with serum glutamic pyruvic transaminase (SGPT). Those individuals who are at risk because of family history of diabetes, hypertension, heart disease and hypercholesterolemia should have appropriate blood chemistry determinations. The results of the screening, whether normal or abnormal, should be communicated to the residents. It will frequently relieve unnecessary worries.

Sexually active females should obtain a pregnancy test. The pregnant girl should be given the option of termination of her unwanted pregnancy. She should be informed of her rights to have an abortion on her own consent, according to the June, 1976 Supreme Court decision. Sex education in its broadest concept of sexuality should be an integral part of health education with inclusion of information on birth control for males and females. Contraception services should be rendered to the sexually active teenagers prior to leave on furlough, work release or parole in order to prevent pregnancy which compounds the problems of the delinquent youth.

The information on availability of contraception and abortion services

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*Presented by Hania W. Ris, M.D., Associate Professor of Pediatrics, University of Wisconsin.

[1]Litt, I.F. and Cohen, M.I.,"Prisons, Adolescents and the Right to Quality Medical Care. The Time is Now." AJPH. 64:894-897, 1974.

[2]Ris, H.W., and Dodge, R. W., "Gonorrhea in Adolescent Girls in a Closed Population." AMJDIS Child, 123:135-189, 1972.

[3]Ris, H.W. and Dodge, R.W. "Trichomonas and Yeast Vaginitis in Institutionalized Adolescent Girls. AMDIS Child 125:206-209, 1973.

[4]Ris, H.W., "The Integration of a Comprehensive Medical Program in Juvenile Correctional Institution." JAMWA 30:367-378, 1975.

should be included in an orientation handbook for residents and reach the residents through formal channels, rather than through the grapevine. A paperback book, "Our Bodies, Ourselves,"[5] which gives a great deal of information about women's health and which is easily understood, should be an integral part of education material.

All efforts should be made to render high quality comprehensive health care with consideration of the social, emotional and intellectual problems of the youth. This should include immunization and other preventive health care, such as consideration of hereditary and lifestyle risk factors, diagnosis of acute and chronic diseases and their treatment, and rehabilitation of congenital and long-standing disabilities, including sequalae of past accidents.

The World Health Organization's definition that "health is the state of complete physical, mental and social well-being, not merely the absence of disease" should be applicable also to residents of correctional institutions. Health education should be an integral part of health care delivery and prepare the individual to assume responsibility for his/her health maintenance. Health education is currently conspicuously missing from most institutions. Such education may alleviate many of the concerns of the residents which stimulate sick calls, which often dominate the total medical services and thus leave little time for the health professionals to render more meaningful care.

Health care in correctional institutions must be a crucial component of an overall rehabilitation program. Medical care is a basic human need and clearly a right, not a privilege. The health problems of the juvenile offender are often more complex than those in the rest of society. Psychological factors play a critical role and therefore a comprehensive, multidisciplinary approach is of paramount importance.

The primary care physician should be able to treat minor psychological problems by developing the necessary trust and rapport required for supportive therapy. This would guard against quest for and abuse of psychotropic drugs and would help to deal with the causes of psychosomatic complaints.

The previously enumerated screening recommendations for youth could be equally applicable to an adult prison population, with addition of blood chemistry panel.

Prisoners commonly view medical services with mistrust. It is little realized that their overt demand for improvement stems from the sense of complete dependency upon the institution in the case of serious illness and the fear of dying as a prisoner.[6]

What are the special health care needs of women? The initial examination should pay special attention to the breasts and reproductive organs. A careful manual examination for breast cancer and the teaching of breast self-examination

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[5] Our Bodies, Ourselves, A Book By and For Women, by the Boston Women's Health Book Collective, Inc. Simon and Schuster, New York, 1973.

[6] Heffernan Esther: Making It in Prison. The Square, the Cool and the Life. Wiley-Inter-Science, Division of John Wiley and Sons, Inc., New York, 1972.

should be an essential part of the initial examination; thus the woman becomes actively involved in her own health maintenance. A pap smear for cancer of the cervix should be done at initial examination and once a year thereafter, at which time a total brief examination should be done, which should include a thorough examination of the breasts.

