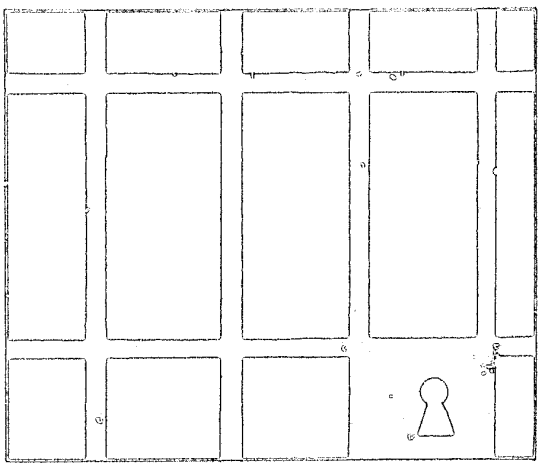
PROCEEDINGS

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



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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.

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