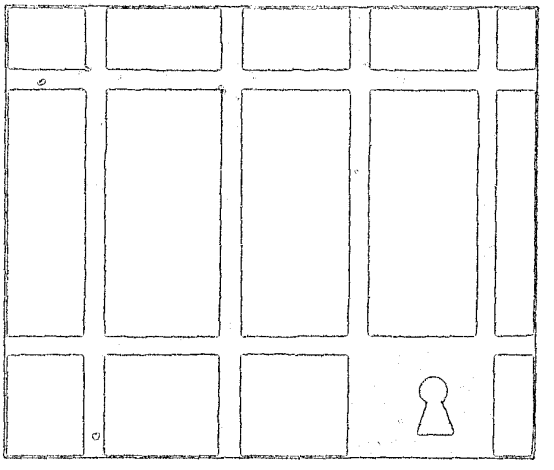
PROCEEDINGS

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



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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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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.

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