Screening for gonorrhea should include cervical, anal and pharyngeal cultures. It is well established that up to 80% of females with gonorrhea may be asymptomatic, yet they can develop serious complications and transmit the disease to their sexual partner. According to the Center for Diseases Control Morbidity and Morality Report, May 12, 1978, correctional or detention center populations have an incidence of 5.2% of gonorrhea. As previously indicated, under optimal conditions of screening of teenage girls in a correctional institution, the prevalence ranged between 11% and 13% (see footnote 2). It is not enought to send the specimen to a reliable laboratory for processing. It is of utmost importance to monitor the collection of the specimen and its handling in transit prior to its arrival at the laboratory to assure the survival of this fragile organism. A case in point is a women's prison which I visited recently with 906 admissions in a one-year period. Ninety-six cases of positive serological test for syphilis were discovered but no cases of gonorrhea. The specimens for gonorrhea were processed by a competent state laboratory. The collection of the specimens and its shipment is currently being investigated to elicit the cause of the alleged absence of gonorrhea in this population, which is contradictory to the high incidence of syphilis.

A large number of women in prison present gynecological problems which will require services of a gynecological consultant.

If a woman enters the prison while she is taking oral contraceptives, she should be allowed to continue at least to the end of that monthly cycle, so she is protected from pregnancy resulting from intercourse occuring immediately prior to her admittance.

Ideally a women's prison should be staffed by a woman physician. The physician, whether male or female, should have some experience in gynecology. The pelvic examination should be conducted with due regard for human dignity with assurance of privacy.

In co-correctional institutions contraceptive services should be handled on the inmates' request by a physician or nurse in a discreet and confidential manner without repercussions. The refusal to offer contraceptives in a co-correctional setting is far more likely to result in pregnancy than in abstinence.

A number of pregnant women deliver their babies while they are inmates of correctional institutions. Needless to day, expect obstetrical care should be provided. Although usually the delivery takes place in an outside hospital, in most instances mother and infant are separated shortly after birth. It has been well established that the mother-infant bonding immediately after delivery and in the first weeks of life plays in important role in future development of the child and mother-child relationship.[7] Since most of the mothers do not give

[7]Klaus, M.H. and Kennell, J.H., Maternal-Infant Bonding, The Impact of Early Separation or Loss on Family Development, C.V. Mosby Co., 1976.

up their infants for adoption and will take care of them eventually, it would seem to be crucial to grant the mother a postpartum furlough of at least six to eight weeks so that attachment of the mother to the infant can be established. Pregnant women who find themselves in prisons are living under great stress. They are at great risk of rejecting their children. Solidification of initial bonding is of utmost importance. Rooming-in in the hospital should also be established.

According to the 1972 Health Law Project of the University of Pennsylvania Law School,[8] mothers whose babies are born in custody are pressured to give them up for adoption. A similar study done in Connecticut revealed that residents of correctional institutions were told that unless they give up their infants for adoption, parole will be denied. At the same time some institutions deny pregnant women the right to abortion services. Those practices are unacceptable.

Federal and some state legislation which denies welfare payment for abortions has resulted in many poor women believing abortions are illegal and unavailable. This common misconception should be corrected. Women in need should be informed that private funds may be available, such as Planned Parenthood's Justice Fund available through their facilities in several states, or private emergency funds such as the Wisconsin Women's Medical Fund, Inc.

Research shows that children of incarcerated women are twice as likely to become delinquent as their socio-economic peers. In addition, their poverty, coupled with low education level of parents, and with minority and single-parent status compromises the development of their full potential.

Cognizant of this fact and the importance of maternal-infant bonding, a private firm, Shared Beginnings/ESP, Inc., contracted with the Federal Bureau of Prisons in 1972 to house pregnant offenders two months prior and six months after delivery. The objectives of the program are to promote mother-infant bonding, to provide education in child care, early child development and family planning, and to facilitate smooth transition from mother to foster care "by encouraging a positive relationship between mother, child and surrogate parent."

In Minnesota an alternate program was developed in the adult women's correctional facility, with a population of about 50, whereby following delivery the infant is placed in a foster home. If the mother so desires the infant can be brought to the facility and stay with the mother from Friday to Monday. This arrangement may continue for her entire incarceration. The only requirement is a crib for the baby, which is put in the mother's room, and of course a willing, sympathetic and understanding administration. This opportunity for visitation is also given to older children.

This arrangement offers a unique opportunity to teach parenting not only to the mother but also to other residents of the institution. The program proved to be a success for mother and child. Kansas and Nebraska women prisons have similar programs.

