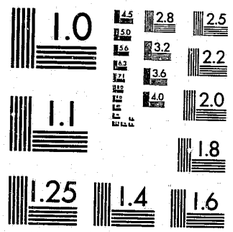
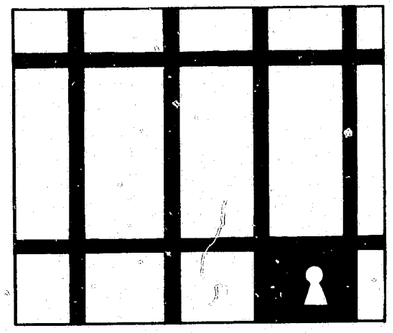


PROCEEDINGS

3rd National Conference on Medical Care and Health Services in Correctional Institutions



Chicago, Illinois
November 9-10, 1979

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PREFACE

The American Medical Association's (AMA) Third National Conference on Medical Care and Health Services in Correctional Institutions was an outstanding success. A total of 550 individuals participated in that conference, which was almost fifty percent more than the number who attended in the previous year. The participants represented a variety of occupational groups including physicians, nurses and other allied health personnel, pharmacists, dentists, mental health workers, sheriffs, jailers, correctional administrators, attorneys, and educators. This multi-disciplinary approach to solving a common problem - improving health care in correctional institutions - is what makes the AMA Conference so unique.

As in previous years, the participants were asked to complete "Evaluation Forms" for the sessions and workshops they attended. The summary statistics indicated that in general, the conference program was very well received. On an overall basis, 91% of the respondents rated the conference at least "good" in terms of providing relevant information about health care in correctional institutions and 75% rated it at least "good" in terms of providing practical solutions and suggestions as well.

The AMA wishes to thank the American Correctional Health Services Association for its cooperative efforts and the many speakers who made stimulating and informative presentations. The real success of the conference, however, was due to the enthusiasm of the participants. We hope you will join us again for the Fourth National Conference to be held at the Radisson Hotel in Chicago on October 24 and 25, 1980. With your participation, we can make the next conference the best one ever.

Sincerely,

B. Jaye Anno

B. Jaye Anno, Director
AMA Correctional Programs

THIRD NATIONAL CONFERENCE ON MEDICAL CARE
AND HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS

INTRODUCTION

These Conference Proceedings were prepared as a service to the registrants and other individuals and organizations concerned with health care delivery in detention and correctional facilities. In order to facilitate publication, it was possible to use only those papers received prior to a deadline.

The ideas and opinions advanced by the speakers are not necessarily those of the American Medical Association nor the United States 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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STANDARDS IMPLEMENTATION IS COST EFFECTIVE.*

Good morning. I'm pleased to be with you. Even though I have been in Congress for twenty years and adopted the title of "Lawmaker," I feel very much at home in this setting. Prior to being elected to Congress in 1960, I was the state's attorney for Winnebago County, Illinois, some 60 miles west of here.

In that capacity, I experienced first-hand the same cycle of frustration and satisfaction, failure and success, disappointment and exhilaration that is part and parcel of the criminal justice system. Therefore, I am truly among friends and fellow "law enforcers" here this morning.

Since I left the criminal justice field and came to Congress, the attitudes of the American public toward law and law enforcement have changed repeatedly. Now, in the dawning stages of the 1980 Presidential Campaign, the public's attention is dominated by unemployment, rising prices, scarce fuel supplies, long gas lines, and steeper taxes. Little more than a decade ago, however, campaign oratory literally resonated with appeals for law and order, safe streets, and swift and exacting punishment of wrong doers.

To be in the front lines of the war on crime was to be at the center of national attention and esteem.

Even though other battles are now being waged, even though there are public enemies other than those pictured on mug sheets at the post office, the law enforcement community remains a bulwark of our society.

In the public's eye, three law enforcement professions--police, prosecutor, and jailer--embody the central elements of our criminal justice system: apprehension, prosecution and punishment. And to the public, the system is as simple as that.

I need not remind you that justice in American is incredibly more complex. Apprehension is no easy task; prosecution never cut and dried; and punishment entails more than simple incarceration. You, who must deal firsthand with those convicted of crime, know that, while the convict is paying his duty to society, society has a duty to the convict.

The impulse to lock 'em up and throw away the key is more than a glib response. It is a derogation of our constitution, which prohibits cruel and unusual treatment in the punishment of crimes. Society must recognize, as you have, that by imprisoning someone we have assumed responsibility for their care, and while it may at times be unpopular, that responsibility must be carried out.

A key component of our duty to the imprisoned is the provision of health care.

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* Presented by: Honorable John B. Anderson, Republican-Illinois, United States Congressman, 16th District, Illinois.

While barriers of stone and chain link may separate the prisoner from the general populace, there is no divide between the concern each group has as individuals for their own health and well-being.

Oscar Wilde wrote in The Ballad of Reading Gaol:

> "I know not whether laws be right,
> or whether laws be wrong;
> all that we know who lie in gaol
> is that the wall is strong;
> and that each day is like a year,
> a year whose days are long."

The inmate develops a need for medical care, in those long days, often that need is for other than medical reasons; but just as often, those needs are real. Any correctional institution which overlooks or denies those needs runs a serious risk of violating the guarantees of the eighth amendment to the constitution.

For many prisoners, the mere fact of incarceration creates the immediate need for medical care. For the prisoner undergoing treatment prior to imprisonment, that process is shortcircuited by incarceration. Immediate access to a physician to continue treatment of previous disorders or for the evaluation of new injuries or problems is often not possible. In addition, confinement itself creates health hazards the prisoner may not have faced on the outside.

These institutional characteristics are not the only problems complicating the provision of health care. The correctional population as a group is medically more vulnerable than the general populace.

In 1972, one survey of local jails indicated that most prisoners reached no more than the 12th grade. Almost 80,000 local prisoners had pre-arrest incomes of less than $3,000; in all 86% earned less than $7,500 annually prior to their arrest.

In society at large, the incidence of medical problems is greater among those of fewer means than among those of greater means. Therefore, when the prisoner population is drawn largely from the poor or near poor, it is logical that group will have more health problems than non-prisoner groups. Drug addiction, tuberculosis, alcoholism, hypertension, diabetes, and mental health problems, while society-wide ailments, are more prevalent in the inmate population.

Proportionally, therefore, prisoners make greater demands on their health care system. Additionally, bogus requests for health care are liable to be high as inmates try to avoid the normal correctional demands made by their keepers.

The institutional and medical components of high demand for health services in correctional centers are not the only burdensome factors. The effect of soaring health costs is further complicated in the prison setting

where medical services are paid by municipal, county, state and federal budgets.

Where inflation has driven up the costs of government and revenues are stretched thin, budgets at all levels of government are under assault. When push comes to shove, correctional budgets are given low priority by those who plan the expenditure of public monies.

Yet, we no longer can be indifferent to prisoner health needs. If they choose to cut costs in health delivery, they very well may be confronted with significant legal costs as they defend themselves against suits protesting malpractice and the unconstitutional denial of adequate care.

Earlier this year, one state correctional system made a half-million dollar settlement to an inmate who suffered paralysis after months of neglect. Certainly, that case was neither the first nor the last of its kind, and you know that your system could be forced to defend itself against this kind of action--if it has not had to do so already.

The federal court system's examination of prison health programs developed slowly. But, just as inexorably as a glacier moving forward, judicial case law in this area has begun to reshape the correctional topography.

Justification for federal involvement is found in the Eighth Amendment, which reads:

> "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

Initially, the courts interpreted this amendment as prohibiting deliberate and harmful actions against an inmate.

It became apparent, however, that the barbarous conduct standard was an inadequate measure against which to judge the denial of health care to inmates. As the case load grew and complaints persisted, the courts endeavored to develop an appropriate legal criterion for assessing deprivation of treatment.

Even with this realization, progress toward an operative and complete standard has been uneven. Even the Supreme Court's decision in Estelle v. Gamble falls short of being a judicial watershed.

(In that case, the Court identified a governmental "obligation to provide medical care to those it incarcerates" reasoning that, at the very least, "Denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose and is inconsistent with contemporary standards of decency.")

The Court reiterated the "Deliberate Indifference" Standard which arose in the courts of appeals but supplied little definition to that standard.

Various reasons exist for this failure to be more precise in detailing how to adjudicate "deliberate indifference" in a penal environment. One primary reason is the reluctance of the court to make judgments on the day-to-day operations of an institution and to make medical judgments. The court chose to remain within the Constitutional bounds of the Eighth Amendment rather than cross into the realm of civil law malpractice.

Certain court decisions have prescribed remedial actions for state prisons. For instance, Judge Frank Johnson, ruling in 1976 that the treatment of inmates in Alabama's prisons violated the Eighth Amendment, mandated various improvements in the system. This mandate included the improvement of physical security for each prisoner, adequate living space, a meaningful job, and the improvement of medical care for each inmate.

Still, correctional officials, while living under the shadow of unfavorable court rulings at the state or federal level, have been given little guidance and fewer resources in order to improve health care for those under their supervision.

Where then can they--and you--turn? How can you use scarce financial and personnel resources to maximize health care delivery while minimizing judicial interference with correctional administration?

Very often, the impulse is to look to the federal government for aid. Admittedly, the federal prison system's health delivery programs are considered to be superior to those of state and local institutions. (The Bureau of Prisons enjoys a significant advantage over its counterparts elsewhere. With roughly 24,000 prisoners, it houses less than 10% of the national inmate population; it has a unified system of management; and as a result, it enjoys significant economies of scale.) Even with these advantages, however, the system is not problem free.

You are here because you believe that other opportunities exist for managing health systems and in this respect, the AMA's Standards for Health Services in Jails serve an inestimable purpose.

First, the program and others like it--such as recommendations of the American Public Health Association -- attempt to bring medical and correctional professionals together in common purpose. Second, it offers guidance and suggestions rather than mandates. Third, through realistic standards and encouragement, it promises discernible progress without considerable cost.

As you will learn, the Standards identify subject areas which deserve attention: Administrative matters, personnel considerations, care and treatment, pharmaceuticals, health records, and legal issues. Identifying these areas, they suggest methods of solving problems that arise within the penal environment.

As some of you know, my political career has been spent as a Republican. Therefore, I believe in certain, fundamental approaches to problem-solving. One approach is to establish private-sector-oriented attainable and workable goals and make systematic progress toward those objectives. It is desirable, in my view, to avoid over-reliance on the federal government as a means of achieving those ends.

In the next two days, you will be discussing reasonable expectations for improving health care in your institutions and how to effectively and reasonably fulfill those expectations. Essentially, those goals must include:

-- prompt medical screening upon entering prison;

-- provisions for medical evaluation on a routine basis;

-- increased use of paraprofessionals to handle basic chores but not to prevent inmates from seeing doctors;

-- cooperation and communication between the medical and correctional staffs; and

-- supplying the patient with the necessary information about his condition or diagnosis.

As for how to meet these goals, I believe quite strongly that you must look to yourselves. The AMA Standards offer the methods which can be utilized; but you, in your institutions, must supply the means.

Looking to the federal government for assistance or waiting for the courts to force you to act will only result in orders that must be followed. I would hope, and I am sure you would prefer, that health care be achieved without coercion and without bureaucratic interference from on high.

The best alternative, therefore, remains the correctional community itself. As long as you and your colleagues are willing to communicate and cooperate, as long as you know what needs to be done and what works, you can do that job.

When I accepted Joe Rowans' invitation to speak, I was asked to emphasize that the implementation of model health care standards can be cost-effective. I want to close, therefore, by highlighting some of those savings that can be made and costs that can be avoided by adopting the approach which you will learn more about today and tomorrow.

First, I understand your preoccupation with dollars and cents in programs that already are less than lavishly funded. Here, the Standards offer the hope of getting better use out of limited dollars because all expenditures will be directed toward visible, workable, and agreed-upon means.

In the 56 institutions that have been accredited by the AMA, costs have risen slightly in roughly one-third, stayed the same in another third, and even fell somewhat in the remaining third. In addition, one source has suggested that, where regular medical care is available, inmate visits actually drop as prisoners are assured that their real needs will be met. Therefore, if prisoners make fewer unjustified demands on the system, that system should operate more cost-effectively.

I believe also that there are more than purely monetary costs. For instance, correctional officials should be concerned about their medical personnel. By utilizing paraprofessionals and physicians on a rotating basis, if possible, those individuals will avoid the burnout which inevitably comes if they remain too long in the institution. Emotionally and physically drained medical personnel do not and cannot always offer optimal services, and if procedures can be regularized within the context of the correctional schedule, authorities can avoid the costly exhaustion of health providers.

Within the correctional environment itself, the costs of poor health care are manifested in crowded sick calls, patient mistrust of health care personnel, and festering hatred for the institution. While better health care may not turn prisoners into pussycats, it can improve attitudes within the prison population, and thereby, reduce inmate tensions which spill over violently and which eventually cost the system time and money.

Finally, there is a moral cost. As someone who has made a Christian commitment in his life and who has striven to elevate politics to a high moral plane, I believe it necessary to raise this issue.

As you may recall, St. Matthew recorded Christ's description of the final judgment in his gospel. Christ told his disciples that:

> "When the Son of Man comes as King and all the angels with Him, He will sit on His royal throne, and the people of all the nations will be gathered before Him. Then He will divide them into two groups, just as a shephard separates the sheep from the goats. He will put the righteous people at His right and the other at His left."

Christ foretold that the people on the King's right would be called blessed, and when those on the right asked:

> "When Lord did we ever see you hungry and feed you or thirsty and give you a drink? When did we ever see You a stranger and welcome you into our homes, or naked and clothe you? When did we ever see You sick or in prison and visit You?"

The King will reply, "I tell you whenever you did this for one of the least important of these brothers of Mine, you did it for Me."

There can be no finer valedictory than that. When we appreciate that in addition to budgetary, personnel and institutional costs, there are moral costs in not providing health care then we can be resolute in devising methods of delivering care and bearing those costs.

HEALTH CARE IN CORRECTIONAL INSTITUTIONS: WHO AND WHERE ARE THE PROBLEM-SOLVERS?*

I'm going to begin my formal remarks here today with this statement: The American Medical Association hereby recommends the establishment of a Presidential Commission to address the serious deficiencies in current health and medical services in this country's correctional institutions.

We believe the establishment of such a commission is absolutely imperative for the following reasons:

- There is strong evidence to suggest that a majority of correctional institutions in the United States are so lacking in appropriate resources that they actually may contribute to the health problems of inmates rather than promote or even maintain inmate health.

- While the fault for such deficiencies may belong to society at large, a substantial portion must be shared by national, state and local governments, the courts, correctional institutions per se, and health professionals and their organizations.

- Although these very same institutions including yours and mine have made some progress during the past few years in recognizing, and attempting to meet, the real need for adequate health and medical services for correctional populations, there has been no strong central focus, no national strategy to make this progress meaningful for the vast majority of correctional inmates.

- Finally, of course, there are compelling ethical, legal and economic reasons to remedy these deficiencies.

I should add, that the progress made by our respective organizations in identifying major problem areas, in developing appropriate models for the delivery of care, and in establishing minimum standards for the quality and availability of inmate care could be of invaluable use to a Presidential commission in a national campaign to upgrade health and medical services in correctional institutions.

Hence, it is all the more important that we continue our efforts in these areas, which I shall discuss in detail a bit later on. Before I do that, however, I'm going to briefly review some of the evidence pointing up the sorry, even inhumane, state of health and medical services in our correctional system.

Since prisons are much larger than jails, with about 590 federal and state facilities holding about 250,000 of an estimated total of 500,000 correctional inmates, prisons are expected to have more comprehensive health and medical services. And to some extent, they do. But the extent is too small. Just last year, a U.S. General Account Office

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* Presented by: H. Thomas Ballantine, Jr., M.D., Secretary, Board of Trustees, American Medical Association, Chicago, Illinois.

(GAO) report[1] observed that:

> "The health care delivery systems of most prisons and jails are inadequate, and although some improvements have been made or attempted in the last few years, progress has been slow." "Widespread deficiencies exist in providing adequate levels of care, physical examinations, medical records, staffing, facilities, and equipment."

Among other things, the GAO report revealed that in many instances, medical records were inadequate, unsigned, undated or simply non-existent; that frequency of sick calls varied widely, from once a day to once a week, and in some cases were administered by unlicensed personnel. Also in visits to two states' prisons, major surgery was being performed within the walls although the GAO was told the prisoners' hospital did not meet state licensing standards and requirements.

A 1975 study of Michigan prisons by that state's health and correctional officials[2] revealed that in a sample of 458 inmates, a 5 percent of the men and 29 percent of the women had urgent medical needs and that 1.8 health problems per inmate were found in addition to dental problems - in fact, all of the women examined and 96 percent of the men examined did need dental services other than teeth cleaning.

Meanwhile, other studies of prisons, as well as jails, demonstrates that unsanitary, outmoded facilities can actually create the health problems of inmates. Thus a 1972 report on a study of Pennsylvania's prisons[3] disclosed that rat droppings were found in kitchens, cockroaches in dining rooms, and that infestations by lice and other vermin were common.

The GAO study I cited earlier found that some prison infirmaries were 50 to 100 years old and could not meet present standards; that some infirmaries did not have isolation wards for patients with communicable diseases and some infirmary wards did not have toilets or washbasins. Furthermore, it's no secret that the same kinds of health and medical deficiencies can be found in most of our nation's 3,900 local jails, where up to 142,000 or more inmates are housed on any given day.

Surveys by the AMA and the Law Enforcement Assistance Administration (LEAA), as well as other institutions, have uncovered such deficiencies. For example, AMA surveys in 1972 and 1977 indicated that:

- In more than one-half of the nation's jails, medical resources are limited to rudimentary, first-aid measures.
- The vast majority of jails do not conduct admission physical examinations to detect communicable diseases or possibly life-threatening health problems.
- Many, if not most jails, fail to keep in-house medical records of the health problems of inmates, and where such records are kept, in many instances, patient confidentiality measures are lacking.

The 1972 LEAA study of the nation's jails indicated that in-house medical services were available in just one of every eight facilities and only about 19 percent of the jails had a physician on the staff - just part-time at that in about two-thirds of these jails.

I could go on and cite many other examples to demonstrate the substandard conditions of health and medical services in this country's correctional institutions, conditions which themselves often border on the criminal. But this audience is familiar with these examples. If those examples I have cited sound like old history, I have reviewed them once more precisely because old history must not become forgotten history.

Yes, various institutions in our society, including yours and mine, have made heartening progress during the past few years in recognizing the crucial need for improved health and medical services in correctional institutions. Yes, we have identified major problems areas and constructed appropriate models to enhance the delivery of care. And yes, we have developed minimum standards to assure the quality and availability of that care. But let's not forget that our efforts to date affect only about 10 percent of the nation's prisons and jails. Thus about 90 percent of these facilities-and 350,000 or so inmates- remain largely unaffected by the progress that has been made. Furthermore, if we are to reach these people and if we are to significantly improve health care in all correctional institutions, I believe we have to do a much better job of finding out "who and where are the problem-solvers?"

Since its establishment in 1975, the AMA's own jail health program has not only been instrumental in the development of jail health standards and delivery models but it also has helped underscore the need for problem-solving at the national and local levels.

The widespread health care deficiencies uncovered on a national scale, at all levels of the correctional environment, obviously demand the involvement of people who can develop and eventually help implement a national strategy to remedy these deficiencies. Hence the AMA is convinced that the establishment of a Presidential Commission to do just that is absolutely essential at this point in time.

I should emphasize that the members of such a commission would be people capable of fashioning a national strategy to squarely confront, and resolve, the problems that exist. To cite some examples, a member of the U.S. Congress might serve as chairperson, with other members representing public organizations such as the LEAA, the Justice Department, the GAO, the Mayors' and Governors' Conferences and similar organizations as well as a member of the White House staff. The private sector members might represent our own respective associations: the John Howard Association, the American Bar Association, the American Nurses Association, the American Dental Association, the American Civil Liberties Union, and so on. Such a comprehensive membership roster would definitively answer the question of who and where are the problem-solvers at the national level.

To be more specific about problem-solving, the commission in developing a national strategy might focus on:

- An in-depth reappraisal of the problems that exist, with emphasis on the collection of hard data on the extent of inmate health problems such as emotional illness, mental retardation, alcohol and drug abuse and suicide.

- The establishment of a set of acceptable performance standards for correctional health and medical services, hopefully including some of the standards developed by those of us involved in the AMA's jail health program.

- The determination of possible legislative remedies.

- The submission of a final report and recommendations to the President.

Obviously, we cannot expect the federal government, and its agencies, to remedy most - or even many - of the problems that exist in state and local correctional facilities. These are primarily state and local responsibilities, after all. But it should be equally obvious that the same kinds of problem-solving people and organizations exist at the state and local levels, if only we get them involved. To cite just a few examples: there are state and local governments; health departments; medical societies; bar associations; dental associations; nurses' organizations and similar groups - not to mention a variety of civic clubs and organizations.

