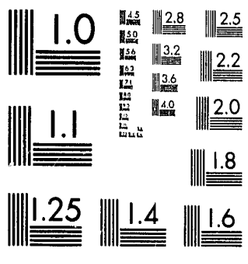

Program to Improve Medical Care and Health Services in Correctional Institutions.

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Introduction

The American Medical Association's Pilot Program to Improve Medical Care and Health Services in Jails, sponsored and staffed by the American Medical Association, is financed by a grant from the Law Enforcement Assistance Administration of the U.S. Department of Justice.

The Program is the result of a 1972 AMA survey of jail medical facilities which showed a gross inadequacy of health and medical services throughout the country. In addition, some successful lawsuits, on behalf of prisoners, focused national attention on the deplorable conditions. A federal court in 1972 ruled that inadequate medical care constituted "cruel and unusual punishment" and, as such, was in violation of inmates' constitutional rights. The U.S. Supreme Court, on review of that decision ruled in 1976 that adequate medical care is a right of inmates pursuant to the U.S. Constitution.

The mission of the American Medical Association Program to Improve Medical Care and Health Services in Correctional Institutions is threefold: first, to develop comprehensive Standards for Medical Care and Health Services in Jails; second, to establish replicable models for health care delivery in jails; and third, to implement a national accreditation program for medical care and health services in jails.

Regarding standards, the AMA *Standards for Health Services in Jails* includes minimum standards for chemically dependent inmates (see May, 1979).

The American Medical Association *Standards* for both prison and jail health services state that, "Detoxification from alcohol and other drugs (e.g., opioids, stimulants or depressants) is guided by written policy and defined procedures which require that when performed at the facility it is under medical supervision; and, when not performed in the facility, it is conducted in a hospital or community detoxification center."

For the purpose of discussion, the term chemical dependence will refer to individuals who are physiologically and/or psychologically dependent on alcohol, opium derivatives and synthetic drugs with morphine-like properties (opioids), stimulants and depressants. Alcohol will be discussed separately; it is emphasized that alcohol is a drug even though common clinical usage does not systematically recognize that this is the case.

Drug overdose and abuse are acknowledged as requiring specific care and treatment; however, this *Guide* seeks to address only the issues surrounding the identification, care and treatment of chemically dependent individuals.

Detoxification is the process by which an individual who is physiologically and/or psychologically dependent upon a drug is brought to a drug-free state. In the event that physiological dependence is present, detoxification refers to the process by which an individual is gradually withdrawn from the drug by the administration of decreasing doses, either of the same drug upon which the person is physically dependent, or one that is

cross tolerant (antagonistic) with it, or a drug which otherwise has been demonstrated to be effective on the basis of medical research and is approved for clinical use.

Diagnosis

The clinical diagnosis of alcoholism and other forms of drug dependence must be based on medically generated criteria.

Alcoholism is a chronic, progressive disease of unknown etiology characterized by repetitive and/or compulsive use of alcohol that interferes with the patient's health and/or adaptation to life. Repetitive and/or compulsive use of alcohol is often but not always accompanied by the development of tolerance, physical dependence and the withdrawal syndrome. It is recommended that medically generated diagnostic criteria, such as are described in the National Council on Alcoholism criteria or Michigan Alcoholism Screening Test, should be utilized.

Drug dependence, like alcoholism, is characterized by repetitive and/or compulsive use of drugs that interferes with the patient's health and/or adaptation to life. Drug abuse may refer to episodic use of unusually high doses or use in settings not conducive to control with the result that the patient's psychological and/or biological stability is threatened. It is recommended that medically generated diagnostic criteria such as are described in the National Institute on Drug Abuse *Detoxification Treatment Manual* should be used.

The diagnosis of chemical dependence in an inmate must be determined by a physician based upon his or her clinical judgment. The intent is to avoid diagnoses by untrained, unsupervised non-health personnel. Tentative assessment can be made by personnel trained in chemical dependence functioning under medical supervision. The results of laboratory tests do not substitute for physician judgment.

Treatment

There should be a written procedure approved by the responsible physician, outlining both the philosophy and the medical management of alcoholism and other drug dependence. This written procedure should include provisions for extended periods of observation and treatment in hospital settings.