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[8] Female Offenders - Workshop Guide. Female Offender's Resource, American Bar Association, March, 1977.

It is well to keep in mind that incarcerated women have special problems as women which relate to greater social disapproval of their criminal activity, problems related to the men in their lives, the anxiety and worry about their children left behind, low self-image and economic problems. In a California study of women in a county jail[9] between 70% and 80% had children, but only 14% to 43% were married at the time of incarceration, an indicator that they were the sole support of their families. Many of them were on welfare. A good medical program has to deal with those problems for the benefit of the women and their children.

A final word about recruitment of physicians for the correctional system: it is not enough to have a well-trained person; he/she has to be compassionate and dedicated and understand the socio-economic and emotional problems of the incarcerated person and above all have a high level of frustration tolerance necessary to function in correctional institutions. The rewards will be most gratifying.

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[9] The Women in Transition Project, Volunteer Counselors for Women in a County Jail. California Commission on the Status of Women, 926 J. Street, Room 1506. Sacramento, California 95814.

LOOKING BACK -- AND LOOKING FORWARD*

I know it's getting late in the day and that many of you want to get home tonight in time to celebrate Halloween, so I will keep my remarks brief. Just before I came up here, I heard some people commenting on the fact that the AMA was requiring participants to pick up their recognition awards in person. Somebody suggested that perhaps this was a ploy to guarantee an audience for the last session, and his friend said that he sure hoped it wasn't a reflection of my speaking capabilities! Well, I hope so too.

At any rate, what I want is just to spend a few minutes with you and talk about my impressions of this conference. In order for you to appreciate my perspective, I would like to begin by telling you a little bit about my role with respect to the American Medical Association's Jail Health Care Project.

There are actually two primary tasks that I perform for the Jail Project. The first is to serve as the research consultant. While these functions are interrelated, there is a subtle distinction between the two. As the program evaluator, I travel around to the different state medical societies which are involved in the AMA's Project and talk to them about the progress they have made and any problems that they have encountered. I try to identify strengths and weaknesses of each state project as well as the overall national program. These findings are then put in a report, along with any recommendations I may have regarding changing the management or operation of the overall program. This report is sent to the state societies, to the AMA staff, and the LEAA as the funding agency.

I see evaluation as a way to make a positive contribution toward improving program operations, and I like to think of myself as helping projects, not "checking" on them. There are those who would disagree with my assessment, however. For example, I remember a few years ago, before I became involved in the evaluation business, I was looking for a job. I had just finished my Master's degree and was living in New York at the time. I heard about a job opportunity as a project director with a firm in Washington, D.C., so I sent in my resume and called the fellow in charge. He seemed very receptive. We arranged a date for me to come in for a job interview, but this man in charge was so positive in his dealings with me that I assumed the job interview was just a "pro forma" gesture. In fact, I was so confident that the job was mine that I packed up my belongings and moved to D.C. On the day of my scheduled interview, I showed up right on time -- which is unusual for me -- only to be kept waiting for about an hour and a half. When I finally did get in to see the man I had spoken with previously, he very politely told me that the job that I was sure was mine had been filled. Now, I don't usually swear -- at least not where I can be heard -- but I was so angry at all of the hassle that I had gone through only to be told there was no job, that as I got up to leave, I mumbled under my breath, "Well, I'll be a son-of-a-bitch." "Wait a minute," he said, "why didn't you say so before? We do have a position open for an evaluator."

At any rate, evaluation is one part of what I do. The other part is more of a straight research function. For example, yesterday you heard Dr. Modlin

*Presented by B. Jaye Anno, B. Jaye Anno Associates, Silver Spring, Maryland (AMA Project Evaluator).

and Mr. Harrison quote some statistics regarding the status of health care in jails. While I wasn't involved in the AMA's 1972 survey, I was involved in the two major research efforts that have been conducted over the past two and a half years. One of these is what I call the Jail Pre-Post Profile -- which was a study designed to measure improvements in the availability and adequacy of health care services in the 30 original pilot jails participating in the AMA's program. The other research effort is referred to as the Inmate/Patient Profile. This was also a pre-post study, and it was designed to measure improvements in the health status of inmates confined in the 30 pilot sites and, more importantly, to determine whether or not the accreditation of jail health care facilities would result in a reduction of the incidence of undetected and untreated illnesses.

I don't want to go into the results of these two studies in any detail. Suffice it to say that on an overall basis, these two studies indicated that the AMA project was very successful in improving the health care delivery systems in the original pilot sites. In other words, accreditation works.