If those of us involved in correctional health and medical reform effectively present our case to these problem-solvers; and if we demonstrate that we do have practical models for the delivery of care to inmates and practical standards to measure performance; and if our own interest and involvement is reinforced at the highest federal levels; then we should be able to get a substantial number of state and local problem-solvers involved too. I'm not saying it will be easy. Too many Americans still tend to believe that correctional inmates deserve whatever they get. Such attitudes, together with the fact that inmates have no votes, tend to make correctional health issues politically unattractive. It follows, then, that we must be particularly forceful in reminding other institutions in our society that there are compelling reasons to upgrade correctional health services - both philosophical and practical reasons.

At the philosophical level, ethical considerations - moral principles - our common humanity, if you will, should compel our society to act. At a time when "me first" has become the operative philosophy of far too many Americans, they will find the simple extension of a helping hand to those less fortunate than themselves a reaffirmation of their own morality. Just about everyone agrees today that no one should be barred from access to health services. But thousands of correctional inmates are, in fact, barred from such care. And unlike the vast majority of Americans, they are largely helpless to secure it. In most instances, their voices are not heard. Yet our society would do well to listen. Because what we will hear is our own humanity.

There are also strong legal reasons to improve correctional health care. In point of fact, and as this audience knows full well, during the past five or six years emerging case law at various levels has held that at least adequate amounts of health care should be available to correctional inmates.

Finally, there are important economic reasons as well. Undetected and untreated health problems of correctional inmates almost invariably will worsen and eventually require the application of even more concentrated, and expensive, care inside or outside the correctional facility. In some cases, chronic health problems will be created which will require long-term therapeutic care. Any failure to prevent the circulation of communicable diseases poses obvious health hazards not only to the correctional community but to the larger community as well, with equally obvious financial implications. Of course, the failure to provide adequate care for inmates can result in additional costs to society by reducing the chances for successful rehabilitation. Parenthetically, the resulting resentment not only tends to reinforce the anti-social behavior of individual inmates involved but can be -- and has been -- an important contributing factor in inmate riots with the attendant threats to the health and lives of correctional staff - not to mention correctional security.

For all the reasons I have cited and because of the deficiencies that we know exist, it is crucial that we ourselves play even stronger roles in designing standards and delivery mechanism for the provision of health and medical services in correctional facilities. Because, while the development of a national strategy to supplement and help coordinate our own efforts is imperative, it also is imperative that we remember this:

> In the last analysis, you and I and thousands of people like us are the ultimate problem-solvers and where we are is in hundreds of communities across the nation. That's where the jails and prisons are. That's where the inmates are. And that's where the people who can help are.

Literature Cited

1 Report to the Congress by the Comptroller General of the United States, Dec. 22, 1978, Washington, D.C., GGD-78-96.

2 Office of Health and Medical Affairs, Key to Health for a Padlocked Society, Lansing, Mich., Michigan Department of Corrections, Jan., 1975.

3 Health Law Project, Health Care and Conditions in Pennsylvania's Prisons, Philadelphia, University of Pennsylvania Law School, 1972.

COURT JUDGEMENTS - THE ROLE OF THE ADMINISTRATOR AND STANDARDS IN ASSURING QUALITY CARE FROM INDEPENDENT PROVIDERS *

The Sheriff of Cook County has multi-faceted responsibilities.

I am the chief law enforcement officer for the county, and that responsibility is covered primarily by the Cook County Sheriff's Police Department.

I have the responsibility of maintaining the security and decorum of the courts throughout the county and for the serving of legal papers. Those are covered by the Sheriff's Court Services Department.

I am also responsible for the cleaning and maintenance of the various courthouses throughout the county, and that is done by my Custodial Department.

But one of my most important responsibilities is that of being the jailer of the county. Illinois law states that the sheriff of each county is the warden of the county jail and has custody of all the inmates in the jail.

" I know not whether laws be right,
Or whether laws be wrong;
All that we know who lie in jail,
Is that the wall is strong;
And that each day is like a year,
A year whose days are long."

Unfortunately, that poem is as true today, in 1979, as it was when Oscar Wilde wrote it some 80 years ago. But it is through the work of organizations such as the American Medical Association, the National Sheriffs' Association, the American Bar Association and the American Corrections Association that efforts are being made to improve the conditions and standards in our jails.

In counties having more than one million inhabitants, Illinois law establishes a Department of Corrections within the Office of the Sheriff, which is to include jurisdiction over the county jail, municipal houses of correction "and any other penal corrections or prisoner diagnostic center facility operated by either the county jail or the municipal houses of correction."

The Cook County Department of Corrections has an average daily inmate population of more than 4,500 and a yearly budget of $31 million.

The law also empowers the department to establish diagnostic, classification and rehabilitation services and programs, and, whenever feasible, to establish separate detention and commitment facilities.

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* Presented by: Richard J. Elrod, Sheriff of Cook County, Chicago, Illinois.

When I became Sheriff in 1970, Cermak Memorial Hospital, which is located in the Department of Corrections complex, was the only general hospital in the nation in a county jail setting. During my first term, Cermak was transferred, by state law, to the control of the Cook County Health and Hospitals Governing Commission, which also controlled Cook County Hospital and Oak Forest Hospital. The commission decided to close Cermak Hospital.

Cook County Hospital did not have a separate area where proper security could be provided without providing a corrections officer for each inmate/patient. I was also very concerned about proper medical care and emergency treatment in the jail proper. After discussing the problem with Dr. James Haughton, the director of Cook County Hospital, we decided to file a lawsuit, Elrod vs. Health and Hospitals Governing Commission (78 CH 1970), in which the Cook County Board of Corrections joined as plaintiffs. On March 1, 1979, a consent decree was entered in the case, and the court so ordered.

All parties agreed 1) that Cermak Hospital would no longer be operated as a general. 80-bed hospital; 2) a 40-bed security ward would be established at Cook County Hospital for inmates requiring hospitalization but not requiring treatment in some special care unit; 3) a 10-bed facility for inmates not requiring acute hospitalization would be maintained at Cermak or in the Department of Corrections complex, with the capability of expansion to 20 beds; and 4) that the following special ambulatory services or clinics be maintained at either Cermak or within the Department of Corrections complex: Emergency, X-ray, Laboratory, Pharmacy, Medical Records, Epidemiology, Physical Therapy, Eye, Dental, Orthopedics, Skin, Obstetrics-Gynecology, Urology, Neurology, Ear, Nose and Throat and Plastics.

The consent decree also stipulated minimum medical staffing. At least one attending physician would be on call in the emergency room at all times. At least two attending physicians would supervise qualified medical and nursing personnel on a five-day-a-week basis of daily sick call. At least one attending physician would supervise qualified medical and nursing personnel doing intake examinations. Physicians, qualified medical and nursing personnel, and supporting medical staff were to be present at all times to service the emergency room, the tiers, sick call, intake examinations, ambulatory services and clinics, and the beds occupied at Cermak.

I was also very concerned with maintaining conditions and meeting new medical standards and, therefore, I insisted that the following be included in the decree: "Should the American Medical Association, or other official accrediting agency for medical facilities in jail complexes such as Cook County Jail, adopt at any time standards for medical care to the inmates of such a jail which require more or different facilities or personnel than described ... above, the commission shall take steps forthwith to attempt to comply with such standards." As you know, the AMA's program to improve medical care and health services in correctional institutions published standards for health services in jails last July.

Recently the number of inmates on the security ward at Cook County Hospital has been averaging around 16 to 17 a day. Yesterday there were 12 on the ward -- nine surgical and three medical. Yesterday there were four inmate/patients on other wards at Cook County. Those inmates, of course required one-to-one security coverage. There were also two other inmate/patients arrested by local police agencies at other area hospitals in conditions too serious to allow transfer to Cook County. An apellate court decision requires that the Department of Corrections maintain security for them. Yesterday in Cermak Hospital there were 15 convalescing inmate/patients: 12 male and three female.

In addition to the facilities available at Cermak Hospital, there are other dispensaries located around the Department of Corrections complex. There is one in the Women's Detention Center which houses about 300 inmates, one in the new Men's Dormitory which houses about 1,000 inmates and one in the old County Jail that will be renovated as part of that Division's overall renovation program and which will then house about 650. There are also examination facilities for intake in the Reception, Classification and Diagnostic Center.

Another aspect of medical care which has concerned many lawyers, including myself, who are interested in corrections is the area of mental health. I suggested to some of these lawyers that one approach to solving some of the problems might be the filing of a class action suit against the State Department of Mental Health and Developmental Disabilities, our Department of Corrections and the Health and Hospitals Governing Commission to acquire additional funding for county jails for the purpose of upgrading psychiatric diagnosis and care in the jail setting.

What resulted was Harrington et al. vs. DeVito et al. (74 C 3290), in the U.S. District Court.

The decision required the Department of Mental Health and the Health and Hospitals Governing Commission to supply adequate medical and paramedical personnel comprised of three full-time psychiatrists; five psychologists; eight medical/psychiatric social workers; four activities therapists; and ten psychiatric mental health technicians. This team is to provide screening, diagnosis and treatment for inmates of the Cook County Department of Corrections.

The commission also is to provide a psychiatric diagnostic and treatment unit at Cermak Hospital as well as a sufficient number of registered nurses and nurses' aides on duty for the unit to comply with the Joint Commission on Accreditation of Hospitals Standards.

The Department of Corrections is required to provide office space and furniture for the mental health team as well as space and equipment for screening. The department also is providing a residential treatment unit (RTU) for 250 inmate patients not requiring hospitalization.

The Department of Corrections is required to staff the RTU with specially trained corrections officers. The training, already in progress, is being conducted under a contract with the University of Chicago's Social Psychiatry Study Center of the Department of Psychiatry. A total of 200 officers will eventually receive ten weeks specialized mental

health training, including two weeks in the field. The department is required to maintain a ten to one ratio, corrections officers to patients, in the RTU on each shift.

Generally, I feel that real progress is being made toward better health care in the Cook County Department of Corrections. And I firmly believe that progress can only be made when there is honest team effort among the various disciplines, professional groups and governmental agencies involved.

As one possible way of measuring progress in several areas involved in services to inmates, I urged the Illinois Law Enforcement Commission and the Chicago-Cook County Criminal Justice Commission to commission an independent management consultant firm to study inmate attitudes toward things like food, court treatment, interpersonal relations and medical care. The study was conducted during three consecutive years -- 1977, '78 and '79. It is the only study of its kind ever made in a correctional facility. Inmate perception of the medical care received in the Cook County Department of Corrections indicates continued improvement.

The law is meant to help all people. We who are administrators do not have to sit back and allow suits to be filed against us to force us into performing actions which in the long run may be cost ineffective, deleterious to proper management and compromising security in a correctional institution. However, we can take advantage of the courts and the judicial process by initiating litigation that may have the result of mandating to a recalcitrant county board or other fiscal appropriating bodies or of determining the parameters of legal responsibility amongst different public agencies.

I strongly urge each of you as administrators to cooperate with one another to accomplish your goals and, when necessary, seek judicial interpretation in an effort to resolve conflict.

In closing, I would like to emphasize the statement contained in the preface of the July 1979 AMA Standards of Health Services in Jails.

"Accreditation means professional and public recognition of good performance; accreditation through standards implementation, based upon the success of other fields, is the foundation for professionalization and the public's recognition of criminal justice medicine. As demonstrated in the AMA Jail Program, implementation of the standards can result in (1) increased efficiency of health care delivery, (2) greater cost effectiveness and (3) better overall health protection for inmates, staff and the community."

That is what we as jail administrators, health care providers, the incarcerated and society as a whole should continually strive for and, with our continued mutual cooperation, will ultimately achieve.

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HEALTH CARE ISSUES AND ILLUSIONS*

One of the things that continues to amaze me about operating a jail health program is how easy it is to deceive myself about what actually happens in the day to day operation of my program.

Several days ago, it occurred to me that I hadn't seen many inmates referred to the clinic from the intake screening area. So, I went over to the screening area. Guess what--no screeners. It turned out that a new administrator had been hired who decided that the intake screeners would be more productive helping the nurses, so she transferred all of them to the in-patient service. As a result, the jail had had no intake screening program for the previous three weeks.

This is an example of a very common illusion that everyone shares--the Illusion of Perminance--the illusion that nothing changes when in fact everything constantly changes. Everyone is familiar with Murphy's Law. Murphy's Law says that anything that can go wrong, does. In a jail health program, anything that can go wrong does, constantly.

The illusion is that nothing changes. The reality is that everything always changes. The corollary is that unless we are willing to allow things to go awry, we must develop the habit of seeing what is really happening as contrasted with what we wish were happening.

The problem is not limited to my program. Let me give you another example, the use of Medical Technical Assistants (MTAs). Many state prison health programs are built around the use of MTAs. Although no one admits it, the MTAs in these systems frequently manage more visits than the prison doctors and nurses combined. When I visit a prison health program for the first time, I always ask the warden and the doctor in charge how well the MTAs are trained and how well they perform. Invariably, I'm told that both are superb.

Not long ago, I interviewed an MTA whose pre-employment training was limited to a 160 contact hour Emergency Medical Technician (EMT) course. I asked him if he could predict when an inmate might commit suicide. He told me no, because the last inmate who had committed suicide at that institution had told the MTA that he was going to kill himself three times before he finally did!

In the second system, in another state, the MTA who conducted evening sick call and manned the emergency room alone at a 600-man prison had recently retired from the Air Force. He had worked as a hospital administrator for the last 15 years of his Air Force career. His last cardiopulmonary resuscitation (CPR) training was in 1956. There was no emergency resuscitation equipment in the emergency room.

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* Presented by: Glen E. Hastings, M.D., Associate Professor, School of Medicine, University of Miami, Miami, Florida.

That was perhaps fortunate since none of the MTA staff knew how to use emergency resuscitation equipment.

The pre-employment training of both of these men was considered satisfactory. Neither had received any type of pre-service training, neither had been given any type of in-service training. No one had ever evaluated their performance either before or after they were employed. Both had been at work for more than a year and both were considered good employees.

The directors of both programs had operated under the illusion that the MTA's in those systems were competent to perform the work assigned to them, yet neither had assessed the reality of that belief.

This is by no means to argue against the use of MTA's in correctional health programs. Some of the most highly skilled and competent personnel I've met in correctional health programs have been MTAs. If MTAs are used, they should be used safely. That means that certain safeguards should be observed:

- The Diseases or Conditions which may be treated by non-medical personnel and circumstances necessitating referral should be specified in writing.
- Drugs and Other Treatments which may be dispensed by non-medical personnel should be specified in writing.
- Specific Pre-Service Training should be mandatory for all personnel in the work they will be required to do.
- A Medical Record should be made of every patient contact and every treatment given.
- Medical Audit should be performed continually to identify patient management problems.
- In-service Training should be continuous and ongoing for identified patient management problems.*
- On-Site Medical Backup should be available daily, on-site for problem patients.
- Emergency Evacuation and Treatment arrangement should be made in advance of actual emergencies.

In short, what is really required to provide high quality correctional health care at a reasonable cost, is a rationally organized, monitored, and self-correcting system which is specifically designed for the task it is to undertake.

In such a system, I would expect about 50% of the inmate complaints to be manageable by MTAs. The rest require referral to someone with

* Beware of the Illusion of Eternal Competence. All technically skilled workers tend to become "stale" or "burned out" and their seldom used skills tend to atrophy without frequent professional stimulation.

more sophisticated clinical skills. By more sophisticated clinical skills, I do not mean those of a licensed practical nurse or a registered nurse without additional training. Does that mean that doctors are needed to manage the other 50%? No. One of the illusions of the past is that it takes a medical degree to treat every runny nose. It's not common for 10% of some inmate populations to turn out for sick call every day. In a 1,000-man institution, that would leave 50 patients for the other doctor to see; too many for one doctor. Fortunately, there are other options. For the past few years, it has been possible to hire nurse practitioners (NPs), registered nurses who have completed a special-one year course of training which prepares them to manage about 85 to 90% of the kinds of problems brought to daily sick call by prison inmates.* Our research[1] (see Figure 1) as well as that in other settings [2,3] shows that nurse practitioners can manage about 90% of the patients we see during clinic sick call, as well as board qualified internists in subspecialty training.

Figure 1. PERCENTAGE OF WEIGHED QUALITY OF CARE CRITERIA MET BY DIFFERENT PRISON HEALTH CARE PROVIDERS AND THE HOSPITAL EMERGENCY ROOM IN DADE COUNTY FLORIDA.

	Average Quality Score
Medical Technical Assistants (MTAs)	49
Licensed Practical Nurses (LPNs)	49
Registered Nurses (RNs)	51
Nurse Practitioners (NPs)	63
Physicians (MDs)	65
Hospital Emergency Room (ER)	75

Does this mean that nurse practitioners may be employed instead of doctors in jail health programs? No! The same controls must be applied to their work as are applied to the work of the MTAs because even though the nurse practitioners are trained to manage 85 to 90% of sick call type patients without assistance, it is precisely the 5 to 10% that they are not trained to manage who are the sickest and therefore the ones which must be filtered through the system for care by the physician.

Some people have argued that a doctor should see every inmate who has a complaint. I have visited systems where I've been told that this was the policy. That's an illusion. The fact is that somebody always end up screening the number of inmates seen by the doctor down to a manageable size even if the system isn't planned that way. The reason is, that it is not sensible to require that every complaint be managed by a physician. The cost of asking a doctor to review all of the complaints of 10% of an inmate population every day would be tremendous. More importantly, when doctors spend that much time with medically trivial, self

* Licensed physician assistants can sometimes be used in this role, but the training and experience required for licensing physician assistants varies so much from state to state that the responsible physician should evaluate the specific training and the clinical skills of each individual physician assistant candidate before employing him in order to insure that he will be qualified to perform the tasks that are to be delegated to him.

limiting conditions, the quality of the care they give to serious problems tends to deteriorate. Any doctor who agrees to dispense aspirin, laxatives, and foot powder all day eventually become proficient at dispensing aspirin, laxatives and foot powder. Meanwhile, he may lose his ability to do the things you really need him for; to detect and treat medical conditions which are more likely to cause discomfort, disability, or death if they are not treated in a timely manner.

In the interests of providing high quality correctional health care at a reasonable cost, what is required is a system which is rationally designed, in the sense that; the roles of all the players are defined; everyone is given the training and experience needed to perform the tasks to which he or she is assigned; it is controlled and self-correcting, in that there are built-in procedures for detecting and correcting problems as they occur. Finally, it contains provisions for upgrading the skills of everyone working within it so that they will not become obsolete as a result of the technical advances that are going to occur in medical care over the next five years.

In a well organized well monitored system, about 50 to 60% of the sick call complaints could be managed by the MTAs. Another 30 to 35% would be managed by a nurse practitioner. This leaves 5-15% who would require physicians' care, specialty care, or hospital care. Fewer than 1% of those seen each day on sick call would be expected to require hospital care.

Once a system like this is in operation, the medical director can sit back, light up a cigar, and put his feet on the desk, right? Wrong! Systems of this type when properly organized and services are much more efficient than those which are not so organized, but it is a terrible illusion to believe that they will continue to operate as planned without constant attention. Without supervision, any organization tends to decrease in efficiency at all levels, and to break down at the interfaces between providers. The reality is that health systems are exactly like other bureaucracies, they tend to drift off course, to expand and to expend progressively less and less of their resources to address the purposes for which they were intended.

It is my opinion that it is the job of the senior physician in every health program to insure that this does not happen. Why a physician?

Perhaps that's my illusion, a person bias because I am a physician. I don't think so. It is my opinion that few people other than physicians possess the requisite knowledge to be able to identify trouble with the quality of care received by the patients and to correct those problems on the spot. I have never seen a lay administrator with the ability to do that no matter how skilled he or she might have been in other areas.

It is a myth that physicians necessarily make poor administrators. It is true that many physicians have different orientation than do most administrators. That is precisely the point. Many administrators tend to be highly skilled at ministering to the internal needs of bureaucratic organizational systems. Physicians tend to be interested in whether or not the organization actually performs the work for which it

was created. It is an abdication of the physicians's professional responsibility when the mission of any health organization becomes subverted to the internal needs of the organization or its staff, no matter what the reason might be.

The physician who has had personal experience in the delivery of health care who can see beyond the illusions, he may wish were true, has far greater potential for identifying serious problems when they occur or before they occur and is less likely than most lay administrators to be misguided by a type of polysyllabolic head tripping that too frequently disguises itself as problem solving in health circles.

The role of the lay administrator is to keep those working within bureaucratic organizations comfortable and this role is of great value. The medical directors' job is to keep the organization on course.