The physician or his designate must be responsible for deciding whether an individual suspected of having a chemical dependence problem requires non-pharmacologic or pharmacologically supported detoxification. An appropriate pharmacologic and social environment support regimen is indicated when there is unquestionable evidence that substantial physiologic dependence on alcohol, opioids or depressants exists.

If an inmate is opioid dependent in a mild degree, the withdrawal syndrome may respond to situational con-

trol and minor tranquilizers. But, if opioid dependence is moderate or severe, usually opioid drugs or drugs whose effectiveness has been demonstrated will be required. The purpose is to prevent the pain, discomfort, and possible danger that can result from abrupt termination of a drug to which the patient had developed a physical dependence.

Detoxification from some drugs (e.g., amphetamines and cocaine) may sometimes require the use of drugs which are not cross-tolerant (synergistic); e.g., the use of diazepam in an amphetamine dependent individual who is ceasing use under medical supervision.

Detoxification in alcohol dependent individuals does not involve administering decreasing doses of alcohol; it does involve administering decreasing doses of drugs which are cross-tolerant (antagonistic) with alcohol, e.g., benzodiazepines.

On clinical grounds, so-called "cold-turkey" detoxification regimens are inhumane, lethal in some cases and inconsistent with the ethical practice of medicine.

The physician or his designate must be responsible for the development and implementation of a treatment plan. The treatment plan should be individualized and based on assessment of the individual patient's needs and includes a statement of the short term and long term goals that the plan will achieve and the methods by which the goals will be achieved. The plan also identifies the roles and responsibilities of treatment personnel. The clinical aspects of the treatment plan should be implemented only by qualified personnel.

The treatment plan should document a physician's decision regarding the following:

(1) Access to a range of supportive and rehabilitation services which includes counseling (individual or group counseling and/or self-help groups, such as Alcoholics Anonymous, Narcotics Anonymous or others that the responsible physician deems appropriate);

(2) Psychotropic medications; and,

(3) Referral to community resources.

The facility should provide for referral to community resources upon the inmate's release. A documented list of approved community resources should be available. The facility and existing community resources should have a contract or letter of agreement, updated on at least a biennial basis, describing their relationship.

The medical record should reflect by documentation a physician's monitoring and review of the progress of the case and the physician's responsibility for the disposition of the case.

The Special Patient

The treatment plan should be geared to the needs of special, chemically dependent patients; e.g., juveniles, patients with psychotic disorders and seizure disorders and those who are pregnant. Detoxification of pregnant opioid dependent inmates should be carried out very

cautiously, if at all. Pregnant women with physiological dependence on alcohol alone or with other drugs should be detoxified only in a medical setting.

Education

There is a need to upgrade physician training regarding diagnosis and treatment of chemical dependence. There is increasingly available to the physician, other health professionals such as alcoholism and drug abuse specialists to assist in diagnoses. These personnel should be utilized.

POTENTIAL MODEL PROGRAMS FOR THE CARE OF CHEMICALLY DEPENDENT INMATES

The health services available to inmates during confinement may be viewed as just one — albeit an essential — stage in the treatment pattern for chemical dependence. As in the free community, a continuum of care, both pre and post confinement, may be necessary.

In order that this be developed for chemically dependent inmates, the following programs and processes are offered as potential models for the integration of health services at various stages of the criminal justice system.

Pre-arrest and Arrest

The Arresting Officer

A model program should recognize the potential for the arresting officer to be an effective intervenor in health crises often associated with arrest. The early detection of actual or potential health problems and the correct referral thereof, should be within the capability of the arresting officer.

The arresting officer should have the competence to carry out an initial elementary health assessment which

includes the ability to recognize, intervene and refer for treatment inmates who are experiencing:

Intoxications

Drug Overdoses

Psychotic reactions secondary to drugs

Traumas

Withdrawal states, including convulsions

Cardiovascular states

States of severe pain.

Resources available to the arresting officers include health facilities which are linked to law enforcement and criminal justice agencies by written agreements (e.g., the Montgomery [PA] County Emergency Service).

The arresting officer should be relieved, as much as possible, of administrative, transportation and custodial responsibilities, so that he may return to his duties. Such relief should be provided by back-up personnel trained in alcoholism and other drug problems.