It was not that many years ago that nobody was interested in the topic of health care in correctional facilities -- except, of course, those of you that have been working in the area. But there was no national attention being focused on the topic. Just in the past five years that has all changed. Now health care in corrections is one of the hottest things going. All kinds of local, state and national organizations are becoming aware of the problems and beginning to get involved in working toward solutions.

I am a relative newcomer to the topic myself and something of an outsider at that, since I am neither a health professional nor do I work in a correctional facility. Nevertheless, just in the three years that I have been associated with the AMA's program, it has been personally gratifying to watch the interest grow.

I can remember when I first started working with the AMA's Jail Project. I was telling a friend of mine that I was going to be visiting some of the nation's jails and looking at their health care systems. This friend of mine is also a criminologist, and he was appalled that I was going to be working with jails.

"Jaye, you can't do that!" he said. "You don't know what you're getting into. Jails are hell-holes! They're terrible places and nobody cares about them. There are some jails that, if you went into them, you might never come out."

I said, "Oh, come on Bill. You're exaggerating."

He said, "Oh no, I'm not. I can remember a couple of years ago I was visiting this one jail and they had the inmates strapped to the walls. No kidding," he said. "There were these two guys who were hanging on the wall. Their arms and legs were bound with leather straps and while I was standing there gawking at them a guard came in, went over to one guy and cut the arm and the leg strap on the right side so now he was just bound on his left side. The other inmate turned to him and said, 'congratulations on making trustee status.'"

Well the jails I saw were not quite that medieval, but I think my friend's

attitude was not all that uncommon a few years ago.

One of the most positive things about the AMA's Health Care in Corrections Project is that it is beginning to make jails and correctional facilities respectable places to work. The kind of conference that you have been attending belies the old notion of corrections as "the last stronghold of the incompetent."

In assessing this conference, I've been impressed by a number of things. To begin with, the turnout has been incredible. Over 350 professionals showed up to talk about health care in corrections. Last year in Milwaukee, the first AMA conference on Jail Health Care was held in conjunction with the American Correctional Association's annual meeting. There were about 200 people registered at that conference. There was some concern expressed this year regarding whether or not a conference on health care in corrections could stand on its own. Your attendance here attests to the fact that it can. There are enough of you out there who have a special interest in this area to sustain a national conference. Hopefully, you will all be back for the third annual conference next year.

I have also been impressed by the fact that there are so many different types of professionals who are here. The number of professions represented is remarkable. This conference isn't just sheriffs talking to sheriffs or doctors talking to doctors. It is sheriffs talking to doctors, doctors talking to corrections officers, corrections officers talking to physician assistants, nurses talking to doctors -- which is a pretty good accomplishment right there.

Beyond that, I have been going around to the different workshops to see what your response has been to the Standards and to the different speeches. I was delighted to find you participating, asking questions, arguing -- sometimes heatedly -- about the best way to proceed, disagreeing -- sometimes vehemently -- with one Standard or another. I think that's good. This conference has given you an opportunity to have some input into the policies and procedures that may someday affect your various professions, and you have taken the opportunity to be heard.

It is always a little frustrating at any conference that problems are discussed, but that often, all of the solutions are not provided. That should not be construed as failure. What is important about a conference like this one is not that it can provide all of the answers to your needs -- it can't. Rather, it is simply the fact that you are here, that you are interested, that you are talking to other professionals who understand your difficulties in trying to provide good health care in a correctional setting and who share your concern for improving health care services. You have been living with your problems for a long time. The solutions will take time too, but little by little, they will come. They will be arrived at by doing what you are doing now: talking to your peers and to representatives of other professions who share your concerns. I hope that when you go back home you will be able to sustain the enthusiasm you have shown here. I hope that when you go back home you will be able to sustain the enthusiasm you have shown here. I hope that you will be not just dedicated, but truly committed to the principle of improving health care in corrections.

I can remember a few years ago when I had an important decision to make regarding whether or not to get involved in a particular project. I was

discussing it with my dad and he said to me, "Well Jaye, are you just dedicated to the idea or are you committed?"

I said, "I don't understand. What's the difference?"

He said, "Well honey, it's like this. You have ham and eggs for breakfast sometimes, right?"

And I said, "Yes."