It is my opinion that the medical director should have high visibility and authority within the correctional hierarchy. I believe he should be accountable directly to the director of the correctional program by which he is employed. This is particularly necessary for defending essential budgetory items which are not always easily understood by correctional administrators or legislative budget analysts. It is also desirable because many of the most serious and intractable correctional health problems occur because of direct conflicts with the wardens of specific correctional institutions over personnel matters or other issues which have little to do with correctional security matters. In order to address such problems effectively, the medical director must be able to discuss them on an equal footing with the person in charge of security.

The medical director also needs to have several special personal and professional characteristics.

- He should have strong leadership skills.
- He should view his role as extending well beyond providing care personally to individual inmates.
- He should understand the organization and operation of systems of health care and should have both the willingness and the ability to work with people from a variety of backgrounds both inside and outside the health care industry with whom he must work in order to keep a complex operational system functioning.
- He should have a working knowledge not only about medical care, but also about medical record systems, quality audit procedures, identification and resolution of staff in-service training needs, cost containment procedures, creation and revision of standing medical orders and other medical policy procedures, public health and sanitation measures, and program planning and budgeting.
- In the words of my Latin friends from South Florida, he must have "heart". Not to be confused with "bleeding heart" -- nobody who is a sucker for a sad story functions well in a jail.

I mean by "heart" that he should all but instinctively feel the operation of the health program from the perspective of its patients. He should have the humility and the clarity of perception to identify its serious flaws, the courage to stick with them until they are remedied, and the wisdom to give the credit to those who need it.

- Finally, he must keep his vision at all times upon the purpose his health program austensively serves.

What is that purpose?

The purpose of any health care system is to prevent avoidable diseases or injuries, and to treat them whenever they occur, either to cure, to limit the disability they produce, or to decrease the discomfort of the victims. From this perspective, any health care system looks a lot like a police force in that its purpose is to prevent certain undesirable things from happening. It is helpful if someone reviews any operational health care system from this perspective from time to time because health care systems are just like other bureaucratic organizations, unless somebody reviews them in terms of their purposes and goals they tend to accumulate a lot of useless functions which once served useful purposes which have become absolete with time.

What are the specific occurences that health care systems are supposed to prevent? I like the list suggested by Kerr White, former Dean of the John Hopkins School of Public Health.[4] They are:

Death
Disease
Disability
Discomfort
Dissatisfaction

So far as I'm concerned, prevention of these phenomena are the goals of any health care system.

If you will look at the major causes of death, disease, disability, discomfort, and dissatisfaction in any correctional health program, you will be surprised. First of all, you'll find major preventable causes of death, disease, etc. that are not now being addressed by the health program. Everyone knows that suicide and homicide are the leading causes of death in most jails and prisons. Yet, how many medical staffs view suicide and homicide as health problems? Secondly, some of the health problems you identify can be addressed by training correctional officers, correctional counsellors, inmates, or the kitchen staff without adding a penny to the budget for doctors, nurses, or medical equipment. Finally, it quickly identifies activities that do not seem to benefit anyone with the possible exception of those performing them.

The American Medical Association's recently published Standards for Correctional Health Care in Jails and Prisons[5] are important. They specify the elements which should be in place in any well run correctional health program. We will need the help of the AMA along with state and county medical societies to help us in translating the guidelines into realities, because in many places this will require translating the guidelines into state and county enabling statues. This is a task with which we will need a great deal of help.

At best however, the guidelines can only provide us with help in obtaining the resources we may then use to develop and operate sound correctional health programs. They cannot be used to determine whether or not a given program is serving the purpose for which it is intended once it is in operation. That is the day to day job of the medical director. In this regard, state and county medical societies may have a second potential role. Let us solicit their help, to periodically review our programs in terms of their intended objectives, and to assist us in addressing them better.

If from time to time, you will review any program of health care from this perspective, or if you will ask someone to review it for you, it will produce several benefits:

- It will help you create a rational system, one in which you've at least tried to address specific problems which affect the health and well being of your patients.

- It contains a built in priority system* which can help you allocate resources when dollars are short, as they always are.

- The rational health care system it will help you to produce, is one your lawyer can much more easily defend in court if he has to.

- Because it is rational, it is easier to defend before legislature budget committees.

- It helps you to create an economical system, because by looking first at what you wish to accomplish, you frequently discover that you can retrain and use existing personnel, instead of buying more medical resources.

- Finally, it gives you something like measurable objectives for the health care system which you may use to evaluate how well or how poorly the health care program goes from year to year.

Those are benefits to which most all of us could subscribe.

* There is an obvious hierarchy of importance among the health system goals; it is more important to prevent unnecessary death than to prevent disease, etc., etc.

At this point, however, it is extremely important for us to avoid another illusion. It is the Illusion of Medical Omnipotence. The fact is that there are many serious health problems that are simply not well addressed by medical means. We may not suffer from this illusion quite so frequently as some of our free world counterparts because the place we work is in many ways like a crucible, it's harder to maintain delusions of grandeur about your effectiveness when you're penned in eight hours a day with your patients.

It is important to remember in this regard that we are not isolated, we are not alone in the institutions in which we are employed. Some of the major health problems we cannot address, can be addressed by others who also work in jails and prisons. It is critically important in this regard that the correctional staff be trained in cardiopulmonary resuscitation, for it is they, not us, who are close enough to prevent death by hanging or cardiac arrest. It is the correctional staff who must be trained to identify and refer those with high risk suicide potential. It is they who must intervene in a variety of crises and to council other inmates with problems before they become crises.

In recent years, many jails and prisons have begun to be inundated with emotionally disturbed men and women who in former years might well have been hospitalized in long term mental institutions. No one would suggest turning away from today's community mental health programs for a return to the "Snake Pit" era, yet, as one legacy of the passing of that era, correctional systems are presented with a group of problem patients for which we have no more satisfactory answers than did the alienists of the asylums of the past. It is important that we know what our limits are in caring for the mentally ill, as well as the medically ill.

There are many new non-medical growth techniques and therapeutic approaches which have in recent years evolved from the Human Growth Potential movement. In my opinion, we should remain open and actively encourage the development of these approaches, for some of them may in fact be effective with the very problems we find intractable.

It is the inmates themselves who must help with other problems such as physical assault, homosexual rape; and the emotional stagnation which tends to accompany excessive idle time.

If we are to be effective in mobilizing the energies of the inmates to these ends, we must to this extent possess the humility and the wisdom to call those inmates, colleagues.

Literature Cited

1 Glen E. Hastings, et al., "Nurse Practitioner in a Jailhouse Clinic," Medical Care, forthcoming.

2 John Shulman and Carol Wood, "Experiences of a Nurse Practitioner in a General Medical Clinic," JAMA, 219: 1453-1461. (1972)

3 David L. Sackett, et al., "The Burlington Randomized Trail of the Nurse Practitioner: Health Outcomes of Patients," Annuals of Internal Medicine, 80: 137-142. (1974)

4 Kerr L. White, "Improve Medical Care: Statistics and the Health Services System," Public Health Reports, 82: 847-854. (1967)

5 Standards for Health Services in Jails, American Medical Association's Program to Improve Medical Care and Health Services in Correctional Institutions. 535 N. Dearborn Street, Chicago, Illinois 60610, July (1979)

CAN ALCOHOLISM TREATMENT BE SUCCESSFUL WITH JAIL AND PRISON INMATES?*

I am the Executive Director of Al-Care, a publicly-funded, compresensive alcoholism service agency in a metropolitan area of over 200,000 population, namely Rockford, Illinois. I appreciate the opportunity to speak with you regarding the ability of alcoholism services to reduce the frequency of revolving-door type admissions of alcoholics into jails and alcoholism services. Due to the dual focus of this conference, I will attempt to highlight both the law enforcement and medical issues involved in reducing the cyclical admissions of chronic alcoholics. My presentation today will involve giving you a brief background on how alcoholism services for this client group developed in the Rockford area, a description of Al-Care's current services to this client group, the impact of services on the client group, and suggestions for assisting with the development of services in your own community.

Overview of the Development of Alcoholism Services in the Rockford Area:

The development of alcoholism services from a custodial level of care on county work farms and rescue missions has been rather recent, given the prevalence of alcohol problems in our communities. In 1955, 24 years ago, the first step was taken by a family service agency to formally address the needs of alcoholics. This agency had difficulty gaining political and financial support for services. After five years of effort, an alcoholism education and 10-bed treatment program was opened. After one year, the funding failed and only the alcoholism education effort could be kept going. This level of effort continued until 1967 (twelve years after the need for services was formalized) when a 58-bed residential alcoholism program was opened in a new state psychiatric hospital. After this difficult beginning, alcoholism services became more available in Rockford. In 1968, Al-Care opened a 15-bed half-way house and the community education program opened outpatient counseling services. In 1970, a hospital-based voluntary 12-bed detox program was opened, a 45-bed quarter-way house was begun by the community education program, and a jail-release effort was begun by Al-Care. The jail release program consisted of daily visits to the jail, conferences with alcoholic inmates and the judiciary, and a diversion of alcoholics from the jail system into a structured, therapeutic environment. Four separate agencies, plus the local mental health center were involved in delivering alcoholism services at this time.

In 1974 the detox program was moved out of the hospital and into a social setting in an attempt to reduce detoxification costs. The agencies involved with the revolving-door clients tried their best to reduce system dependency and service abuse by these clients. The detoxification problem maintained many of the medical procedures and medication protocols previously utilized when the program was hospital-based. The cumulative frustration brought on by these clients spawned the development of means to exclude the abusing clients from access to services, in an attempt to break the cyclical dependency of clients. This attempt at exclusion only resulted in an escalation of system manipulations, namely, mention of

*Presented by: Eldon Tietje, Executive Director; Al-Care of Rockford, Rockford, Illinois

suicide, by the clients to access the services. Also, the premature services administered by this group led to persons under sedation being at risk in the community. The demands of the Illinois alcohol program licensing requirements led to very extensive and costly facility renovations being required by the agency to continue providing detox services. In late 1976, the agency providing detox services chose to discontinue detox services rather than undertake a very costly remodeling of their facility. The Illinois Department of Mental Health then asked other alcoholism service agencies to submit proposals to provide the detox services. Al-Care's proposal was accepted and in March, 1977, Al-Care began to provide social setting detox services.

Meanwhile, a 7-bed women's half-way house was opened in 1975 by Al-Care. Also in 1975, an 18-bed, hospital-based residential treatment unit was opened in the community hospital which had previously provided detox services. Also, at the time Al-Care assumed detox services, it closed its 18-bed men's half-way house. Due to the expansion of community based alcoholism services, the 58-bed, state hospital-based alcoholism services were being under-utilized. This under-utilization led to a reduction from 58 to 29 beds in this state hospital-based program in 1977.

The Rockford alcoholism treatment system continued to evolve in 1978. The Illinois Department of Mental Health began to more clearly focus on the chronic, revolving-door alcoholic as the major target group for service funding. The remaining 29 beds of the state hospital-based alcoholism program were closed. The 45-bed half-way house program was reduced to 30 beds when it was forced by the demands of state licensing, into a smaller, but licensable facility.

In the fall of 1978, the Rockford area HSA and the County Health Department Mental Health Division recommended that there should be one comprehensive alcoholism service agency in the Rockford community. These recommendations grew out of an attempt to avoid the extra cost of administrative duplication by the two alcoholism service agencies, and to promote better coordination of levels of service for the chronic alcoholic. The Department of Mental Health responded to these recommendations by appointing a fact-finding community task force to study the current service needs and service agencies. The task force held a public hearing at which the two agencies presented their proposals to provide comprehensive alcoholism services for the Rockford community.

In early 1979, the Department of Mental Health announced its support of the task force recommendation, namely that Al-Care would become the comprehensive, publicly-funded alcoholism service agency for the Rockford area. In July, 1979, Al-Care assumed responsibility for the residential and outpatient alcoholism services previously provided by the other service agency.

Al-Care's Current Comprehensive Alcoholism Services:

This 12-year evolution of publicly-funded services has resulted in Al-Care providing social-setting detox services, residential services for adult men and women, and outpatient counseling and evaluation services. At this time, all of Al-Care's services are primarily focused on the chronic, public-inebriate alcoholic; the group of alcoholics which have also been involved with the police and jail systems. The services in this system can briefly be described as follows:

A. Detoxification Services: (A 20-bed social setting detox program with 24 hour nursing staff on duty) Physician and psychiatrist back-up are provided through a shared consultant contract. All nursing procedures are physician authorized. Beginning in February, 1979, clients are brought directly to detox for evaluation and admission to services (see Al-Care Detox Admission Pattern). The shift away from unneeded hospital admission evaluations of detox clients has resulted in a large cash savings to the Department of Mental Health. Detox services are coordinated by a recovering alcoholic with background experience similar to the client group. The average length of stay for clients is 2½ days, with a maximum of five days. The detox program monitors the client's physical condition during alcohol withdrawal, stabilizes clients physical condition with minimal medical support, assesses client's alcohol problem, and refers clients to appropriate level of care. A staff attitude of empathic, helping care is conveyed by staff to clients, and punitive, rejecting frustration with client relapse is minimized.

B. Residential Services: (A 30-bed residential program combining intermediate care and half-way house services for adult chronic alcoholic males and females) The program offers a CETA-funded 15-week work-readiness program for 15 clients. In this program, clients are paid minimum wage for participating in a 30 hour work week divided between living-skills training and a supervised work experience. This program is designed to re-establish a personal re-orientation to employment schedule routines, raise self-esteem and self-confidence that positive life changes are possible for the clients, and to help engender the life attitude in the client that he has something to gain by staying sober and something to lose by drinking. The work-readiness participants are charged reduced room and board costs on the condition that 25% of their income is placed in a savings account for use as apartment rent and security deposit when they move to the next level of care. The residential services have a community rather than "office" orientation. If relapse occurs, staff try to find the person as soon as possible to detoxify the person and re-enter them in the residential program. All group and individual counseling occurs in early evening or on week-ends to insure accessibility of working clients. All group services are jointly staffed by residential and outpatient staff to facilitate client comfort in moving from residential care to outpatient care.

C. Community Outpatient Services: Services are provided by a seven member staff. Services are primarily directed at follow-up aftercare of clients previously served by Al-Care's Residential Program. These services include individual and group counseling. Emphasis is given to working in the community rather than providing "office" services. Community services relates to the county probation office and circuit court by providing pre-sentencing alcoholism assessments and post-sentencing alcoholism counseling.

Community services also relates to adolescents experiencing difficulties with alcohol by having a staff member work in the juvenile probation department and the juvenile division of the police department. This staff member interviews every adolescent who is arrested on an alcohol related or alcohol-involved offense. Education sessions regarding alcohol use, value clarification, etc. are provided for adolescents and their parents (separately). Similarly, requests for community education presentations by schools, churches and other community groups are filled by Community Outpatient Service Staff.

Impact of Services:

The above comprehensive services directed at chronic alcoholics and the positive cooperation of the police, emergency rooms, Department of Mental Health, County Health Department, A.A., other alcohol service agencies and other social service agencies has indeed had a positive behavioral impact on this client group. The attachment of residential services to this client group has led to lower the number of detox admissions, particularly by the revolving-door client (see "Detox Admissions by System-Dependent Alcoholics").

The percent of clients leaving detox services before being detoxified was reduced from 67.9% of admissions in 1977 to less than 12% of detox admissions in the last month of service. This reduction was primarily due to policy changes directed at reducing the secondary gains derived by system-abusing clients when entering detox services. The change in medication usage for detox clients also lowers the risk factors of clients leaving detox prematurely. The increased percentage of detox referrals coming from informal referral sources (see "Al-Care Detox Admission Pattern") also indicates that clients are accessing services at earlier stages of difficulty and that a positive attitude towards Al-Care's ability to help alcoholics exists in the community.

Ways to Help in Your Own Community:

Rockford's community experience would indicate that education of the medical and/or the legal/judicial system are key areas to begin mounting community support for alcoholism services. Both of these groups have first hand experience with individuals having alcohol problems. Similarly, these two groups frequently have access to community leadership.

The Rockford experience in alcoholism service development would underscore the need for support and involvement of community agencies (police, hospitals, physicians, social service, etc.) in the development and coordination of alcoholism services.

Al-Care's recent positive experience in coordinating client services for a very difficult alcoholic client group would support the concept of having all publicly-funded alcoholism service being coordinated by one comprehensive agency in that community.

Do not underestimate the impact individual involvement in influencing the establishment and refinement of effective alcoholism services in your community. One should become aware of and involved in the local community's alcoholism services. One might also become a board member of a community service agency. Work to establish and improve the support for alcoholism services by your local government and business community. Work to gain the support of the medical community and the attachment of appropriate medical components to alcoholism services. Most of all, support appropriate levels of funding to attract well-qualified alcoholism counseling staff into your community alcoholism services. Effective and articulate service staff can have a positive impact on the chronic alcoholic client group. Concerned staff can also greatly assist an alcoholism agency's ability to garner the political support and treatment creditability needed to develop alcoholism services to the level needed by your community.

CRISIS INTERVENTION IN JAILS AND CORRECTIONAL FACILITIES *

The term crisis intervention has been around for quite some time now and is probably familiar to most people involved in the helping or care giving professions. It is hard to imagine someone in those professions who has not been called upon to perform some form of crisis intervention whether they were aware that that is what it was called or not. Crises and their resultant reactions are a daily part of human existence. They range from rather mild innocuous but nevertheless unsettling events such as receiving a traffic ticket or having a minor accident in which one's car is scratched or dented, to major catastrophes (involving death, loss, injury and illness), which are severely threatening in actuality as well as in our perceptions of them.

Individual reactions to crisis are as varied as the types of crisis to which one may be exposed. To some people they seem to have little if any effect, even when they are major events, while to others even the most seemingly insignificant of events may bring on an unexpected and serious disruption of normal functioning.

Crisis has been most simply defined as "an upset in a steady state,"[1] an upset which then calls for a new adaptation in order to either obtain a new level of equilibrium or a return to the state of equilibrium that existed prior to the occurrence of the crisis.

Some crises are considered positive and growth producing. Many theorists such as Erick Erikson postulate that the development of the ego and personality result from a series of conflicts and crises, the resolution of which leads to a strengthening and maturing of the individual's ability to cope and adapt to society and the problems of daily living.[2]

However, here we are concerned with the concept of crisis in which the individual's normal state of equilibrium and normal methods of coping are so overwhelmed and upset as to lead to a breakdown, a breakdown in which intervention by others becomes necessary. This happens very simply when there is an event or occurrence which results in a threat (this threat may be actual or perceived as such), the result of which is an inability to cope. The reasons for this inability may be due to the individual involved experiencing a break in his usual defense mechanism. This results in a flood of both conscious and unconscious feelings ar perceptions which can result in confusion, disorientation and an inability to clearly understand all that is happening. In other instances, the inability to cope may be due to the event of occurrence being so foreign

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* Presented by: Teddie L. Ramsey, Chief of Counseling Services; Department of Corrections, Springfield, Illinois.

1 Howard J. Parad, ed., Crisis Intervention:Selected Readings, New York: Family Service Association of America, 1969, Page 24.

2 Erick H. Erikson, Identity:Youth and Crisis, New York: W.W. Norton and Company, Inc., 1968, Page 44-135.

to the individual as to be completely outside of his/her normal range of experience, to the point, that the knowledge of how to respond is just not there.

The behavioral responses to a state of crisis are varied and many. They may range from rather short episodes of mild confusion and an inability to take actions - to severe withdrawal - depression - suicidal ideas and behaviors, disruptive or acting out behaviors resulting from unresolved conflict and frustration, to full blown psychotic episodes. The extent of reaction varies according to the individual involved and his/her particular ego strengths and weaknesses and according to the degree of threat posed by the crisis event.

From this, it becomes evident that early detection and intervention in crisis situations is of paramount importance in order to minimize the degree of deterioration and decompensation as much as possible.

People in a state of crisis are particularly susceptible to intervention and help. Due to their feelings of being overwhelmed and helpless, and to the openness resulting from the breakdown of defenses - sincere and strategic contacts are not only more possible, but are also more results-producing in many cases.

APPLICATION IN CORRECTIONAL FACILITIES

Prisons, or as they are now called, correctional institutions, are most definitely appropriate environments for the application of crisis intervention services. I earlier defined crisis as an upset in a steady state and this could also be one definition of daily prison life.

Not only do residents of correctional facilities experience the usual crises as experienced by all of us, such as loss of loved ones - divorce-financial reverses - illness, etc. (and these may be exacerbated by their imprisonment and inability to take action due to confinement), but they also experience crises due to the prison environment itself, with such problems as isolation from family and support group, loss of freedom and resultant grief, and the need to repress personal feelings, particularly those that are generally considered negative, such as anger and frustration. They also face violence and the threat of violence, sexual pressuring, sexual assault or threat of such assault, with a resultant feeling of total vulnerability in the face of such circumstances. Furthermore, one frequently sees loneliness, despair, sexual confusion, and/or massive self doubt in correctional settings. These may be brought on by the residents' recognition of their criminal behavior, feelings of failure, anger over having been caught and the sometimes harsh unresponsive environment resulting from overcrowding and other such conditions in prisons with which most of us are familiar.