Diversion

A model system should provide for diversion of appropriate offenders to assessment and treatment modalities such as detoxification centers and other drug and alcohol treatment programs or hospital facilities, where appropriate.

Persons presenting a nuisance or danger to themselves or others as a result of alcohol intoxication should not be logged in jail but placed in a detoxification facility. Law enforcement officers should not arrest alcohol intoxicated persons for vagrancy, indecent exposure, disorderly conduct and the like, as a way of shunting the intoxicated persons from treatment into incarceration.

Community resources such as Alcoholics Anonymous, Narcotics Anonymous, chemical dependency treatment programs, half-way houses, hospital facilities and community mental health centers, should be utilized to the fullest degree possible.

Diversion programs modeled after Treatment Alternatives to Street Crime and Delaware Bureau of Subject Abuse may be adapted to local conditions.

The diversion programs should have multiple points in the criminal justice system where offenders are diverted (e.g., pre-arrest, pre-trial, pre-sentence, post sentence).

Any diversion program should establish linkages between community based treatment programs and criminal justice agencies. These linkages should be reduced to writing and re-evaluated biennially.

Incarceration

Screening

A model program should recognize the potential for early detection and primary prevention of health problems. Training modules should focus on this and be delivered periodically to correctional personnel.

A model program should employ an admission screening procedure, such as that outlined in the *Practical Guide* developed by the American Medical Association Program to Improve Medical Care and Health Services in Correctional Institutions. Where appropriate, additional screening may be carried out with special investigation into:

A. The use of alcohol and/or drugs, which includes types of substances abused, mode of use, amounts used, frequency of use, and date or time of last use.

B. Current or previous treatment of alcohol or drug abuse and, if so, when and where.

C. Whether the inmate is taking medication for an alcohol or drug abuse problem such as disulfiram, methadone hydrochloride or substances under clinical investigation: naltrexone, LAAM (levo-alpha-acetylmethadol).

D. Whether the inmate is taking medication for a psychiatric disorder and if so, what drugs, and for what disorder.

E. Current or past illnesses and health problems related to the substance abuse such as hepatitis, seizures, traumatic injuries, infections, liver diseases, etc.

F. Whether the current charges or any past criminal record have been related to problems with alcohol or drug abuse.

The screening procedure should have a component for referral to treatment modalities.

Treatment

A model program should make available a detoxification and/or maintenance treatment component to appropriate offenders as determined by physician judgment. This treatment component may be implemented by hospital affiliations, by affiliation with community based chemical dependence treatment programs or may be carried out in-house.

A model in-house program should have an active continuing relationship with Alcoholics Anonymous. Other appropriate self-help groups such as Narcotics Anonymous may be used.

The design of work release programs should take into account the need for on-going treatment and evaluation of the chemically dependent inmate with particular attention to preparing them for re-entry into the general population.

The utilization of community resources with respect to job placement, counseling and treatment for chemical dependency problems should be an integral component of work release programming.

Training

A strong emphasis should be placed on training medical personnel, non-medical personnel and inmates in chemical dependence.

Such training should focus on the nature of chemical dependence and its medical, psychological and cultural

aspects, including attitudes toward personal use, detection and their implications for health. The National Institute on Drug Abuse has developed manuals appropriate for these purposes.

Pre-Release

An explicit plan of action for each inmate should be developed in the pre-release period. The inmate should be an active partner in the planning process. Such parts of the plan as require specific action on the part of the inmate (e.g., attending a self-help group on the outside) should be in effect prior to release.

Post Release

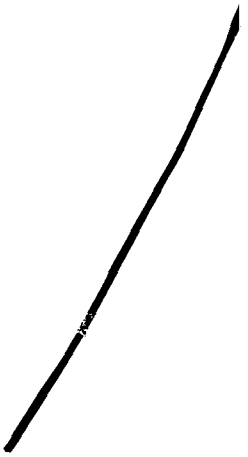
Provisions should be made for regular follow-up with resources in the community to which the inmate has been referred for continuing treatment.

Post release contact should be provided on a regular basis. These contacts should be based on two perspectives:

(1) the adequacy of the treatment plan for a given individual; and

(2) the effectiveness of the program as a whole.

A model program should evaluate its success in achieving its stated objectives and have a plan for so doing.



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