He said, "Well that chicken who gives you those eggs for your breakfast -- she's dedicated. But honey, that sow who gives you that ham, she's committed!"

Stay committed. Thank you.

HEALTH CARE FOR WOMEN INMATES AT THE NEW MEXICO STATE PENITENTIARY *

Health care for women inmates in less populous states presents several unique problems. Health care for these patients is often disorganized and crisis oriented. Usually housed in small units separate from the main prison facility, these inmates often have less access to health care providers, the providers having to rely on the objectivity and medical judgements of correctional officers to call their attention to the needs of women. The potential exists for abuse in this system if the officer denies medical care as a form of punishment.

Because the number of women inmates in any one facility is small in relation to the male inmate population, their health care needs are often a secondary priority. At the New Mexico State Penitentiary, for example, there are 50 women and 1100 men. Male inmates have access to medical providers on a daily basis, whereas the women inmates have sick call only 1/2 day a week for non-emergency problems.

The prison doctor is often ill-prepared to deal with the unique health concerns of women. At the Women's Division of New Mexico State Penitentiary, over 50% of medical problems relate to gynecologic or even obstetric pathology. The last two physicians employed by the penitentiary, a surgeon and a general osteopath, felt limited in dealing with these concerns.

The penitentiary of New Mexico has addressed these problems in a manner which may be applicable to small women's facilities in other states. An agreement to provide health services at the Women's Unit was arranged between the penitentiary administration and a woman resident in the Family Medicine program at the UNM School of Medicine. A weekly clinic was established to deal with all non-emergency medical problems of the women inmates. Any inmates who required specialized care or hospitalization were referred to physicians in nearby Santa Fe. However, medical evaluation and treatment was carried out at the Women's Division when possible. This arrangement has served to provide women prisoners with an on-going system of preventive medical care. Medical problems which were largely ignored previously, such as abnormal pap smears and prenatal care are now treated or referred appropriately. Medical problems which had previously been handled by adequate work-up of the problem, treatment where appropriate, and counseling or relaxation therapy for problems where no organic pathology is found.

The fact that the health provider is an "outsider" not employed by the prison sysrem served to increase the inmates' trust and communication with

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their doctor.

In addition, the fact that the doctor is also a woman facilitates this inmate acceptance. Since women physicians in post graduate training programs comprise a much larger percentage than their proportion in the practicing community, prison administrators seeking women health providers might explore a university linkage to improve the health care of their women inmates.

DRUGS, MEDICINE AND HEALTH CARE IN THE NEW MEXICO STATE PENITENTIARY *

Traditionally, prisoners equate pill consumption with health care. Compliance with this expectation can lead to rampant overuse of drugs. The first step in attempting to control drugs in the prison, both prescribed and contraband, required that medicine be prescribed only for a specific indication. This prevents overprescribing as an excuse for not taking the time to work up a problem adequately. A case in point was the prevalent use of phenobarbital for presumed epilepsy. When we carefully monitored dilantin levels, withheld phenobarbital and performed diagnostic EEG's, we discovered very few epileptics. The prevalence of this diagnosis fell from over 100 to 6, and few inmates now receive phenobarbital.

A method for dispensing medication is also important. At the New Mexico State Penitentiary when medication is ordered, it is set up for each inmate each day in labeled unit doses. Every pill must be swallowed at the pharmacy window and pill call is 3 times per day. If the medicine is not claimed, the non-compliance is noted. If the medicine is not claimed twice, it is cut off and the inmate is called in for an interview to determine the reason. Psychotropics require both the signature of the psychologist - in-chief and the physician. A medication profile is entered in every inmate's record. In 12 months since the implementation of this system (for a prison population over 1100) the average percentage of inmates on any medication has fallen from 25% to 3%; the number on psychotropics, from 12% to 0.5%; the number of those coming to daily sick call, from over 8% to 1%; and the non-compliance in taking medication, from over 70% to 2%.

Dealing with medicine abuse is another principal thrust of the medical program. For the first time in the history of the State Penitentiary, a surprise urine drug screen on all inmates was conducted during the month of September, one year after the institution of the new medication control program. Over 1100 urines were collected early on a Monday morning and tested for opiates, barbiturates, minor tranquillizers and hypnotics. Only seven inmates were found to have "dirty urine": 5 for Valium and 2 for opiates.