Developing a crisis intervention program in the light of the above described conditions is of utmost importance to prevent long term damage to the mental health of those imprisoned.

To use an analogy here, if we were to have as a proscribed punishment the concept that for certain crimes an individual deserved to be smashed in the leg with a ten-pound sledge hammer, we would not be surprised at the resultant damage and pain. If we also believed that the punishment should be time limited, it would then be necessary to quickly repair the damage through surgery, casting, or whatever, in order for the person to recover and not be permanently crippled, thereby extending the punishment beyond its proscribed limits. It then follows that if we are going to expose people in some cases to this same type of effect, psychologically speaking, then we must be prepared to provide emergency aid to prevent the response or effect to such exposure from becoming crippling and permanent.

Crisis intervention is just the tip of the iceberg in terms of what may be needed but it is at least a beginning.

In order to effectively establish such a program several things are needed:

First of all, for such a program to even be possible it must have the full support of the institutional staff from the Chief Administrative Officer on down, and secondly, it must be a cross departmental program involving all facets of institutional staff.

More specifically, it would first be helpful to form a crisis intervention team, since crisis intervention is highly applicable to the team concept. This team should include clinical or counseling staff, security personnel - nursing, medical and psychiatric staff. All team members and their functions need to be clearly identified. Training of these staff and any auxiliary or back up staff in the essentials of crisis intervention techniques is absolutely necessary in addition to exposing and training all institutional staff in reference to the functions and purposes of such a team and program.

Choice of staff and their training cannot be overly emphasized for several reasons: first of all, the results of most therapeutic intervention rest heavily upon the ability of the intervenor and the recipient of that intervention being able to form a significant and meaningful rapport. Staff characteristics needed to facilitate this should include at the very least, a capacity for objectivity (very important in a correctional setting), a demonstrated capacity for empathy and warmth, since a key factor in crisis intervention is the offering of sincere support. Highly developed diagnostic and assessment skills are necessary in order to identify and separate crisis situations from ongoing problems or more severe mental and physical illnesses. Good supervisory and communication skills are also desirable to facilitate a cooperative effort on the part of all staff in response to a crisis situation.

There should be a clear identification of the leader and co-leader of such a team and the team should include supervisory staff and at least one security officer with rank high enough to facilitate quick decision making. A back up staff member should be designated for each team member and plans effected for weekend, holiday and evening responses. Crises are not likely to occur only on an 8-5, Monday through Friday basis.

Once a team is chosen and trained, a second component of almost equal importance is the development of a crisis intervention unit, a physical area to which the resident in crisis can be placed when necessary both for accessibility and close supervision, and in order to remove him/her from the stress of daily prison life. The ideal would be to make it a therapeutic environment but at the very least it should be a relatively benign and protective environment in which the individual can feel safe, know that he or she is being responded to in other than a punitive fashion and where the stimuli coming at him/her can be somewhat controlled. It should include a suicide watch area which may include cells with unbreakable plumbing, fire retardant clothing and bed linens, and security lighting fixtures. It should also have close 24 hour a day staff supervision and, though disciplinary or security procedures cannot be ignored, this unit should provide for more flexible application of those for the individual who is truly in an overwhelming crisis state.

In terms of the actual program it should have at the very least the following components:

1. A clear system by which the team is notified of either an actual and/or impending crisis.

2. An immediate response by a designated team member to evaluate the situation.

3. Quick communication of immediate needed responses to all team members and administrative staff followed by the implementation of these as soon as possible.

4. Quick involvement of medical, nursing, and psychiatric personnel to rule out medical problems and to provide appropriate and necessary chemotherapy, if indicated.

5. Removal, when indicated, to the crisis intervention unit with as little delay and disruption as possible.

6. Priority involvement by crisis team members with frequent visits, including medical checks, as well as short but frequent therapy sessions as dictated by the residents' emotional and mental status.

7. Early staffing by the total team to establish a working diagnosis.

8. Careful evaluation in reference to terminating crisis intervention and transfer from the crisis unit.

9. Careful and frequent follow-up by a designated staff member following termination of the crisis approach.

10. Future assignment, if possible, to needed ongoing programs and treatment indicated by the intensive evaluation performed during the crisis period.

11. Last but not least, careful and comprehensive documentation of all that was done during the crisis intervention phase.

In summary, correctional facilities are by their nature environments of high crisis risk indicating a need for vigorous, comprehensive crisis intervention programming including a designated team and a relatively benign if not therapeutic environment offering removal from the daily prison environment. It should include extensive training of crisis team members in crisis intervention techniques and of the institutional staff in goals and purposes of such a program with full support to such efforts being granted from top staff on down.

References

Cumming, Elaine; Cumming, John. EGO & Milieu. New York: Atherton Press, 1970.

Erikson, Erick H. Identity:Youth and Crisis. New York: W.W. Norton and Co., Inc., 1968.

Menninger, Karl. The Vital Balance. New York: The Viking Press, 1969.

Parad, Howard J. Crisis Intervention: Selected Readings. New York: Family Service Association of America, 1965.

Reusch, Jurgen, M.D. Therapeutic Communication. New York: W.W. Norton and Co., Inc., 1961.

CRISIS INTERVENTION IN JAILS AND CORRECTIONAL FACILITIES *

Acknowledging that many of the participants at the Conference had expressed a desire to focus on the practical issues of the struggle to bring quality health care services inside the jail, Dr. Peters presented a description of the process, with its attendant successes and failures, which have led over the last 8 years to the extensive work of forensic health care services now in place in San Francisco. He expressed the hope that the conferees could, depending on the status and history of their attempts within their own localities, draw from this description suggestions and strategies that would be helpful.

Several of the main points stressed by Dr. Peters were:

1. To make extensive use of the standards for jail health care, particularly the AMA standards, as a guideline for program development.

It was suggested that attempts be made to draw into the jails representatives of local health professional organizations to assist in making a needs assessment of the health problems existing therein. It is common to find in most localities a long history of ignoring or denying that jails tend to house an unusually high population of medically and psychiatrically high-risk individuals. Having a professional and independent assessment of the health problems, as well as an analysis of the health system in place (if any), and then comparing this to the AMA Standards, is a good and probably mandatory first step.

2. To present this needs assessment and program outline to the appropriate public body responsible for funding decisions.

Given the considerable legal and social history pertaining to the delivery of health care services to the jail which has developed particularly within the last several years, many local jurisdictions are inclined now to voluntarily support the provision of such services within their own jails. Such a decision may be made on a sound public health basis, but in many instances also reflects a jurisdiction's attempt to reduce the legal liability which would result from a failure to provide such care. In other instances of course, the decision to fund adequate health programs will not be made voluntarily, but will have to come as a result of legal challenge. (In that regard, Dr. Peters cited the influential decision in Smith v Hongisto, United States District Court, Northern California, C-70-1244-RHS. This decision, handed down in 1973 after extensive investigation and testimony, found that the conditions of San Francisco's county jails, including its lack of appropriate health care services, constituted a violation of the United States Constitution's prohibition against cruel and unusual punishment, and the Court ordered an immediate plan for improvements. This decision, and others like it in other jurisdictions, have set a clear precedent of the mandatory nature of such jail health care services, and can be most helpful in any legal battle undertaken now.)

* Summary Presentation by: Tom Peters, Ph.D., Director of Forensic Services; Department of Public Health, City and County of San Francisco, San Francisco, California.

3. To determine what revenue sources are available to support jail health services.

Many local and state jurisdictions have allowed, either by direct or indirect means, the establishment of policies which have the effect of denying equal access to health benefits for jail detainees. One example of this at the State level is the allowance of provisions for the cancellation of insurance benefits to incarcerants, or State Medicaid program policies more restrictive than Federal guidelines permit. Such policies, along with the decreasing amount of local public revenue availalbe in many localities, serve to foster either inadequate or altogether non-existent health services within the jails. Given that most local jails house people with minimal financial resources, and given the multiple health care problems so frequently concomitant with this economic status, the effect of such public policies can be the restricted access or outright denial of health care services to those who are most in need of but least able to obtain the necessary care. Again, legal and political assistance may have to be sought in order to bring about the necessary redress. (Dr. Peters pointed out the clear legal history establishing that a jurisdiction's financial difficulty is not an acceptable explanation or excuse for the denial of constitutional rights; see again the Smith vs. Hongisto decision).

4. To ensure that the relevant health agency or department assumes an independent authority and responsibility within the jails.

While the Sheriff or other local authority has a basic responsibility for the safe and appropriate conditions of the jails, it was suggested that the local health department also has a unique responsibility to provide services to this medically and psychiatrically high-risk population, just as it has a responsibility to apply its expertise to other special and pressing community health problems. The ideal of course is the joint and cooperative effort of the health and sheriff's departments, which, though it sometimes can be difficult to establish at first, has many successful precedents across the country. (Dr. Peters has pointed out that, on this very issue, Ms. Carole Morgan, a co-panelist, has considerable expertise in the provision of consultation services).

5. To ensure that there is the proper use of medical professionals in the provision of care.

No matter under whose jurisdiction, the critically important point is that the basic responsibility for the provision and monitoring of jail health care services must be in the hands of medical professionals. While the training of deputy and volunteer personnel can be of invaluable assistance in establishing emergency medical readiness and the formation of a comprehensive team effort, the fundamental skills and responsibilities must continue to be seen as the purview of health professionals. Additionally, the attraction of affiliating with other health professionals in the challenge of bringing health care to a difficult yet responsive population can be an important element in the recruitment of quality staff to this demanding and rewarding effort.

CUSTODY/MEDICAL INTERFACE: PRINCIPLES AND MODELS FOR PRISONS AND JAILS *

I would like to open our panel discussion by merely stating that unless your individual system is different than most, for every single medical function performed it is necessary to have a custody/medical interface. It may be an interface that relates to medical personnel coming in the building to deliver care of it may relate to the actual delivery mode.

For reasons of self-preservation and a desire for continued employment in the custody envor nment, there is one basic ground rule or fact of life that is imperative to accept. We, as health care providers, whether working directly for the system, or contracted from the outside to come into the facility and provide service, must acknowledge one thing. The primary objective of a custodial facility is merely that ... custody. It is not a medical facility.

Medical personnel are used to working in systems where everyone in the facility and organization have medical care goals. In correctional institutions, as previously stated, the basic goal is security. We are only one component of their system.

This background and understanding sets up our discussion on interface.

There are two kinds of systems that we interface and work in. The behaviors and salesmanship skills required may differ somewhat based on these two systems. To make it simple, in one system the health care paychecks come from employers outside of the custody system. In the other, the paychecks come from the same system. You may have your own preference. Depending on which way your system is organized and whether it works well for you.

A group of us were talking earlier and concluded that what really makes interface positive, more than the kind of system, is the specific individuals involved in both custody and medical services in a given facility. If there are willing, listening individuals on both sides, able to accept and understand each others' goals, then all problems are minimized. If the vision is "tunnelled" on either side, big problems arise.

I mentioned earlier the two types of health delivery systems in corrections. I happen to work for the one where my paycheck comes from the same department as the custody personnel. I work for the Sheriff of Los Angeles County. The custody personnel are deputy sheriffs. I am a strong supporter of this system because it works well for me in the county and circumstances in which I work.

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* Presented by: Bonnie Norman, R.N., Director, Medical Services Bureau, Los Angeles County Central Jail, Los Angeles, California

I work for a sheriff who prefers to maintain total control. In order to maintain control, he must keep medical care (as) inmates in "his shop".

With the current outside forces and pressures hammering away at jails regarding health care, there is only one way the sheriff can hold onto medical care. He must give it the same status and attention that he does to custody in general, patrol services and other units within the department.

I am extremely lucky. My sheriff has done exactly that. I have executive status along with the sworn chiefs of divisions. I sit on the executive planning council which meets weekly. At least 75 percent of the information discussed has no relevance for me but I do not miss a meeting, if it can be helped. I want and need to be there; not only for the 25 percent that relates to me but for the visibility it gives me. I want the other executives to know me and to realize that I am an interested, viable, important person in the organization.

One thing that seems to be a big help to me is that I do not report to custody. I report, the same as the chief of custody, to the assistant sheriff. I have my own budget and set there fighting for my dollars along with the sworn division chiefs.

Another reason I am happy to be under the sheriff, rather than the department of health services, is a budgeting survival reason. In Los Angeles County, the health services budget is something like 600 million. My small operation of 300 staff and a 10 million dollar budget would have low priority in the total population. In the sheriff's department, I have a chance to be heard on an equal basis with other executives in the department.

Let's get back to the everyday world of interface in a large county jail. Our system houses 10,000 inmates. We process an average of 450 new bookings daily. The interfaces are numerous, constant, painful and improving.

In our central jail, which houses 5,000 inmates, nurses and other medical personnel go to fifty module areas throughout the jail to deliver services. They operate a screening process in the inmate reception center. They man a 24-hour-day clinic and emergency services. We operate a 500-bed skilled nursing facility within the jail.

We have a 16-hour a day pharmacy operation, 24-hour laboratory and X-ray services and a dietitian who maintains all medical diets and, in addition, supervises the diets of all inmates in the general population.

The interfaces are constant. When I first came to the system, 2½ years ago, the comments I heard most from medical personnel had to do with their feelings about custody personnel. For the most part the feelings were negative; feelings of lack of cooperation, lack of understanding, etc.

Not all of the negatism is gone today, but it is greatly lessened. We have come a long ways. Why? Because of two things. We have become less paranoid and we have cooperated to make things work better in their environ-

ment, a custody environment. We are actively and constantly working on different methods of housing, preventive malpractice programs and deputy education programs. We try not to attack or accuse each other. We sit down and do meaningful interface. We problem solve. It's still painful, but it is working.

An immense help to us has been the initiation of a medical services security unit. Their primary function is not only to resolve issues between medical and custody but to facilitate medical care of inmates where assistance of custody is needed. I am talking about areas such as transportation, special housing, etc.

There are 500 deputies at central jail and with their constant movement it was impossible to keep the deputies educated as to special medical problems of inmates and preferable handling techniques. For example, the handling of psychiatric patients. With our new liaison unit, there is an effort made to assign permanent deputies to the medical areas of the facility. The training becomes much easier. They like it better and so do we.

We invite the lieutenant of the liaison unit to attend staff, quality of care, space utilization, and other meetings as he wishes.

For the most part, the deputies no longer feel like we are sabotaging their system and we are getting over our paranoia about deputies. The deputies have started coming up with ideas for us to improve medical services. They appear to be enjoying their work assignment. In fact, there is a waiting list of deputies requesting to come to work in the medical areas.

Communications is hard work. The pay off is worth it. Interface becomes an enjoyable activity. Once I stopped listening to a few employees complaining that I was giving the store away and moved ahead with unbiased and cooperative attitude, good things started happening.

CUSTODY/MEDICAL INTERFACE: PRINCIPLES AND MODELS FOR PRISONS AND JAILS*

We all have the same goals; to improve health care in jails. The AMA has selected an excellent approach by encouraging jails to apply for accreditation. The accreditation standards are high but attainable. However, a significant amount of time may be required in order to get states to implement these standards.

Another approach to improve health care is by instituting a system of quality medical care directly into the jails. This medical system would be run by well motivated and licensed practitioners who would be directly responsible to county or jail administrators. This system is working well in Los Angeles and has produced outstanding results.

We in Kentucky have gone to a third system, one that has proved to be inexpensive and also one that we have been able to implement in a very short period of time. The Kentucky Department of Corrections, Bureau of Training, in cooperation with my department, The Department of Emergency Medicine of the University of Kentucky Medical School, has created and implemented a course in first aid and disease recognition for jailers. One of the "side benefits" of this system is the creation of an environment/attitude conducive to a positive custody/medical interface. This training takes 24 hours of classroom instruction. The curriculum is broken down into the following parts:

1. Cardiopulmonary Resuscitation (CPR)
2. Red Cross First Aid
3. Classroom instruction:
    a. Communicable Diseases Recognition
    b. Medical Record Keeping
    c. Dispensing of Medication
    d. Evaluation of the Inmate
    e. Evaluation of Patients' Complaints
4. Psychiatric Problems in Jails Including Recognition of The Suicidal Inmate.

Integral to the development of this program has been preparation of a manual for jailers that is aimed specifically at jailers needs. The manual is written for jailers with an eight grade education (which has proved to be the education level of most of the jailers in our smaller facilities).

The system that we are using, (training jailers directly), has been able to make an impact on health care in Kentucky jails with a minimal financial investment and in a rapid manner. We look forward to training most jailers in Kentucky within the next two years.

For those desirous of obtaining more information about the Kentucky Jail Health Program or obtaining a copy of the Jail Health Care Manual, you may contact Lawrence J. Guzzardi, M.D., Division of Emergency Medicine, University of Kentucky Medical Center, Room H-134, Lexington, Kentucky 40536.

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* Summary Presentation by: Lawrence J. Guzzardi, M.D., Assistant Professor, Emergency Medicine, University of Kentucky, Lexington, Kentucky

HEALTH PREVENTIVE MAINTENANCE MODELS *

The ultimate goals of prevention of health maintenance strategies are to enable each person to live long and free from disability. Each health professional, I believe, has a part to play in promoting health and healthful behavior in those for whom we provide services. I direct my remarks, however, to primarily the nurses in the audience. By virtue of our educations and the concepts we learned, nurses represent a significant investment by society to insure a supply of persons knowledgeable in matters of health. Because nursing represents the melding of theories and practice from the social, biological and psychological sciences, we are prepared by education to focus our efforts toward promoting health and well being in those we serve. Moreover, most nurses, unlike physicians, do not usually have the same professional and emotional preoccupation with disease diagnosis and intervention. Nurses are frequently more interested in the patient as a person and look upon health maintenance and educational activities as a major challenge rather than as evidence of failure.

Because of our orientation, I firmly believe nurses have a special commitment and a special responsibility to initiate or improve correctional health care delivery systems to include preventive services.

Before we can discuss prevention strategies in the correctional setting, we must first look outside to the total American health care system. Trends and issues in the larger society are the origins of developments within prisons and jails. This remains true with respect to the potential success of preventive services. Obstacles inherent in the overall health care system will also be obstacles within correctional facilities.

Why Our Preoccupation With Illness?

Throughout most of recorded history, responsibility for health has been placed on the individual. As knowledge of the human body and disease mechanisms were acquired and refined, however, medical practice became more scientific and society came to place increasing dependence on medical intervention. Concomitantly, decreasing emphasis was placed on individual behavior and responsibility. Both the doctor and patient accepted the authoritarian, curative role of the physician as the primary avenue to health.

Dramatic advances in infectious disease control, chemotherapy, diagnostic intervention serve to reinforce the emphasis on medical intervention. "Health", in the vocabulary of the public, has become equated with access to medical care. Health care has come to mean, in reality, disease care. We identify "health" care almost totally in terms of visits to the doctor, hospitalization, complex often risky diagnostic and surgical procedures and above all else, the use of prescription medications.

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Presented by: Carol Charney, R.N., B.S., Director of Nursing Activities; Health Education Foundation of Eastern North Carolina, Inc., Tarboraugh, North Carolina

Not only has our vocabulary been altered to reflect this orientation to illness care but expenditures for health care have increased exponentially. Our belief in the power in medicine to alleviate our ills has been solidly supported by the sum of over one billion dollars a year.

This traditional model of health care has survived to this point because real gains have been made in decreasing the severity and duration of episodes of illness. There is data to suggest, however, that we have met the point of diminishing returns (Somers et al., 1976). The ills that most commonly effect human beings at this time are not easily amenable to prevention or "cure" through traditional medical care. The majority of health problems today are manageable through alteration in life style and improvement in living conditions. The latter statement is particularly true for the poor, who experience more frequent and more severe health problems than the general population and who, of course, make up the vast majority of prison and jail inmates.

I raise these issues as a preface to discussing preventive services in correctional facilities to illustrate the tremendous obstacles we face. The broad implementation of preventive services is easier said than done in a culture which first gives overwhelming priority to the management of firmly established disease and second, whose principle health care providers are prepared to deal with illness and not necessarily the maintenance of health.

Preventive Health Services

There are many approaches to preventive health activities. Some services focus on the individual, some on the total population. For the discussion today, preventive services have been divided into three categories: Promotional Health Services, Protection Services and Detection Services. All of these components are necessary to an effective preventive care system.

Promotional Health Services: Promotional health services are those services directed toward informing, educating, and motivating persons to adopt improved changes in their personal life style, hygiene, and nutritional habits. Such changes should result in promoting optimal health, avoidance of unnecessary risks, and more appropriate use of available health care resources.

