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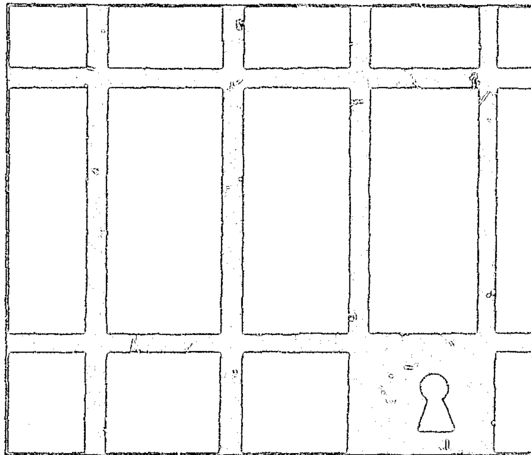
PROCEEDINGS

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



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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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[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

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[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.

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