An important by-product of the successful control of psychoactive drugs in the prison concerns its impact on the level of prison violence. With the decline in both legal and contraband drug use at the penitentiary, the incidence of assaults and murder has decreased markedly, so that self-inflicted injury now outranks assault as the major cause of trauma. This

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relationship is currently being studied quantitatively.

More vigorous diagnostic work-ups and drug control programs may increase health care costs in the short run. The hospital budget increased roughly from $303,000 to $456,000 during the first year of operation. However, the overall long-term cost to the Department of Corrections may be much less in light of fewer malpractice suits, diminished court intervention and the ultimate decreased cost of prison violence in general.

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SEPARATION, DEPRIVATION AND LONELINESS AMONG JAIL INMATES*

The effects of separation and deprivation, including loneliness, among institutionalized persons are obvious to the most casual observer of populations in mental hospitals, prisons, army camps, nursing homes, general hospitals and often boarding shcools. The behavioral manifestations of institutionalized persons as evidenced by posture, gait, facial expression, and affect often betray the inner feelings of loneliness, despair, hopelessness, sadness, and purposeless existence. In recent years much attention has been given by concerned health professionals to the concept and the process of institutionalization in an attempt to understand the impact this process has on the individual in terms of the adaptive process. As a result there has been a nationwide attempt in the area of mental illness to de-institutionalize the large state hospitals through the community mental health programs. Custodial care, recently referred to as "warehousing" of large numbers of people has been recognized as demoralizing, dehumanizing and non-therapeutic (Brocking and Young, 1973).

This is a hopeful trend for a large segment of our population whose behavior earns for them the label of mentally ill or emotionally disturbed. But what of that other large population whose behavior brings them into conflict with society and earns for them the labels of criminals or inmates in our ever growing penal institutions?

A jail or prison is a total institution that imposes complete separation and deprivation on its inmates. The process of institutionalization begins as a person enters the system and is locked away from the outside world. One could certainly hypothesize that the emotional impact is overwhelming. The feelings of anger, fear, frustration and despair come quickly to mind as one imagines himself in the position of being confined in a jail or prison. While working with children adjudged delinquent and committed to institutions under the State Department of Corrections, and with inmates in a large city jail over a period of time, the predominant emotional response that was apparent through both verbal and non-verbal behavior was that of profound and persistent loneliness.

The purpose of this study was to measure the social phenomenon of loneliness, an effect of separation and deprivation, experienced by inmates in a large city jail.

The Richmond City Jail, Richmond, Virginia is a total institution that imposes complete separation and deprivation on its inmates. No contact visits with anyone outside of the jail, with the exception of lawyers and clergymen, are permitted. An inmate may have a twenty minute non-contact visit with a friend or family member once a week. During this visit a wall with a window

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*Presented by Mary C. Brocking, R.N., B.S., M.S.N., Associate Professor, Medical College of Virginia, Virginia Commonwealth University. This study was supported by USDHEW, PHS, Division of Nursing grant NU00503 and by Virginia Commonwealth University, School of Nursing. The author gratefully acknowledges Andrew J. Winston, Sheriff, City of Richmond, Virginia, for making this study possible.

in it stands between him and his visitor. Conversation is carried on by way of a telephone. Phone calls outside of the institution are infrequent. The inmate is separated from his home, his family, friends, job, pets, familiar surroundings, possessions and his lifestyle. His losses include his freedom, mobility, decision making, self-direction and self-esteem. He is objectively separated or alienated from all that had been significant to him.

Studies of separated populations have been conducted which suggest that theorectically there is a relationship between separation and secondary loneliness. Secondary loneliness is defined as a "vague and dysphoric reactive response to the separation from social and physical cathectic objects." These objects include persons. The separation referred to must be from those persons or things in which the individual has some cathectic investment. The term cathectic investment is defined as "the endowment of social and physical objects with meaning, import and energy" (Francis, 1976).

Francis, in her studies, describes loneliness as an "abstraction" and a "universal." "It is always a part of a human being when it exists at all. It cannot exist by itself; it needs a host...(it) always will be whatever its host perceives it to be. To identify the lonely one simply asks who is lonely. Respondents place themselves in or out of the loneliness category." However, her studies and this study made loneliness an observer category. Indicator items were asked of the respondents and based on their response the investigator was able to measure the degree of loneliness.

Francis (in press) also refers to the concept of alienation which is frequently used interchangeably with loneliness. She differentiates between the concepts of alienation and loneliness. She defines alienation as an objective state of being separated from something. She describes loneliness as "not a state of separation but the human response to it."