The concepts of informing, educating, and motivating are the keys to successful health promotion services. In the past, these terms have been synonmous with information giving and, as such, have been viewed as a task adequately performed by anyone who is capable of speaking and had both the time and inclination to do so (Jacobson and Pellegrino, 1977). The implications of this model present a very limited understanding of behavior and decision making. In this context, people are viewed as consistently rational beings who act in their own best interest, who avoid potentially harmful acts or behavior and therefore, only lack specific knowledge. To supply them with the missing scientific information is all

that is required for the necessary change to take place. Behavior change, we understand now, is often more difficult than just providing information and is sometimes even threatening. Belief systems and basic values must be critically reviewed and questioned. Educational activities, thus, are viewed as the process of planned behavior change. This model of promotional health services will be described in more detail by the other two panelist.

Protectional Health Services: Protection services include those aimed at the welfare of both individuals and groups.

Protection services for individuals primarily include immunizations. Although required by law, many individuals today have not received the full array of immunizations for preventable communicable diseases. Crowded living conditions in most prisons and jails and erratic contacts with the health care systems prior to incarceration, make complete immunizations imperative for inmates.

Strategies for the protection of health for groups of persons include primarily maintenance of a safe environment. Meeting the standards for water supplies, waste disposal, ventilation, food handling, occupational safety, and minimal housekeeping cleanliness will insure against health problems related to environmental hazards.

Detection Health Services: Detection services are designed to evaluate and assess individuals without recognized symptoms for the purpose of identifying those at risk from unrecognized diseases.

There is rapidly growing scientific and professional consensus that risk factor intervention should be intensively explored as a way of maintaining and improving health during the present era (Breslow, 1978). Without ongoing services for the detection of physiological changes and personal habits that put people at higher risk, we cannot insure that incarcerated individuals leave our institutions at least as healthy as they entered.

Detection services should have a truefold emphasis. First, the detection of physiological changes that are the precurses of disease such as high blood pressure, elevated serum cholesterol or glucose, and cervical dsyplasia. Often these changes are not sufficient for typical clinical diagnosis but they put up red flags that require attention. It is not enough that individuals receive thorough health appraisals upon beginning their incarceration. We are obligated to monitor health status, including those "silent" bodily changes that do not bring people to sick call.

Secondly, detection services should include assessments of behavioral, or life style, risk factors. Noting that the life expectancy of the 45-year old male has increased only about 4 years since 1900, Dr. Lester Breslow, Dean of the UCLA School of Public Health, estimates that an additional eleven years could be added to such life expectancy, if people were to exercise regularly, maintain moderate weight, eat breakfast, not snack between meals, avoid smoking, limit liquor consumption, and sleep at least seven hours a night (Breslow and Belloc, 1972). While there

have been few controlled studies, evidence continues to accumulate concerning the association of particular risk factors with disease and mortality. Likewise, the prospects for improving health through reducing risk factors seems to be rapidly improving.

Conclusion

Based on this description of the three types of preventive services, the following are proposed:

1) Health education programs for groups of inmates as will be described shortly by Mr. Johnson and Ms. Hunter.

2) Expansion of efforts to provide a healthful environment. As the resource persons with both the necessary knowledge and skills, nurses must provide leadership and direction to correctional administrators.

3) Better documentation and follow-up to insure completed immunizations as necessary.

4) Yearly blood pressure screening for every incarcerated adult should be routine matter, as should yearly Pap smears for adult females.

Before concluding this portion of the presentation, I ask each nurse in the audience to consider the following issues carefully:

Does your nursing practice reflect an orientation to health?

Do you spend as much time promoting health as you do caring for illness?

Does your vocabulary reflect an orientation to health or to illness?

Do you more frequently speak of health care or medical care? Health records or medical records?

Do you work in the "Medical Department" of the correctional facility or is it called "Health Services"?

References

Breslow, L. "Prospects for improving health through reducing risks factors: Preventive Medicine 7, 449-458, 1978.

Breslow, L. and Belloc, N.D. "Relationship of physical health status and health practices" Preventive Medicine 1, 409-421, 1972.

Jacobson, L. and Pelligrino, E.D. "Change agents in a changing system". Preventive Medicine 6, 379-385, 1977.

Other Resources

U.S.D.H.E.W. Forward Plan for Health FY 1977 - 81 June, 1975.

Somers, A.R. etal. Preventive Medicine USA Health Promotion and Consumer Education New York: Prodist, 1976.

Worth, R.M. "A health care system designed to give rewards to the maintenance of health rather than just for the treatment of illness". In The Changing Health Care Team. Zoog, S. and Yarnall, S. editors Seattle: MCSA, 1976.

HEALTH PREVENTIVE MAINTENANCE MODELS*

One could hardly find an environment more in need of the anticipated benefits of health education than a prison. In order to fully appreciate this statement, common understanding of the term health education is required. Health education oftentimes has meant different things to different people--but a 1972-1973 Joint Committee on Health Education Terminology produced a definition that seems particularly appropriate to corrections:

> Health education is a process with intellectual, psychological, and social dimensions relating to activities which increase the ability of people to make informed decisions affecting their personal, family, and community well-being (Marshall, 1975).

This definition reflects the expanded role of health education--a role that does more than teach people how not to be sick. Health education can be viewed as a preventive measure that will encourage healthful behavior both inside and outside the prison.

The prison environment can create stress and pressure for residents which can at least partially be addressed through health education. For instance, the residents are placed in a foreign physical environment where they experience drastic changes in personal behaviors and lifestyles. In addition, the institutional setting places many limits on personal responsibility and decision-making. Health education offers an opportunity for them to learn to recognize the effects of these changes and to take responsibility over some area of their lives. They can also acquire the information necessary for positive decision-making. For instance, a person can learn good nutritional habits and then make the decision to lose weight if that will be more healthful. As anyone who has lost weight knows, there is a tremendous sense of accomplishment and power when one learns to control or modify their daily habits.

In addition, recent research supported by a U.S. Public Health Service Grant (No. HS 00874) found that prisoners were more likely than the general population to harbor serious, undetected health problems. Health education can help inform this population of the signs and symptoms of various disorders. This same research grant stated that if resources were allocated realistically according to needs, there would be extensive health education programs inside prisons (Newport, 1977).

Benefits to the residents are only one component of health education in prisons. Correctional health care staff are likely to benefit as well. By becoming involved with conducting health education classes, staff are able to share the knowledge they spend years acquiring and possibly to increase their sense of professionalism. Communication between staff and residents will likely be improved. The staff may additionally discover that their time is more appropriately allocated to health concerns when residents no longer need to use sick call as a way of getting some attention.

* Presented by: Susan Hunter, M.S., Department of Community Health Science Michigan State University, East Lansing, Michigan

There are also benefits to the correctional system itself that could potentially occur through a health education program. In the private sector, the Blue Cross Association found that health education offered the potential for both cost containment and improved quality of patient care (Fogarty, 1976). They found that health education might contribute to reduced costs by decreasing the unnecessary utilization of health care services and by encouraging use of the most appropriate locus of care for health problems. In addition, several studies have demonstrated that patient education enhanced the understanding of and compliance with the process of care, thus improving the quality of care. In fact, due to the anticipated benefits of health education, the Board of Governors for the Blue Cross Association in 1974 recommended that Blue Cross Plans encourage health care institutions to establish and operate such programs and to support them financially through existing payment mechanisms. While this writer is not aware of parallel studies in correctional health care, it seems reasonable to suspect there would be benefits to the correctional system itself through implementation of a health education program.

Given the recognized needs for anticipated benefits of health education in the correctional setting, the staff of the Correctional Health Care Program at Michigan State University selected health education as a topic for inclusion in their program. In conjunction with the Michigan Department of Corrections' Office of Health Care, a pilot health education program was established at the women's prison in Michigan. A systematic program development process was employed which addressed planning, development, implementation and evaluation activities.

The delivery model at Huron Valley Women's Facility was based on the concept of utilizing community resources in the prison setting. The county health department agreed to coordinate the prison health education program. They arranged for community health educators to conduct classes at the prison in their respective specialty areas. These subject areas were determined after consulting with the prison health care staff and the residents. The topics included in this initial program were: general physiology of women; personal health; self care (hair, skin, body odor, etc.); menstruation; contraception; self-breast exam; venereal disease; nutrition; and exercise. Classes were held once a week over a ten-week period and lasted approximately 1½ hours each. Upon the recommendation of both staff and residents, the classes were conducted in the study room of the participating housing unit. This allowed the regular unit housing staff to provide security at the sessions without necessitating any additional personnel. One member of the health care staff sat in on each class to help monitor the class and assure consistency between the clinic personnel and the community health educators.

The classes were designed to increase information gain and to help improve the women's feelings about themselves. To this end, several educational strategies were employed. Involvement by the participants in the class was essential so activities were designed to be fun, interesting, and informative (examples: learning and doing self-breast exams, participating in exercise classes etc.). Oppor-

tunity and encouragement to express personal feelings also contributed significantly to the learning experience. Weekly solicitation of feedback to help improve the classes and to test learning gave the women an additional sense of commitment to the program.

Several problems were encountered during the implementation phase of the program. For instance, although the community health educators were "briefed" by the prison health care staff prior to commencement of the program there was not enough preparation to allay the fears of persons not accustomed to the prison setting. Also, coordinating the activities of the residents so that there were few scheduling conflicts with school, work, visiting, etc., was oftentimes quite difficult.

Despite these problems, the evaluation confirmed that there were benefits to be gained in this facility from a health education program. The results showed a significant knowledge gain by the participants which was measured by their ability to apply the information they received to practical situations (example: they were asked to explain how a contraceptive method worked and how they and a partner could utilize it). They also were questioned about self-reported behavior and attitude changes. Their responses indicated that indeed some behaviors had been affected (weight loss, changed nutritional habits, increased exercise) and that their overall concept of themselves had improved. The women were eager for another class to commence and recommended a variety of additional topics which indicated the seriousness with which they regarded the class (for example: drug and alcohol abuse, foot care, loneliness, human sexuality, stress, suicide, child care, cancer, smoking, aging, and infection).

In this instance there were no evaluations conducted to assess whether there was any impact on a system-wide basis. Because there were only 20 participants (out of a prison population of 400), it is doubtful there would have been much large-scale change. However, the benefits to the residents were unmistakeable. Also, the health care staff who participated expressed awareness of an improved relationship with the residents. Given these reports of success, it certainly seems that there are many benefits to be gained by implementing a health education program in the correctional setting.

References

John E. Fogarty International Center for Advanced Study in the Health Sciences, Appendix K White paper; patient health education. In Preventive Medicine U.S.A. New York: Prodist, 1976.

John E. Fogarty International Center for Advanced Study in the Health Sciences. Part I Lifestyle and health status: the challenge to health education. In Preventive Medicine U.S.A. New York: Prodist, 1976.

Marshall, C.L. Consumer health education: the state of the art. In Toward an education health consumer: mass communications and quality in medical care. Washington, D.C.: U.S. Government Printing Office, 1975.

Newport, J. Review of health services in correctional facilities in the United States. Public Health Report, 1977, 92, 564-569.

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HEALTH PREVENTIVE MAINTENANCE MODELS *

On the bulletin board in my office hangs a quote by W.R. Spencer, President, of Spenco Medical Corporation, and I quote, "health care involves more than surgery, pills, and devices. When it comes to preventing tomorrow's health problems today, health education is our best buy in health care." This statement reflects, very well, my own personal inclination toward the subject of health education. Accordingly, my own professional feelings dictate that the single most pervasive health problem in this nation today is not the high cost of health care, the lack of sufficient number of primary care physicians, or even the availability or accessibility of health services in general; but rather the inability and/or unwillingness on the part of individuals to accept responsibility for their own health, poses the greatest threat to our ever being able to develop a workable and efficient national health policy.

Thus, in the spring of 1976, and in conjunction with the Minneapolis City Health Department and the Minnesota State Department of Health, I set out to translate my philosophy into a structured education program for the inmates within the Minnesota State Department of Corrections.

What were we out to change? The crux of the situation is this. Many inmates of correctional facilities have long histories of neglecting their health. At the same time, however, these people, at least verbally, show some concern about their bodily functions and anxiety about their health. For example, sixty percent of the inmates entering the federal correctional system have never received professional medical care, yet ninety-five percent of them do, in fact, require such attention. The prison experience then only exacerbates already existing tendencies. The existence of these problems is further substantiated by the many studies of the health behavior and practices of people with social, cultural and economic backgrounds similar to that of many inmates in correctional institutions.

The need for health education programs in correctional facilities has been documented by the American Bar Association, the American Medical Association, the American Public Health Association and the Law Enforcement Assistance Administration (LEAA) to name a few. No serious attempts had been made in the Minnesota state correctional system, however, to address this need in a systemwide, on-going manner. All previous health education programs, in this state have been the result of individual efforts by staff members at the institutions. Despite the success of some of these programs, none of them has ever been offered on a continuing basis. A similar experience can also be found in the local jails. The health education program which we are developing is, therefore, the first of it kind in Minnesota and possibly the nation.

Goals and Objectives

The long term goal of the Minnesota Department of Corrections is to establish an on-going preventive health education program for inmates at all

* Presented by: Howard L. Johnson, Health Care Administrator, Minnesota Department of Corrections, St. Paul, Minnesota

of the correctional facilities under its jurisdiction. The purpose of the program will be to address the health problems of inmates in terms of their neglect of personal health and the associated anxieties. This will be accomplished through increasing the inmates' levels of awareness and knowledge of what they, as individuals, can do to maintain their personal health and at the same time prevent illness. The more immediate and specific goal was the generation of an educational format and structure which could be adapted for use throughout the entire state system. The initial step in that direction involved the development and implementation of two demonstration projects - one at the Minnesota Correctional Institution for Women, Shakopee, and the other at the Juvenile State Training School, Red Wing.

Methodology for Achieving Goals and Objectives

The Conceptual Framework: The conceptual framework for the demonstration projects is the Health Activation approach to health education developed by Dr. Keith Sehnert, former Director of Continuing Health Education, Georgetown University, Washington, D.C., and now President of Health Activation System, Minneapolis. This is a consumer oriented approach that can be tailored to fit the specific needs and interests of different groups of people. The basic concept is that an activated patient is one whose clinical skills and understanding of his health are up-graded in order that he becomes an active participant in his own health care in contrast to the passive one traditionally assigned to him. In other words, you do not need to be a doctor to be concerned about your own health. The concept has three general goals:

1.) To teach patients how to use health care resources more effectively;

2.) To give them a better understanding of self-help and preventive medicine; and the effect of lifestyles on good health.

3.) To train them to do certain easy procedures and make better observations of clinical events in minor illnesses.

One of the salient features of the Health Activation approach that distinguishes it from other health education philosophies is that it attempts to involve people in the maintenance of their own health as active, participating members of the health care team. In this respect, the inherent facet of the concept is the involvement of course participants in all major phases of curriculum planning, development and implementation. Through this involvement course participants develop the confidence and ability to deal with their personal health needs in a knowledgeable manner. The subjects for a particular course, for instance, are developed through the efforts of a planning committee composed of course participants, community and health resources and the educational staff. The courses are furthermore conducted by facilitators rather than instructors per se. The atmosphere is one of sharing information and experiences among equal members of the group. The educational process is thus far different from those using traditional methods and strategies - an important consideration in working with inmate populations. Thus, a grant was submitted to and funded by LEAA. In July, 1978, I hired a health educator whose job it was to

carry out our plans for developing health education throughout the state's system.

Target Populations: As I indicated earlier, the initial phase of our plan called for the development of two demonstration projects - the women's facility at Shakopee and the juvenile facility at Red Wing.

The Minnesota Correctional Facility for Women is located approximately 20 miles southwest of the Twin Cities and houses adult women felons convicted by the courts and sentenced to more than one year. It has a capacity of 65 and last year's average population was 56. The average length of stay is 18 months. Sixty percent of the residents are chemically dependent, 75 percent are mothers and 52 percent are between the ages of 18 and 25.

The State Training School is located approximately 45 miles from the Twin Cities. It was recently converted from a co-educational juvenile facility to a school for delinquent boys whose ages range from 12 to 18. It has a capacity of 230 and last year's average was 120. The average length of stay is 4 months. In order to accomplish our objectives, we divided our activities into three phases - 1.) Curriculum Planning and Development; 2.) Program Implementation; and 3.) Evaluation.

Planning and Development: During the initial planning stage, contact was made with the institution administrators, program professionals, and educational staff to make a more detailed assessment of any Health Education present within the institution. If Health Education was present, the next choice was to continue present programs or combine them with The Activated Health Education Program. It was critical that local community health resources were notified of the program. Valuable advice was gathered from programs similar in scope. It was also vital that we establish interest on the part of community health resources in participating in our programming.

Needs Assessment: In order to establish interest, health priorities of inmates, and identify health problems of the institution: 1.) A health curriculum committee consisting of inmates was established; and 2.) An assessment of medical records with the assistance of medical and institution staff was completed. Promotion was achieved by a presentation of project goals and objectives directly to the population. Promotion among captive populations was quite easy since daily cottage meetings were held to discuss institutional, interpersonal and individual problems. It was at these meetings that program content, needs assessment, and Health Education in general were discussed. A pamphlet was drawn up by residents during the first session. For the program to work within any institution, health care providers, administration, and inmate support were needed. In this unique program it was the input of the inmates which was most central in determining course content. This gave some assurance that those going into the program would do so with an open mind and a willingness to learn. Perception of need by staff and medical records were reported to the Inmate Health Committee to help promote an objective representation of health needs.

To keep the program as relevant to "outside" consumer health programs as possible, an assessment of hospital and community programs in the metropolitan area was done by the health educator and presented to the curriculum

committee. This committee, along with feedback from the general population, developed main areas of interest and the areas were prioritized. Those topics which were found to have a low priority were excluded from the curriculum content. Before securing teaching resources and pre-test design the final curriculum was presented for approval to inmates and the administrative staff. Controversial subjects were discussed to eliminate misconceptions of program topics.

Health Resources: To save limited resources we attempted to use State and Department sources where possible. However, the use of outside health experts from local area programs and clinics was necessary. It appeared that the outside resources which were most effective were from local clinics interested in client centered Health Education. There also appeared to be a hunger among the inmate population for contact with the new resources. This led to a constant need to increase and update our resources file.

Implementation: Before sessions were started pre and post tests were designed to measure knowledge, attitude towards preventive health, intent to follow preventive health practices, and the practice of behavior which was affected by course content. Testing measures had to be kept simple and easy to understand since the educational levels of the populations varied between 5th grade level and that of post graduate.

At the women's facility, classes were held three times a week for eight weeks and each class lasted for 1½ hours. This eight week period comprised a session. There were three sessions spaced throughout the year. The same was the case at the juvenile facility except that classes met only twice weekly. Curriculum topics at the State Training School were found to be less varied than the one chosen by the women. This could possibly be attributed to the high turnover rate among the juveniles as compared to the much lower rate among the adult women.

Evaluation

Those women who participated in the original curriculum committee were in general still involved at the finish of the first year. In fact, many were anxious to start planning for the coming year. Again, the adolescent male population has a much higher turnover rate and there involvement cannot be measured much beyond a single session. Among the female population, self care and first aid type skills were perceived as the most valuable and consistently rated by the inmates themselves as high priority areas.

Minnesota Correctional Institution for Women (MCIW): An increase in knowledge did occur since a total of 16 inmates were certified in some type of self help skills. (Certification at MCIW means attendance at 20 out of 24 sessions and at STS attendance at 14 out of 16 sessions.) Attitude towards self care and preventive health behavior has increased among the majority of respondents (80%). Many of the women feel they are more able to cope with their day to day health problems and feel less dependent on health services. There is also a general perception that participants feel they are more activated and assertive patients. Attitude towards health

services did not change to a significant extent, it is the attitude of participants to self and their ability to cope that has changed.

Behavior change is the immediate goal of Health Education. Reduced morbidity and mortality is the ultimate goal. Self reported behavior change was noted by approximately 50% of participants in the areas of stress management, diet and exercise, first aid, dental health, and smoking cessation. Long term follow-up will, of course, be necessary to measure the consistency of this behavior.

State Training School - Red Wing: At least 75% of participants had increase in knowledge upon post testing. Measures which were most successful were short and to the point. In-depth measurement had a tendency to not hold the attention of this population. Eighty-five percent found new ways to take responsibility in their own health and 75% found ways to help others. It is interesting to note that the area of mental health and emotional health was found quite important among this population. The areas of sexuality, drugs, disease, birth control and dental health were also of great interest.

Differences exist in attitude towards health services at the two institutions. The more positive attitude which was noted among the male adolescents may be due to a lack of exposure to the medical care system and less experience in the manipulation of health care providers. The intent to use health services in a more effective manner and to follow preventative health behavior was stated by at least 75% of the participants. The most successful behavioral change came in the area of dental health. Gum disease was decreased among the target group by peer and professional education, and daily monitoring. This would suggest that the component of disease control should be applied to the daily living situation by institution staff. This will be attempted during the coming year - with the hope of attaining better evaluative tools by the end of the year.

Problems in Corrections

Inmates visiting health services for non-health reasons with the intent to manipulate for personal gain will most likely continue. In order to minimize this problem, however, we must continue to explore the phenomenon of patients' dependence on physicians while at the same time teaching independence.

A second year continuation grant was funded by LEAA, beginning July 1, 1979. This step two involves three basic activities:

1.) The continuation and refinement of the activated health programs already begun at Minnesota Correctional Facility for Women and the State Training School.

2.) The expansion to two additional institutions: a.) The Minnesota Home School - a 100 bed co-educational juvenile facility; b.) The State Reformatory for Men - a 600 bed maximum security facility of younger adult males; and

3.) The development of a guide which may be used for future Health Activation classes. This guide will be presented in an easy to follow format which will direct staff and inmates in continuation of the Health Activated approach.

The health care system of Corrections, as that of other health care systems, is overburdened. Resistance to change and a continued practice of unhealthful behavior is not limited to those in incarcerated settings but is a mirror image of society as a whole. For example, drug abuse, obesity, lack of exercise, smoking and indifference to safety measures are areas with which the whole nation has problems. Many people are aware of these problems but fail to take action or realize that they are ultimately responsible for their health or ill health. Additionally, statistics show that certain nations that have instituted a "free" national health program have had their health system stifled by a high rate of inappropriate patient use. In our own country the same experience has been noticed at the site of certain Health Maintenance Organizations. A factor which adds to our problem is our insistent reliance on the obsolete practice of depending on the physician for all health services. Of course, in corrections, the task often becomes that of structuring the environment in the most humane way possible in which health care services may be used more effectively.

It can, of course, be alleged that by educating an individual in such matters as health could cause more harm than good in the long run. And this is always a real danger.

"Studies undertaken in Britain and Denmark (although among non-incarcerated populations) conclude that 90% of self care behavior that occurred prior to seeking medical care was rational and relevant." Our attempt in Corrections should be to promote health learning at the same time hoping that information such as symptomology will not be used as a sham or con. We are thus faced with a dilemma, an area for future research.

IMPROVED COMMUNICATIONS ESSENTIAL TO GOOD HEALTH CARE *

The ability to communicate on a person to person basis and within an organizational framework is a critical issue to the smooth operation of any program. In order to develop an excellent team spirit, the ability to communicate on a person to person basis is an essential principle. If any organization possesses excellent communication skills, there will be good conflict resolution and confrontation will be minimized.

There is probably no other health care environment in the world that produces more opportunity for person confrontation and organizational conflict. Correctional health care programs are poorly understood by the general public. An effective health services program meets and addresses the communications problem with the various public that impinge on health care delivery.

Fellow Employees: Correctional custody employees do not understand the health services program and do not regard health services as priority within the correctional framework. All health care personnel must be willing to educate and explain our medical skills to fellow employees in primary health care services. An employee health care program is an important ingredient in this strategy.

State and Government Officials and Legislators: All health care employees must make a legitimate effort to understand the problems of legislators and other state officials. Government leadership is under great pressure by various vested interest groups, and health care personnel must learn to appreciate the pressures that are brought to bare upon legislators. The implementation strategy of communicating with legislators is by written communications that are brief and understandable. In most cases, state officials do not like to communicate orally or by telephone. Health services personnel have the responsibility of providing appropriate information without it being understood as a lobbying effort. Communication with this component of our general public is probably the most sensitive and requires the greatest skill.

General Public: Everyone will agree that the image of correctional medicine is poor in the eyes of the general public and the health care professionals. It is generally understood by the public that the third rate performer is the person who works full-time in a correctional medical status. All health care employees must tell the correctional story accurately and understandably, and in an authentic manner. The implementation strategy is to encourage all health care employees to speak in their community whenever feasible about the importance of the health care program within the custody environment. All health care employees share the responsibility of recruiting top quality skilled professionals to correctional medical positions.

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* Presented by Armond Start, M.D., Medical Director, Oklahoma Department of Corrections, Oklahoma City, Oklahoma

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IMPROVED COMMUNICATIONS - ESSENTIAL TO GOOD HEALTH CARE *

The purpose of this presentation is to briefly describe how the Medical and Health Care Services Branch has become an integral part of the Correctional Service of Canada. I will also attempt to illustrate how the organizational structure of the Correctional Services of Canada facilitates communication within the Medical and Health Care Services Branch, between this branch and other branches in the Correctional Service of Canada, and between this branch and services in the community. Permit me to begin this talk with a brief overview of the Correctional Service of Canada and the Medical and Health Care Services Branch.

Correctional Service of Canada (C.S.C.)

The Correctional Service of Canada, along with the Royal Canadian Mounted Police and the National Parole Board, report to the Federal Solicitor General. The correctional service is responsible for inmates sentenced to terms longer than two years. Inmates sentenced to less than two years are the responsibility of the provincial governments.

The Correctional Service of Canada is a combination of branches which are separately responsible for personnel, financial, inmate rehabilitation and health care services. Each branch exists at the national, regional and institutional levels. Each level has an administrator in charge of all the branches. The head of each branch is a member of a management team which, under the direction of the administrator, attempts to formulate and execute an integrated administrative program for that particular level.

The Correctional Service of Canada is responsible for the administration and operation of approximately fifty (50) penal institutions. The personnel in National Headquarters at Ottawa formulate and define policy. The five regional offices under this national administration interpret policy, and assist administrators and service personnel at the institutions with the implementation of policy. Administration in the institutions is responsible for the details of implementing policy. Although this model suggests centralized, hierarchical decision making, in fact extensive interaction among the personnel at Ottawa, the managers at the regional offices, and the institutional administrators takes place before a new policy is issued. In addition, much time and effort is expended by regional and institutional personnel in the discussion, modification and analysis of these policies before implementation actually occurs.

Medical and Health Care Services Branch

Prior to 1974, medical and health care services were administered by an Inmate Programs Branch. This branch was also responsible for psychologists, and a variety of inmate related services including inmate classification, work placement and socialization. Hospitals in the institutions

* Presented by: Phyllis Peters, R.N., B.S.N., Regional Nursing Officer, Regional Headquarters Prairies, Saskatoon Saskatchewan, Canada.

resembled first aid stations. They were primarily staffed by personnel with first aid qualifications and a few psychiatric nurses. The service provided by these hospitals was mainly restricted to band-aids and pills. Any situation requiring medical expertise was handled by the local community hospital.

In 1974, medical and health care services became a separate branch with an administrative structure similar to other branches in the Correctional Service of Canada. Shortly thereafter, national headquarters and regional offices were staffed with medical and nursing personnel.

It was decided to expand the scope of health care to include more comprehensive surgical, medical, nursing, dental, optical, psychiatric and support services. Consequently, the number of health care staff at each institution had to be increased. The new staff required registered nurse qualifications and existing staff were encouraged to apply for subsidized educational leave to obtain a registered nurse diploma. At present, two-thirds of the nursing employees in the institutional hospitals are registered nurses.

Although the scope of the service increased, institutional hospitals are primarily restricted to outpatient service with the capability of providing some inpatient care. Any patient requiring diagnostic and/or treatment services not available in the institution is referred to appropriate community health care resources. As you may expect, the transition from a first aid station to a small, self-contained health care centre is not yet complete and the retraining of hospital personnel has been a major undertaking.

Communication Within The Medical and Health Care Services Branch

The new organizational structure, administratively staffed by experienced medical and nursing professionals, provided a basic framework for a new communications network. Personnel in the institutional hospitals now had access to medical and nursing expertise, and the administrative personnel at the regional and national offices were willing to offer suggestions and assistance to improve the quality and quantity of service.

Fortunately, the Medical and Health Care Services Branch has been able to hire and/or contract a number of experienced physicians, nurses, dentists, optometrists and psychiatrists. These people have contributed significantly to the reasonably smooth transition from a first aid station to a comprehensive health care service. These health care professionals have also been active in the establishment of health care policy and procedures. They strive to achieve the goal of providing health care in a penitentiary equivalent to the health care available to the general public.

To achieve this goal of equivalent health care, a relatively informal communications structure has been found to be effective. Standards for health care and administrative procedures have been developed from suggestions submitted by institutional, regional and national health care staff. At the institution, ideas are freely exchanged at regular

meetings of doctors and nurses. Regionally, regular meetings are scheduled between the regional nurse and the senior nurses from the institutions. The regional doctor also has regular meetings with the institutional physicians. Periodically these regional meetings are arranged to occur simultaneously to accommodate a discussion of mutual concerns between the two groups. In addition, the nurses and doctors from regional offices also meet frequently with their national counterparts to share information, analyze recommendations, spawn new ideas, and review and amend existing policies. To ensure intimate contact between regional and institutional health care staff, the former visit the institutions a number of times each year. The health care staff in Ottawa may also visit the institutions as required.

Additionally, effective and organized communication is essential to the efficient operation of institutional, regional and national health care groups. At the institutional level, nurses communicate at the change of shift by a detailed verbal or tape recorded report. In one institution, an open file is kept for each member of the health care team so personal memoranda and/or significant details about health care and administrative procedures can be placed in the file folder for review and reference. At another institution, information relevant to the health care staff is filed in a communication drawer for reference and perusal. At regional and national headquarters the number of health care personnel is usually small and their offices are in close proximity; consequently, communication is frequent and most issues are discussed as they arise without the formal organization of a meeting.

Recently, the entire Medical and Health Care Services Branch has been expressing dissatisfaction with the defects in our existing medical information system. A program, initiated by institutional nurses and now involving the entire institutional, regional and national health care staff is under way to improve and standardize the health record. This would ensure the continuity of health care, especially when inmates are transferred from one institution to another.

Communication Between Institutional Health Care Staff and Inmates

As the Medical and Health Care Services Branch continues to develop, there is an increasing emphasis on the preventative aspects of care. Institutional nurses counsel inmates on health and social topics. Health care tips and brochures are distributed to inmates and/or posted on bulletin boards.

Newly admitted inmates receive a verbal orientation from a nurse, as well as written material explaining the type of health care service available in the institution and the procedure for obtaining this service. Inmate feedback about health care is encouraged and facilitated by periodic meetings between the senior nurse and the health representative of the Inmate Welfare Committee. These meetings provide opportunities to explain and interpret health care policies to the inmates, as well as gather inmate response to these policies.

Communication Between The Medical and Health Care Services Branch and Other Correctional Service of Canada Branches

Throughout the three levels of administration, health care staff

actively participate in the development of policies and procedures for the Correctional Service of Canada. At the institutional level, meetings of health care staff often include representatives from security and the Inmate Rehabilitation Branch. At these meetings observations about an inmate's physiological and/or psychological condition are shared. The discussion of these observations has often led to the evolution of remedial and preventative programs. The senior nurse represents health care services on a committee consisting of the warden and other branch managers. Institutional operating procedures are discussed in detail at these institutional management meetings. With representatives of all institutional branches present, policies can be formulated which minimize interference with the operation of other branches.

Similar exchanges of ideas exist in the regional and national administrative offices. Representatives from health care initiate and/or contribute to the development of the respective regional or national policies. This communication structure has encouraged cooperation between branches. Whenever an individual branch wishes to introduce a new policy, it must be accepted by all branches. Before acceptance is granted, the implications of this new policy on the programs of other branches is critically examined. The theme of this communication arrangement is to establish and implement an administrative program where branches cooperate in an effort to provide the best possible program for the inmate.

The Interaction Of The Medical and Health Care Services Branch With Community Services

I have indicated that community hospitals and specialists are utilized when the inmates' health needs cannot be met by the correctional health care program. These services are provided on a contractual or fee-for-service basis and personally arranged by health care staff at the institution or regional headquarters.

Unique and extensive communication exists between institutional health care personnal and the medical and nursing staff in community hospitals. As the health care in the institution became more comprehensive, the degree of cooperation between institutional and community health care services has changed. Since 1974, health care staff at a few institutions have adopted a program whereby the community health care professionals are informed in detail about the health care capabilities of the institutional hospital. Since the scope of institutional health care is still in an evolutionary stage, occasional meetings with community health care professionals are necessary to keep them aware of recent developments. Also, these meetings include an exchange of ideas about administrative procedures and advances in clinical techniques. Senior nurses from the institutions visit community hospitals, and staff from the community services occasionally visit the institutional hospital.

It is not economical for an institution to employ a full-time pharmacist, physiotherapist or radiology technician. Rather, these people are employed on a contract basis. Health care personnel in the institution are careful to inform these part-time professionals about the unique working conditions in a penal institution. The contracted personnel have been most cooperative, and have appreciated the administrative efforts

and the informative talks provided by the institutional staff. Concise, complete information transfer has improved the effectiveness and efficiency of these "part-time" services.

At all levels of the Medical and Health Care Services Branch, active communication with universities and community colleges is nurtured. These educational institutions have cooperated with the Correctional Service of Canada to provide correctional nurses with refresher courses, inservice sessions and bridging programs for those staff members who wish to obtain a registered nurse diploma. Faculty at university and community college schools of nursing would like to incorporate aspects of penitentiary health care in their respective baccalaureate and diploma programs. They are interested in allowing their students to utilize the institutional hospitals for training and research purposes. Incidently, the Director of Nursing at national headquarters is a part-time faculty member in the School of Nursing at the University of Ottawa.

Most nursing staff at the institutional level, and all nurses at the regional and national levels are members of their respective national and provincial professional associations. Correctional nurses frequently consult these associations about professional matters such as nursing responsibilities, and the legal implications of correctional nurses performing non-nursing duties. Also, the medical staff at the institutional, regional and national levels frequently interact with their colleagues in the provincial and national medical associations.

Summary

As indicated in this summary of the organizational structure and communication network, the Medical and Health Care Services Branch maintains informal channels of communication between all levels within the branch, cooperates with other branches in policy formulation for the Correctional Service of Canada, provides an active clinical and educational service to the inmates, and incorporates available community services in the development of a comprehensive and integrated correctional health care program. The Medical and Health Care Services Branch has become an integral part of the Correctional Service of Canada and the society it serves.

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LEGAL ISSUES IN CORRECTIONS *

Is there a right to health care? If so, who holds this right? The debate over National Health Insurance scarcely recognizes the startling fact that there already exists a well-defined group of Americans for whom access to medical treatment is not merely a right, but a constitutional right. They are prison inmates.

This right, which has been developing slowly over the past decade, applies to pretrial detainees as well as sentenced prisoners in both state or federal institutions. Is is grounded in the Eight Amendment's prohibition against cruel and unusual punishment. The relevant cases argue that putting someone in a prison where he or she cannot secure private medical care obligates the prison to provide that care; failure to do so is an excessive and disproportionate punishment not included in or permitted by the sentence.

Furthermore the courts have reasoned that providing "grossly inadequate" or "callously indifferent" or "deliberately indifferent" care is not adequate, since it offends contemporary concepts of fairness, decency, and dignity, those Eighth Amendment standards against which punishments must be measured for constitutional acceptability. Grossly inadequate medical care is therefore a "cruel and unusual" punishment and has been prohibited by law.

This constitutional right to medical care in prison grew over the last decade in the context of the general expansion of inmates' rights. Despite decades of reform efforts, jails and prisons for all practical purposes removed an individual from the rights, remedies, and scrutiny of civilized society. The federal courts supported and encouraged this seclusion by holding firmly to a "hands off" attitude toward problems of prison administration. Judges regularly commented that the problems of prisons in America were so complex and intractable, and more to the point, so ill-suited to resolution by judicial decree, that a policy of support for administrators' discretion, rule-making power, practices, procedures, and disciplinary punishments would be accepted as adequate and proper.

The civil rights and the antiwar movements of the late sixties and early seventies directly affected society's attitude toward prisoners, and prisoners' attitudes toward themselves. These movements, and the various politically militant organizations they spawned, created a new kind of prison population; prisoners became more aware both of their rights as minority members (which most were) and of their rights as inmates. Moreover, for the first time since the American Revolution, political activism brought large numbers of well-connected, middle-class people to jail. This atypical prison population contributed to a growing awareness of prison conditions, legislative committee reports, and exposes in the national media.

At the same time, publicly funded legal service projects created a new group of attorneys unfettered by fee-for-service client relation-

* Presented by:Nancy Dubler, L.L.B., Department of Social Medicine, Montefiore Hospital and Medical Center, Bronx, New York.

ships who were able to focus on the needs of those individuals and groups unable to afford lawyers. These attorneys formulated strategies and structured litigation that called upon prison administrators to justify previously unquestioned policies and to demonstrate that the "regulation or practice in question furthers an important or substantial government interest" (Procunier v. Martinez, 416 U.S. 396, 413 1973). The total privacy of administrators in shielding prison abuses came to an end because of these efforts.

The Legal Thicket: Litigation over adequate health care in prison has been one of the key areas in the prisoners' rights struggle. When an inmate audience was asked why such emphasis was placed on health care, one "lifer's" answer was, "Everything hurts more in prison." An inmate is particularly vulnerable because of the lack of connections with outside issues and events, fear of disease and illness, and uncertainties about the competency of medical authorities to respond appropriately to an illness.

It is undeniably important than an inmate has the right to receive uncensored mail, or engage in a private conversation with an attorney, or be protected by due process safeguards in displinary proceedings. These rights were secured in the early seventies by litigation. However, in most cases it is even more important that an injury be treated, or a chronic illness be managed effectively. Survival in prison depends on effective medical care; survival may also be supported by the ability to exercise the right to that care. On reflection, the right to medical care in prison is the inmate's single daily exercisable right.

Although there were earlier cases dealing with individual incidents of maltreatment, Newman v. Alabama (349 F. Supp. 278, 503 F. 2d 1320, 5th Cir. 1974), cert. denied 421 U.S. 948) was the landmark case that addressed the conditions of an entire state prison system. The court upheld allegations that "unsupervised prisoners without formal training regularly pull teeth, screen sick-call patients, dispense as well as administer medication, including dangerous drugs, give injections, take x-rays, suture, and perform minor surgery". Several dramatic instances of abuse were cited, including the case of a quadriplegic whose bedsores had become infested with maggots because his bandage had not been changed in the month before his death, and a patient, whose prescribed intravenous feeding had not been administered in three days before his death.

The court found the overall health care delivery system in Alabama prisons constitutionally impermissible. Nor were these conditions unique to Alabama. In 1975, in preparation for a grant from the Law Enforcement Assistance Association (LEAA) designed to improve health care in the nation's jails, the American Medical Association (AMA) surveyed thirty jails of varying sizes, both urban and rural, in six states. On June 1, 1977, the AMA published a "Summary of the Jail Pre-Profile", which stated in part that there were:

> In general, (a) dearth of available health care facilities and services . . . less than 50% of the surveyed jails provided a regular sick call, and only 17% held sick call on a daily basis. Twenty-seven percent of

> the jails had no emergency equipment at all. Six percent of the jails did not even have a first aid kit. Fewer than 33% of the jails had any written policies regarding the delivery of health care to inmates . . . only 10% of the jails were doing receiving screening or initial health assessment upon admission to detect communicable diseases and referring inmates to treatment who had acute illnesses.

What was glaringly at fault, in other words, was not simply instances of maltreatment but the entire setting of prison health care.

At the behest of legal services attorneys, the federal judiciary entered the situation in recognition of these shocking conditions and in pursuit of a legal standard that would improve conditions without overburdening the federal court system. The search for such a standard was governed by the necessity of restricting litigation so that the federal courts would become neither a forum for the litigation of malpractice claims (which are state issues), nor a supervisory body for general medical practice. This reluctance to intervene is perfectly in keeping with the general federal "reluctance to supplant existing state remedies and administrative fears of swamping limited federal judicial resources" (Eric Neisser, "Is There a Doctor in the Joint? The Search for Constitutional Standards for Prison Health Care," Virginia Law Review, 63 (No. 6) 1977, 926). However, this attitude was tempered by a recognition of the intractability of many of the horrors of prison life.

Most federal court decisions in the late sixties and early seventies declared that only a total "denial" of care would qualify as a constitutional claim; if "some" care or "any" care had been delivered, the court would not review the constitutional adequacy but would declare that a state court should adjudicate the case under relevant malpractice law. Quickly a series of phrases groping toward a constitutional standard of reasonable care modified this rule. Various circuits declared that "some"care, which was delivered with "callous indifference" or "callous disregard," or "deliberate indifference," amounted to a denial of care. This tortured search for a linguistic standard was made necessary by the grounding of the right to medical care in the Eighth Amendment, and by the need therefore to justify decisions by the jurisprudence of that amendment.