Sommer and Hill (1958) in their study, "Alienation and Mental Illness," noted that the length of time individuals are separated from meaningful persons and things is a significant variable. They found a difference between patients on admission wards and those on other wards. They reported a difference in values between those newly admitted and those longer-stay patients. This suggested a relationship between social isolation and subjective response. In other words, length of separation would affect psychological response of the individual.

In the present study, a replication of previous works on loneliness was accomplished through use of the same research design and method. Theoretical framework was consistent with the loneliness studies. The hypothesis was that within the population at the Richmond City Jail there is extreme loneliness. This hypothesis does not support the myth one often hears about inmates of penal institions "they never had it so good."

The assumptions were that the jail population is capable of cathectic investment, contrary to another myth "those people don't care about anything"; that there is a positive association between loneliness and cathectic investment; and that knowledge of date of parole or release influences loneliness.

Methodology

Data were collected through personal interviews lasting approximately twenty minutes each using the highly reliable tool designed and tested in previous loneliness studies.

Sample

A stratified probability sample of 144 inmates was drawn from a total population of 671 inmates on the first day of data collection. Of the total, 618 were men and 53 were women. The sample consisted of 129 men and 15 women. The inmates are housed in dormitory type tiers and in individual cells. Informed consent was obtained and inmates were escorted to and from the testing center at the jail by off-duty deputies.

Analysis of Data

Data analysis revealed an age range of 16-62 years with a mean age of 26. Of the sample, 91% were male, 65% black, and 58% were single. The largest group, 33% held jobs prior to incarceration described as "skilled" by the United States Department of Labor; 28% were unskilled. The remainder were unemployed. The mean number of years of education was 10 years. No religious preference was stated by 36%, Protestanism was preferred by 36%, Roman Catholicism by 11%, "other" by 16%, and none were Jewish. Profile summary revealed young, black, single males with a 10th grade education with Protestant or no religious preference.

Findings

Loneliness score and cathectic investment score were determined and based on a scale range of 5-25.

The loneliness score for the inmates was 18 which bordered on the upper one-third of the range identifying them as high moderate to severe loneliness. The mean cathectic investment score for the inmates was 19, close to the loneliness score of 18, and in the upper one-third of the range. This validates the theory that the greater the investment in people and things the greater the loneliness upon separation from these people and things.

This present study was a replication of two studies of hospital patients which showed a loneliness score of 13. A third study of residents in a home for the aged revealed a loneliness score of 11. The inmates' score of 18 is tne highest and identifies them as the group experiencing the greatest loneliness of all separated groups studied. The assumption that the jail population is capable of cathectic investment was validated by the cathectic investment score of 19. The positive correlation between loneliness and cathectic investment is substantiated by the closeness of the two scores (loneliness score 18, cathectic investment score 19).

Conclusion

Moderate to severe loneliness is present among the inmates of the Richmond City Jail. The significance is obvious in view of the fact that suicide is the leading cause of death in jails and prisons. The psychological pain and suffer-

ing accompanying loneliness is recognized at least to some degree by even the most indifferent. Recent research by Lynch (1977) revealing evidence of a relationship between loneliness and the incidence of heart disease suggests actual physical pathology resulting from loneliness.

In summary, this "side effect" of incarceration is neither intended nor desired. Increased knowledge and recognition of its existence and its effects on both the emotional and physical health of individuals, hopefully, will result in increased efforts on the part of correction authorities to identify and implement measures to alleviate it.

REFERENCES

Brocking, Mary, and Young, Delores. "Institutionalization of the Individual." Slide-tape program. Communications Learning Center, Inc. Buffalo, New York, 1973.

Francis, Gloria. "Loneliness: Measuring the Abstract." Int. J. Nur. Studies. 13 (1976):153-160.

_____. "Long Term Residence and Loneliness: Myth or Reality." J. Gerontological Nursing, (in press).

Goffman, Erving. Asylums. Garden City, New York: Anchor Books, Doubleday and Co., Inc., 1961.

Lynch, James J. The Broken Heart. New York: Basic Books, Inc., 1977.

Schmieding, Norma Jean. "Institutionalization: A Conceptual Approach." Perspectives in Psychiatric Care, VI(5) (1968).

Sommer, Robert and Hall, Robert. "Alienation and Mental Illness." American Sociological Review, 23 (1958):418-420.

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