The facts of these early cases, however, even where some care had been given, compelled judicial action. In Martinez v. Mancusi (443 F. 2d. 921 2d Cir. 1970, cert. denied, 401 U.S. 983 1971) an Attica inmate, following corrective leg surgery, was treated by prison officials in disregard of the surgeon's order. The surgeon had ordered that he be kept flat on his back, be moved as little as possible, and be given pain medication as needed. Instead, the inmate claimed that correctional officials moved him from the hospital, required him to walk on the leg, denied him the prescribed medication, and forced him to stand. The court found that the allegations, if true, would amount to a violation of a constitutional right as they would "constitute a deliberate indifference to, and a defiance of, the express instructions of the operating surgeons." This case and others led

to the rule that the disregard of a doctor's order would satisfy the requirement of "deliberate indifference" and would therefore constitute a violation of the inmate's right to care. In Williams v Vincent, a prisoner was assaulted by another inmate who cut off a large portion of his right ear (508 F.2d. 541, 2d Cir. 1974). The complaint alledged that when the inmate asked that the ear be saved, the physician in charge "told him that he did not need his ear, threw it away, and sewed up the stump with ten stitches." Six operations were needed in order to repair the damage. In response to this outrageous cruelty, the court decided that a constitutional violation exists in medical care which "shocks the conscience, such as deliberate indifference . . . to a prisoner's request for essential medical treatment."

The Supreme Court finally entered the arena in 1976 with the case of Estelle v Gamble, 429 U.S. 97 (1976). The Court confirmed that there was indeed a constitutional right to care and supported the majority federal court language, which had decreed that individual cases should be measured against a standard of "deliberate indifference."

In his complaint, Gamble, a Texas inmate, alleged that he had been injured when a bale of cotton fell on him while he was unloading a truck. He stated that the resulting severe back pain was never adequately treated, despite numerous visits to and prescriptions from the medical staff and despite repeated exemptions from work. He also alleged that he had been punished for his inability to work, which was interpreted as refusal, and that he had been denied access to the medical staff. Gamble did not allege a denial of care; indeed he acknowledged being seen by medical personnel on seventeen separate occasions over a three-month period beginning with the day of the injury. Rather he based his complaint on lack of adequate diagnosis and treatment. The Court characterized the allegations as a classic example of a matter of judgment, which could at most be medical malpractice but not be the cruel and unusual punishment required for a constitutional violation.

However, in reviewing the history of the Eigth Amendment and the various circuit court decisions involving an inmate's right to medical care, the Court declared that "the deliberate indifference" to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain . . .proscribed by the Eighth Amendment." It then suggested three instances that would clearly demonstrate a constitutional violation: "indifference. . .manifested by prison doctors in their response to the prisoners' needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." While these three examples give some guidance, they unfortunately leave much of the standard shrouded in the vagueness of "delibertate indifference".

The Medical Thicket: Despite the fact that the standards, even in AMA-accreditation institutions, do not have the force of law, judges are recognizing them as describing a minimal acceptable level of care. This recognition is being reflected in increasingly specific judicial orders, couched not in vague language, but in concrete language directing practices. The best example of this development is Todaro v. Ward (431 F. Supp. 1129, 565 F.2d 48 2nd Cir. 1977).

Todaro was a class action suit, brought in 1977, challenging the health-care system at Bedford Hills, the New York State women's prison. The trial evidence described women with acute symptoms left untreated for weeks or months; nurses' examinations conducted through wire-mesh screens; physicians' examinations conducted with no privacy; medication dispensed without obtaining prior records and with no system for ongoing record keeping; patients in the infirmary locked in cells in acute illness with no help.

The judge in Todaro used individual instances to examine, critique, criticize, and eventually order specific reform in the health delivery system of the prison. He held the system constitutionally inadequate by finding that the administrative and record-keeping procedures were "grossly inadequate" resulting in the "denial of necessary medical care for substantial periods of time." This, he said, violated the constitutional norm.

The remedies ordered in this case were not individual but systemic and involved inspection and certification of the x-ray machine, creation of a communication system for the infirmary, establishment of a sick-call and physician referral system, establishment of procedures and a time frame for diagnostic testing and follow-up appointments, and creation of recordkeeping procedures. The order also required periodic audits by an independent agency. The order closely resembled the applicable standards developed by the private medical organizations.

By ordering that "screening shall be conducted by licensed medical personnel" and that there be "specific written protocols, defining evaluation procedures," the judge in Todaro replaced the vague thicket of a constitutional rubric with the sharp clarity of measurable procedure. As such Todaro is the first "quality of care" case; from now the right, and the remedy for violations of that right, will focus on assuring the adequacy of the delivery system - a measurable process which can be supervised by audit. Todaro mandates the specific creation of a medical system capable of delivering adequate care. The court in Todaro extended the right of individuals to care delivered without "deliberate indifference" to issues of health care delivery service and of quality care. This analysis, at least in the second circuit, has become the yardstick to measure the constitutional adequacy of care.

The Ethical Thicket: Despite the growth of institutional standards, conflicts remain, some framed by law and some dictated by the facts of prison existence. Health care delivered in a jail or prison is health care delivered in a medically alien setting. In delivering care to inmates, prison health care staff are responsible to their patients while simultaneously being constrained by the structure and routine of the institution; they must care and treat in a setting designed to separate, confine, and punish. They must accommodate the different and often conflicting norms that govern health care providers on the one hand and correctional staff on the other.

Inmates are not passive receptors in this process. They regularly press for access to this noncorrectional and therefore theoretically

more humane service. Therefore, not only is the health care staff expected to serve in regular ambulatory medical and specific referral tasks, but it must also provide an avenue for the expression of human feelings, a route to escape from boredom, a place for meeting friends in a more unsupervised setting, a way of escaping from the tyranny of work and programs that continue unrelentingly, and an ongoing possibility for the exercise of individual autonomy.

These needs create an overwhelming list of responsibilities for a health-care staff and an unrealistic set of expectations for an inmate population. Given budgetary realities and security limitations, both groups must be regularly disappointed; sufficient funds are lacking; isolated and oppressive surroundings make it difficult to attract capable and well-trained staff; patients are often difficult and potentially violent individuals.

Moreover, the law exacerbates certain dilemmas. An inmate who refuses initial screening procedures is segregated. To have it otherwise would be to permit inmates who may have a contagious disease to infect others; to have it so means that, at least in the inmate's view, the initial interaction with the medical care system is overshadowed by the presence of the correctional system. In many jurisdictions, an inmate who refuses treatment in a life-threatening situation may be forced to accept that treatment.

In many states, medical records including drug and alcohol histories are included in prison records and are fully accessible to prison authorities. In one system where this was not the case, the Department of Corrections required inmates to waive their right to confidentiality if they wished to participate in a much-desired program. The independent health service only gradually became aware that inmates en masse were signing releases for medical information, and it then challenged this coercion. Reports of psychiatric interviews regularly become part of the evidence in a parole hearing. Finally there is the ever-present threat than an altercation with a physician about an illness may result in disciplinary action. Little in most discussions about medical ethics provides guidance in these and similar circumstances.

Some of these conflicts can be resolved more easily when the health care delivery system is controlled by an independent health care provider. The experience of the Chesapeake Physicians Association in Baltimore, Maryland, and Montefiore Hospital and Medical Center at Rikers Island in New York City indicates that the rights of patients and the conflicts between patients and physicians are minimized but not negated by the independent authority of a health-care provider. The protection of medical records, the confidentiality of the doctor-patient relationship, the acceptance of the appropriateness of medical judgment are all enhanced by the independence of the service. But neither the courts nor the AMA have supported this solution.

Although there is a constitutional right to health care in prison and although the dimensions of the right have received private and judicial outline, the conflicts persist. In a separated and segregated system to designed to infantilize, humiliate, and punish, the need to

be cared for is overwhelming. The caregivers, primarily from medical care staff, must function within the boundaries set by the institution they serve. There is scant support for challenging the system on behalf of individual inmate patients; there is overwhelming pressure to adapt to the norms and mores of the correctional staff.

How can the various needs of these three groups be accommodated and what further role will the courts play in fashioning the solution? Private and judicial energies are now directed at the establishment of systems capable of delivering reasonably adequate care. On the whole that is positive. It must be remembered, however, that in prisons, individuals tend to be ignored, overlooked, or punished; generally adequate systems may not be permitted to shield specific violations.

Prison inmates have a constitutional right to medical care. However, in practice, that care is often characterized by gross disregard or abuse. Inmates cannot exercise this right without the aggressive support of medical staff who are aware of the conflicts and pressures inherent in a prison setting and who are able to confront these situations effectively.

The paradox is that the nonincarcerated population, without a legal guarantee of care, can generally secure adequate care while inmates guaranteed care are often given only hollow promises.

LEGAL ISSUES IN CORRECTIONS *

1. A Description of the Role of the U.S. Department of Justice in Institutional Reform Litigation

(a) The Special Litigation Section of the Civil Rights Division is responsible for affirmative trial level litigation on behalf of institutionalized persons, i.e., persons in prisons, jails, juvenile facilities, mental health and mental retardation facilities.

(b) The Special Litigation Section receives information concerning institutional problems regarding health care delivery services from many sources, i.e., citizen and/or inmate correspondence; press; advocate groups; Courts; and members of the Bar.

(c) Before becoming involved in litigation, an investigation is undertaken, documents collected and reviewed, and knowledgeable persons interviewed. Based upon the investigation, and after appropriate research of applicable law, review of professionally accepted standards, and consultations with experts, if necessary, a decision is then made as to whether to initiate action. In short, the U.S. Department of Justice becomes involved in litigation involving institutional health care delivery systems only after an adequate data based to justify such action has been established.

(d) The U.S. Department of Justice participates in cases as a plaintiff, plantiff-intervenor, and as litigating amicus curiae.

2. A Brief Review of Legal and Underpinning of Prison and Jail Health Services Litigation

(a) The whole area of prison litigation is emergent and evolving. Until 10 years ago, the Courts for the most part adopted a "hands-off" approach to such litigation in deference to the presumed expertise of prison administrators. However, as cases presenting egregious abuses of prisoners began to flow into the Courts in every increasing numbers, the Courts began to address the nature and scope of Constitutional and statutory protections secured to inmates.

(b) In the medical area specifically, the United States Supreme Court in Estelle v. Gamble, 429 U.S. 97, 103-104 (1976) has recognized:

> the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce "torture or a lingering death", ... the evils of most immediate concern to the drafters of the (Eighth) Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose... The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common law view that "it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.
>
> We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the necessary and wanton infliction of pain," Gregg v. Georgia supra, at 182-183, 49 L. Ed 2nd 859, 96S. Ct. 2902 (joint opinion), prescribed by the Eighth Amendment. (citations and footnotes omitted)

The Court went on to say that

> in order to state a cognizable claim, a prisoner must allege acts of omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend "evolving standards of decency" in violation of the Eighth Amendment.
>
> Id. at 106

3. The Evidentiary Underpinning of Prison and Jail Health Services Litigation

(a) In determining whether a viable claim of deprivation of Constitutional or statutory rights to minimally adequate health services has been established, Courts look at a variety of evidentiary sources, a few of which follow:

(1) adequacy for the population served of physical facilities and equipment;

(2) the adequacy for the population served of medical personnel;

(3) the adequacy of medical records and of safeguards for the protection of the confidential information included therein;

(4) the adequacy of the formulary and practice and procedures for the safekeeping of medications;

(5) the adequacy of training of health care providers for the functions which they discharge;

(6) the nature of any tasks assigned to inmates and whether they can adequately or properly perform them;

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* Summary Presentation by: Lynn Walker, J.D., Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, Washington, D.C.

(7) the adequacy of sick call procedures and practices;

(8) the adequacy of specialized services for special need patients such as the non-ambulatory, the elderly, diabetics, the retarded, epileptics, etc.;

(9) the adequacy of protocols and procedures;

(10) specific instances of problems experienced by inmates in obtaining minimally adequate health care services.

(11) professionally accepted standards, such as those published by APHA, AMA, ACA, JCAH, etc., for health care services and

(12) expert testimony concerning deficiencies in the system,

In summary, legal challenges to the minimal adequacy of health care delivery systems usually are presented in a "totality of circumstances" context, and, there significant deficiencies are established, the Courts have not hesitated to mandate sweeping reforms and improvements in health care services afforded to the imprisoned.

4. Conclusion

The object of litigation concerning health care services is to assure that health care providers are given minimally adequate resources to discharge their duties in accordance with professional standards and thereby serve the needs of the imprisoned adequately. The object of such litigation is not to impugn the integrity of institutional health care providers, nor to question their commitment to adequately servicing the needs of their clients. Quite to the contrary, the United States Department of Justice recognizes that institutional health care providers are frequently overworked, underpaid, and afforded inadequate resources to do quality work. In this sense, then, those who prosecute health care reform litigation in institutions are really the allies of the health care providers, and it is hoped that our goals in prosecuting such cases will be viewed in that light.

LEGAL ISSUES IN CORRECTIONS *

The following summarizes three issues in Correctional Health Care: Confidence, Confidentiality and Autonomy.

I. Importance of inmate confidence in medical personnel.

A. Patient care hinges on the amount of candor that exists in patient communications to physicians.

B. Patients, particularly the less medically-sophisticated who often comprise the bulk of inmate population, cannot be expected to know which circumstances and habits are pertinent to their treatment.

C. Patients must therefore feel free to disclose all to a physician without fear of reprisals or jeopardizing of their legal status.

Example: Michigan v. Bland, 218 N.W. 2d 56 (Mich. 1974) arrested on drug charge. Needed medical care for withdrawal. Court ruled: inmate could not be required to sacrifice one constitutional right (self-incrimination) for another (adequate medical care).

II. Confidentiality of Medical Records.

A. Not an absolute right.

1. Required reporting/disclosures by law.
Example: venereal disease, gunshot wounds, child abuse.

2. Interest of public health.
Example: tuberculosis

3. Welfare of the patient.
Example: diet, physical limitations due to heart or back ailments.

B. General Rule: Do not disclose without patient's consent. This means records must be kept separate from confinement record.

C. Where corrections personnel must have access to records, duty of confidentiality is imposed on such personnel as well.

III. Autonomy of Medical Service.

A. Involvement of medical personnel in disciplinary, correctional or security activities creates perception of them as part of corrections process, destroys trust.

* Summary of presentation by: William P. Isele, M.A., J.D., Health Law Counsel Amer

B. Strip Searches.

1. Supreme Court ruled reasonable, without probable cause.

   Purposes: deterrent, discovery

2. No need of medical personnel for visual search. Guards may reasonably conduct.

C. Body cavity searches.

1. Supreme Court has not ruled.

   In lower court cases, medical personnel have performed them.

2. Dilemma.

   a. Possible health danger if conducted by untrained personnel.

   b. Destruction of essential medical confidence if medical staff conducts.

3. May be resolved by training corrections personnel in proper procedure.

D. Forced medication.

1. For control purposes.

   Recent cases support rights of patients.

2. For discovery of contraband.

   Unreasonable and improper use of medical resources.

Overall guiding principle is that enunciated by the World Medical Association in 1975:

> a doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The Doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive - whether personal, collective or political - shall prevail against this higher purpose. (Declaration of Tokyo, Principle 4, October, 1975)

LONG RANGE HEALTH SYSTEMS PLANNING*

Serious problems in delivering health services to prisoners continue despite an increase in professional interest and concern in the 1970's. In general, four problem areas need attention. They are:

1. Planning of health services
2. Administration and provision of services
3. Data storage and retrieval
4. Quality assurance

Because solutions may require expenditures of additional millions of dollars in State systems, serious attention must be given to quantitative health planning in each area.

In this paper we describe the major issues in health planning for state planning systems.

1. Planning Health Services

As Taylor has observed,[1] the first step in health planning is to plan the planning process. Effective planning requires that the planning process have the support of the cabinet level official responsible for state prison systems. It also requires that other policy makers, particularly attorneys general, senior health department officials and state legislators, be informed and in some cases actively involved. Although it is rare to obtain a prior commitment to expend a significant amount of public funds on new health programs in state prison systems, it is nonetheless imperative to obtain a commitment for planning and implementation from as high a level as possible before investing in technical expertise.

It is also important to involve those in the planning process who will be responsible for implementation. These persons or agencies will vary from state to state, and even within states. Nonetheless, once commitment to planning has been obtained from the political policy makers, the technical expertise should be sought from health systems agencies, local health departments, state and local medical societies, and private practitioners.

For example, in Maryland, differences among the geographical regions with respect to patterns of medical practice, will determine the nature of viable health services programs at prisons and in those regions. In Baltimore city there are large group practices at University Hospital, whereas in Hagerstown, where we have two large correctional institutions, there are only small group practices.

2. Administration and Provision of Services

Planning for mental health services and for primary health services

* Presented by: Gordon Kamka, Secretary; Maryland Department of Public Safety and Correctional Services, Towson, Maryland

requires data not often available in prison systems. Once a commitment has been obtained from policy makers, the planning group must then define as precisely as possible, the nature of the problems of the population for which there are planning services.

In mental health services in particular, there is a serious lack of data. In general, patients' demands for services arise mainly from three groups of people.

a. Persons with psychoses and attempted or threatened suicide. If these persons were in a free living population, they would be considered for in-patient hospitalization, either voluntary or involuntary.

b. Persons with neurosis and/or personality disorders. The number of persons in this category is probably large, and the demand for services should be estimated. It is in this group of persons that the psychologists may have the greatest impact. In a free living population, these persons would receive intensive group or individual therapy on an outpatient basis, or might be hospitalized for intensive therapy of short duration.

c. Persons with mental retardation. These persons may require special programs or living arrangements, but there can be no rational planning without an estimate of the number of persons in the various categories of mental retardation.

The primary health services will include not only the sick call services, but also a referral system to more intensive or more specialized modes of intervention. It may be possible to estimate utilization with existing data, but unless the primary care services are comparable to those in community health centers, one may expect to find excessive numbers of referrals to specialists and hospitals. Engebretsen and Olson [2] have surveyed the types of health care problems encountered in a jail population. This data, as well as our own unpublished data, suggests that non-physician practitioners physician assistants, nurse practitioners - may be appropriately utilized in jail settings. There have not been comparable studies in prison populations, and we can only infer that mid-level practitioners will be the appropriate persons for this setting as well.

Another issue in planning primary health services is that available standards, those of the American Medical Association as well as the standards of the American Public Health Association, do not address a critical factor for health planning, the duration of the primary care encounter. The average duration of visit for all visits was 15.4 minutes in the National Ambulatory Medical Care Survey.[3] About 47% of visits had a duration of 10 minutes or less. For black patients, the average duration of visit was 13 minutes, and 47% of patients had a duration

of visit of 10 minutes or less.[4] If this is felt to be an appropriate duration of encounter for a primary care visit by a prisoner, then staffing patterns must permit sufficient practitioners to enable this duration of visit.

3. Data Storage and Retrieval

The need for data storage and retrieval is self evident. Froom, et al.,[5] have described a data system for New York State correctional facilities which provided summary statistics on daily encounters at each of three facilities in the system. However, the decision to employ automated data systems should be made only after thoughtful analysis of the administrative and clinical needs for data.[6]

Of equal or greater importance is a uniform health records system for all institutions so that the transfer of records and inmates can be made with minimum disruption in the data storage and retrieval functions. It is important to note that the need for health data may transcend the closed prison system, and extend to local State Health Departments, particularly in the area of tuberculosis control. The prison system must notify health departments to continue the medication prophylaxis for released inmates.

4. Quality Assurance

During the past decade much effort and thought has been focused on the problem of quality assurance. Two major and different approaches may have relevance to quality assurance in prison health services.

The Professional Standards Review Organization (PSRO) program has at least three major goals, summarized by Goran:[7]

1. The elimination of inappropriate and unnecessary health services (freeing scarce resources to alleviate unmet needs);

2. The improvement in the quality of health services (making quality services more uniformly available as well as raising the overall level of performance);

3. Providing assistance in the identification, and where possible, correction of the small minority of practitioners and providers whose practices are harmful to the health and safety of patients.

Although the PSRO has devoted most of its resources toward reducing the variation in hospital use and bring hospital rates closer to those levels being achieved in the more efficient prepaid and fee for service sectors, it has developed methodologies and legitimacy among the professions for quality assurance. We should invite and challenge the PSRO to assist us in quality assurance in prison health systems.

Williamson[8] has proposed basing quality assurance on outcomes of care. He has criticized the medical audit approach because of "its narrow focus on problems that can be identified and measured from patient chart or claims form information, thus requiring the use of methods suited to the data, to the neglect of methods that might have greater potential impact in terms of improving patient health." He suggested that "important variables will often have to be measured by means of special encounter forms, utilizing perspective assessment designs adapted specifically to the talents and resources of the quality assurance teams as well as to the particular characteristics of the topic."

Quality assurance should not be seen as an isolated function. As data accumulates on programs which are evaluated with sound quality assurance methodology, the standards on which such health programs were based may themselves be evaluated and revised. Additionally, professionally competent quality assurance programs may be used to document the adequacy of health services programs to federal courts as well as to legislatures and the public who seek increasingly to know whether public funds are being appropriately spent.

In summary, the involvement of federal courts in the constitutional issue of prisoners' assess to health services has presented the legislative and executive branches of state governments with the challenge to respond to prisoners health needs. These policy makers, in turn, will look to the health profession for the planning of cost effective programs. Such planning must be characterized by awareness of the political realities of State and local jurisdictions, by quantitive assessment of needs, and by documentation of the effectiveness of new programs.

Literature Cited

[1] C. Taylor, Stages of the Planning Process, In Reinke, W.A. (ed), Health Planning: Qualitative Aspects and Quantitative Technics. Baltimore, Maryland: The John Hopkins University Department of International Health, 1972.

[2] B. Engebretsen, and J. Olson, Primary Care in a penal institution: A Study of health care problems encountered, Med. Care 13: 775-781, 1975.

[3] T. Ezzati, and T. McLemore, 1977 Summary: National Ambulatory Medical Care Survey, Advance Data 48 U.S. Public Health Service, 1979.

[4] H. Koch, and R. Gagnon, Office Visits by Black Patients, National Ambulatory Medical Care Survey: United States, 1975-76, Advance Data 50, U.S. Public Health Service, 1979.

Literature Cited (continued)

[5] J. Froom, B. Howe, D. Mangone, C. Swearingen, and P. Warren, A health data system for New York State correctional facilities, Am. J. Pub. Health 67: 250-251, 1977.

[6] J. Miller, Information systems planning in health care organizations, J. Ambulatory Care Management 1: 11-27, 1978.

[7] M. Goran, The Evolution of the PSRO Hospital Review System, Med. Care 17: Suppl., 1979.

[8] J. Williamson, Assessing and Improving Health Care Outcomes: The Health Accounting Approach to Quality Assurance, Cambridge, Massachusetts: Ballinger Publishing Company, 1978.

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LONG RANGE HEALTH SYSTEMS PLANNING *

Long neglected by public health and medical care organizations, issues in the delivery of jail and prison health services have only recently begun to be explored in established medical publications. Two important areas that have been explored are epidemiologic characteristics of jail and prison populations (1,2) and the innovative participation of physician extenders and other medical technical personnel in provision of correctional health services (3,4, and 5). Current knowledge of both epidemiologic and personnel factors will be utilized in the calculation of primary care physician needs in correctional facilities.

METHODOLOGY

As in other institutional health systems, physician and other staffing requirements in correctional facilities should be predictable on the basis of health care needs of the population to be served. There has been little previous experience with prospective methods of determining the physician and physician extender coverage necessary to provide adequate health care needs in correctional institutions. Such determinations must take into account all program components requiring primary physician involvement, epidemiologic analysis of any special health care needs of incarcerated populations, and particular administrative and institutional factors affecting health care delivery in the jail or prison setting.

Mandel had developed a useful model for determining the need and available supply of primary care physicians in such health care settings as private physicians' offices, neighborhood health centers, and hospital outpatient departments (6). This method may be summarized in the following six steps:

1. "Define the population-at-risk for primary ambulatory care physician services.

2. Calculate the expected number of primary ambulatory care physician visits (use rate) for each population group to each type of primary ambulatory care physician.

3. Calculate the expected number of visits (productivity) each type of primary care physician could serve in a fully utilized practice.

4. Derive the full-time equivalent number of primary care physicians needed to serve the expected number of visits for the population-at-risk for each type of primary ambulatory care.

5. Identify the number, age and type of primary care specialty of currently licensed physicians whose practices are located in the towns in which the populations-at-risk reside.

* Presented by: Lambert King, M.D., Ph.D., Cook County Hospital, Assistant Professor, Northwestern University Medical School, Chicago, Illinois.

6. Calculate the difference between number and type of primary care physicians needed to serve the expected number of visits for the population-at-risk (step 4) and the number and type of primary care physicians available to meet such need (step 5)".

Steps 1 - 4 may be adapted to the purpose at hand, namely the determination of the level of primary physician coverage necessary to provide adequate health care in correctional institutions. The question of physician availability will not be directly analyzed in this paper since there is already extensive documentation of the gap between health needs and physician availability in the majority of correctional institutions (7,8).

Before deriving a formula for the calculation of primary physician staffing in correctional health programs, a number of specific program components must be analyzed. Each component will be described and an appropriate measure assigned to be utilized in the overall calculation of primary care physician coverage.

Entrance Examinations: In a recent analysis of jail and prison health services, the General Accounting Office has emphasized the inadequacy of physical examinations provided upon entrance to many jails and prisons. In a population that has generally received only sporadic or acute health care in the past, there is an expected high frequency of previously undetected health problems. A careful medical history, physical examination, and standard laboratory evaluations are an essential prerequisite to the establishment of an accurate health data base and the formulation of an adequate treatment plan. A proper entrance examination is thus the cornerstone of any adequate health care program in a correctional institution.

Unfortunately, entrance examinations are often the most neglected aspect of prison and jail health services. The responsibility for obtaining medical histories may be limited to the inmate alone by use of a self-administered questionnaire or may be delegated to health or custodial personnel with no training or skills in taking medical histories. Similarly, physical examinations are often performed by personnel without documented skills in physical diagnosis. If there is any physician involvement in such examinations, it is often quite cursory and poorly suited to the establishment of an accurate data base. The crucial area of tuberculosis and venereal disease screening is often imcomplete and may be delegated solely to nursing staff or medical technicians without physician supervision or epidemiologic control.

For the purpose of the present analysis, it will be assumed that the responsibility for entrance medical evaluation resides in the particular correctional institution being considered. In some state prison systems, entrance examinations may be performed at a central reception facility and the results forwarded to other prisons in the state upon prisoner assignment and transfer. In many states, the inadequacies that have been described above pertain also to reception center examinations and the responsibility for a more comprehensive evaluation still

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devolves upon the particular prisons in the state. Therefore, the direction of an adequate entrance examination program will be included in calculation of primary physician needs in correctional institutions.

Since jails have a higher turnover rate and shorter lengths of stay than prisons, an argument may be made that jail health programs require less extensive entrance medical evaluations than prisons. Such an argument is probably fallacious. The higher turnover rate in the jail setting increases the necessity for accurate identification of infectious disease since the number of potentially contagious persons entering is greatly increased. Jail populations also include a larger number of persons with immediate sequelae of trauma than do prison populations. From both a public health and medical care perspective, the performance of careful entrance examinations in jails (particularly large urban detention centers) remains an essential element of an adequate health care program. Physician involvement may be reduced if the entrance examinations in a jail are limited primarily to detection of infectious disease or acute illness.

Table 1 (see appendix) summarized the essential time and staffing elements for entrance medical examinations in correctional institutions. It will be noted that most of the activities involved in entrance examinations can be performed by properly trained physician extenders such as certified physician assistants or nurse practitioners. Based upon the time elements of Table 1, it will be noted that approximately 1.2 hours of physician or physician extender involvement will be needed for each entrance medical examination. Assuming a well organized and qualified physician extender staff, the amount of primary physician involvement for each entrance examination will be calculated in the overall system formula as 0.5 hours. Thirty minutes of physician input is not an excessive time allocation for the completion of an accurate data base, review of any abnormal physical or laboratory findings, and formulation of any further diagnostic or therapeutic plans that may be indicated. In a jail setting this figure may be reduced to 0.25 hours per entrance examination if emphasis is limited primarily to detection of infectious disease or acute medical problems. In a large urban jail with a daily admission rate of more than 100 persons daily, this physician time allocation of 0.25 hours per entrance examination might be expended largely in the direction and supervision of the physician extender personnel necessary to perform such numerous examinations. The figures of 0.5 hours per examination for jails include physician time necessary for direction of tuberculosis and venereal disease programs, both of which are of major magnitude in correctional institutions.

Sick Call Services: Based upon national studies, the expected physician visit rates for males of age comparable to a prison population would be 3.2 visits annually (9). Utilization is somewhat higher in females of corresponding age groups. Thus if these utilization rates were applied to a prison or jail population, one would expect a minimum of 3.2 visits per year to institutional sick call in order to see a primary care physician. In a prison with 2,000 inmates, for example, one would expect at least 6,400 physician visits annually. Based upon available

physician productivity figures, 6,400 visits annually would be somewhat more than the average number of patient visits of 5,414 managed by the general practitioner/internist category (10). Therefore, utilization of physician sick call services alone in a correctional institution with 2,000 persons will require at least 1.2 full-time primary physician equivalents. Such a calculation assumes that the level of medical need in a correctional institution is approximately equivalent to age adjusted national averages.

It is well known that sick call utilization rates in jails and prisons are significantly higher than physician utilization in outside communities. In many institutions, sick call services may be requested by five percent or more of the population daily (11,12). High sick call utilization rates may be associated with grossly inadequate health care quality; the physician providing sick call services may do little more than elicit a brief chief complaint and write a prescription without benefit of further medical history, physical examination, or laboratory evaluation. In order for physician sick call services in correctional institutions to be of acceptable quality, there must be adequate physician extender, nursing, or other personnel available to appropriately manage the large volume of minor complaints which account for the almost three-fold difference between national physician utilization rates and sick call utilization within correctional institutions.

Factors which at least partially account for high sick call utilization rates in correctional institutions are summarized in Table 2. (see appendix) Although some additional primary physician involvement beyond national averages is undoubtedly necessary in planning physician coverage, two logical assumptions will be made to deal with high sick call utilization. First, it will be assumed that a well functioning and properly trained ancillary health staff is available to handle much of the "excess" sick call load. Secondly, since there is some expected overlap between physician involvement in other program components (e.g., entrance exams, chronic care clinics, and emergencies) and baseline primary physician utilization according to national rates, part of the additional physician involvement necessary for high sick call utilization will be balanced out by the overlap from other program components. In conclusion, a figure of 1.2 full-time primary physician equivalents will be minimally necessary for the provision of sick call services to a population of 2,000 persons in a correctional institution. This figure can be adjusted proportionately for institutions of different size.

Chronic Disease Prevalence and Programs: There is convincing epidemiologic evidence that certain illnesses are more prevalent among residents of correctional institutions than within the general population. Such health problems include severe dental and gingival disease, tuberculosis, seizure disorders, hypertension, venereal disease, sequelae of trauma, chronic liver disease and other sequelae of drug and alcohol dependence (13, 14, 15 and 16). Other chronic diseases such as bronchial asthma and arteriosclerotic heart disease, although not increased in prevalence among prisoners, require special medical attention in the often stressful confines of correctional institutions. Special primary physician attention (in addition to psychiatric services) must also be provided to the significant percentages of prisoners who may be under treatment for psychosis at any given time (17). In addition to primary physician services

required on general sick call, additional primary physician involvement must also be provided for chronic care clinics and programs.

For example, the age adjusted rate of epilepsy in an outside population is 0.6% compared with approximately 1.6% in a jail or prison population. Thus in a prison population of 2,000, there would be an excess of twenty epileptic patients compared with the outside community. These additional twenty patients would be expected to generate legitimate need for at least 80 additional physician visits per year, each visit requiring about 0.25 hours. Thus, in the course of the year, at least 20 hours of primary physician coverage would be required.

The additional need for primary physician involvement in tuberculosis and venereal disease detection, treatment and control was calculated previously within the entrance examination components. Other special clinics and programs that are required in an adequate correctional health care system include seizure disorders, asthma and chronic lung disease, hypertension and heart disease, chronic liver disease, and monitoring (in collaboration with psychiatric staff) of patients on antipsychotic medications. Integrating these special program needs together (assuming that 10% of the total population is affected and that 2% of the total population require 0.25 hours of special physician services weekly), it is estimated that at least 0.25 additional full-time primary care physician equivalents is required to provide chronic disease clinic services for an institution with a population of 2,000 persons. An additional 0.10 full-time equivalents must be allocated for patients requiring infirmary care or convalescent care after return from outside hospitals. Thus, 0.35 full-time equivalents will be required for the overall chronic disease and special programs component.

Administration, Supervision, and In-Service Training: Unlike a private physician's office or a small community health center, the health service programs of major correctional institutions represent highly complex management systems - systems that directly impact on the collective and individual health of large numbers of both inmates and correctional staff. Primary care physicians working in such systems must deal not only with individual medical problems but also with supervision and in-service training of significant numbers of ancillary staff, monitoring and resolution of public and environmental health problems, and medical audit and quality assurance procedures. Although some correctional health programs have medical directors responsible for the performance of a number of these functions, primary care physicians must still participate actively in these processes. Such participation is especially necessary in the supervision of physician extender and nursing staff who may be delegated responsibility for managing the numerous minor health problems presenting at sick call or for the cell house screening. Delegation of these responsibilities by a primary care physician requires a considerable time expenditure for the preparation and review of protocols, in-service education, and periodic audit for maintenance of adequate standards.

Assuming that a medical director is available to handle the majority of administrative responsibilities in a major prison or jail health system, it is estimated that an increment of 0.3 full-time primary physician equivalents must be available in order to meet the foregoing special administrative responsibilities adequately in an institution with 2,000 residents. This increment also includes any additional time allocations that may be necessary for responding to emergency calls from ancillary staff who provide institutional health service coverage during nights and on week-ends.

Inefficiency and Vacancy Factors: Physicians and other health care staff working in correctional institutions are familiar with the decreased efficiency in the delivery of health care which results from special institutional factors. For example, the physician often must spend considerable extra time passing through multiple locked security check points in traversing the institution. Delays are often involved in moving inmate patients from one part of the institution to another. In comparison with more educated populations, the elicitation of an accurate medical history may take longer in the prison or jail setting. Explanation of special procedures or treatments may be difficult with patients who have received little health education in the past.

As a total institution, the prison or jail medical service is responsible for acute medical services at all times, day and night, throughout the year. The constant physician coverage and back-up that is required, plus the foregoing inefficiency factors, necessitate that allowances be made in calculation of the primary care physician needs. This allowance will be called the institutional factor and will be estimated as a ratio of 1.1/1 compared with previously calculated factors.

SUMMARY OF RESULTS

Table 3 (see appendix) summarizes the method that has been used to calculate primary care physician services necessary to provide adequate health care in correctional institutions. Table 4 (see appendix) utilizes the specific measurements derived for each program component in order to calculate the number of primary physician full-time equivalents required in a prison with 2,000 inmates and a turnover rate of 600 new admissions per year. In this setting, 2.2 FTE's would be required. Thus, the ratio of 1000:1 or greater internees/primary care physician currently used to designate a correctional institution as medically underserved conforms well to the minimal primary care physician needs derived from the program component formula. The current Federal regulations, however, may somewhat overestimate primary care physician needs if the ratio of internees/primary care physician remains defined simply as the number of new admissions per year rather than average daily population. The program component formula that has been developed provides for consideration of both turnover rates and average daily population.

The program component formula contains three major variables:

1) time alloted for physician involvement in entrance exams for jails versus prisons;

2) annual population turnover rate; and

3) average daily institutional population.

If the premises of the formula are met, the number of FTE's of primary care physician required can be approximated based upon actual needs rather than an arbitrary estimate. This method should prove useful in assessing the degree of additional primary care physician services needed in many correctional institutions.

APPENDIX 1

TABLE 1

STAFFING AND TIME ELEMENTS
FOR
ENTRANCE MEDICAL EXAMINATIONS

PHYSICIAN OR PHYSICIAN EXTENDER ACTIVITIES	EXCLUSIVE PHYSICIAN ACTIVITIES	ESTIMATED TIME REQUIRED[1]
MEDICAL HISTORY[2]		0.3 Hrs.
PHYSICAL EXAMINATION[3]		0.3 Hrs. (males) 0.4 Hrs. (females)
ADMINISTRATION, READING AND RECORDING OF TUBERCULIN TESTS		0.1 Hrs.
OBTAIN AND LABEL INITIAL BLOOD AND URINE SPECIMENS INCLUDING VDRL		0.1 Hrs.
	REVIEW OF DATA BASE, FORMULATION OF INITIAL TREATMENT, OR FURTHER DIAGNOSTIC PLANS	0.2 Hrs.
PATIENT EDUCATION		0.2 Hrs.
	TOTAL	1.2 Hrs. (males) 1.3 Hrs. (females)

[1] assuming 100% efficiency, not including mental and dental health evaluation.

[2] includes completion of release forms to send for previous medical records.

[3] includes dictation or recording of results.

APPENDIX 2

TABLE 2

FACTORS RESULTING IN HIGH SICK CALL RATES IN CORRECTIONAL INSTITUTIONS

Increased prevalence of pre-existing disorders.

Lack of direct availability of non-prescription items.

Increased somatic awareness and complaints resulting from institutional stress levels and/or lack of meaningful activity programs.

Use of sick call for recreational/social/illicit functions.

Musculoskeletal complaints related to variable environmental conditions.

Lack of effective health education.

Aggravation of pre-existing disorders or initiation of new disorders by institutional conditions.

APPENDIX 3

TABLE 3

CALCULATION OF PRIMARY PHYSICIAN/PHYSICIAN EXTENDER NEEDS IN A PRISON OR JAIL HEALTH SERVICE

1. Hours of coverage for entrance medical evaluation based upon population turnover rate, plus

2. Hours of coverage for sick call services, plus

3. Hours of coverage for chronic care clinics, infirmary and convalescent care, plus

4. Hours of coverage for physician administration, supervision, internal audit, and in-service education, emergency coverage, then

5. Calculate inefficiency factors, vacations, continuing education, etc.

APPENDIX 4

TABLE 4

NUMBER OF PRIMARY CARE PHYSICIAN FULL-TIME EQUIVALENTS NECESSARY =

$$\frac{1.1 \times (0.5 \text{ hr./entrance exam.} \times \text{no. exams/yr.})^*}{2080 \text{ hr/FTE}}$$

+

1.1 x (factor 1 + factor 2 + factor 3) x (average institutional census/2000)

where factor 1 = 1.20 FTE's for sick call services;
factor 2 = 0.35 FTE's for chronic care clinics, infimary and convalescent services;
factor 3 = 0.30 FTE's for administrative and supervisory services;

1.1 represents correction for special institutional and vacancy factors.

Thus, in a prison facility with 2000 residents and 600 admissions per year,

FTE's = 1.1 (0.5 x 600/2080) + 1.1 (1.20+0.35+0.30) (2000/2000)
= 1.1 (0.15) + 1.1 (1.85)
= 2.2 FTE's required to provide acceptable care

ESSENTIAL PREMISES

1. Adequate numbers of qualified and trained physician extender and nursing personnel are available for minor sick call problems, triage, and other functions relating to entrance exams., and
2. There is a medical director available to provide most administrative services.

If these premises are not met, the necessary number of primary care physician FTE's increases greatly.

* In a jail health service 0.25 hr./exam. would be allotted for physician involvement rather than 0.5 hrs.

Literature Cited

1 Novick, L.F. and Al-Ibrahim, M.S., Health Problems in the Prison Setting, Springfield, Illinois: Charles C. Thomas Pub., 1977.

2 Novick, L.F. et al., Health Status of the New York City Prison Population, Medical Care Vol. XV, March, 1977, p. 205.

3 King, L.N., Utilization of Former Military Medical Corpsmen in the Provision of Jail Health Services, Journal American Public Health Association 67: 730-734, 1977.

4 AMA Jail Health Project Monograph on Use of Physician Assistants in Correctional Health Programs.

5 Manual of Policy and Procedure for Montefiore - Rikers Island Health Services, copyright Montefiore Hospital and Medical Center, 1977.

6 Mandel, M.D., A Planning Model for Determining the Need for And Available Supply of Primary Care Physicians, Journal of Ambulatory Care Management, July, 1978, p. 23.

7 Newport, J., Review of Health Services in Correctional Facilities in The United States, Public Health Reports 92: 565-569, 1977.

8 Steinwald, C. et al., Medical Care in U.S. Jails - A 1972 AMA Survey, American Medical Association, 1973.

9 See Mandel.

10 See Mandel.

11 Novick, Problem in Prison Setting, p. 37

12 Derro, R.A., Health Problems in a City-County Workhouse, Public Health Reports 93: 379-385, 1978.

13 AMA Jail Health Project: Summary of the Jail-Inmate Patient Profile, June, 1977.

14 Derro, R.A., Admission Health Evaluation of Inmates of a City-County Workhouse, Minnesota Medicine 61: 333-337, 1978.

Literature Cited (continued)

15 King, L. N. and Geis, C., Tuberculosis Transmission in a Large Urban Jail, Journal American Medical Association, 237: 791-792, 1977.

16 King, L. N. and Young, Q., Increased Prevalence of Seizure Disorders Among Prisoners, Journal American Medical Association, 239: 1674-1675, 1978.

17 Petrich, J., Care of the Mentally Ill in a County Jail, Presented at 2nd Annual Meeting of the American Correctional Health Services Association, August 20, 1978, Portland, Oregon.

LONG RANGE HEALTH SYSTEMS PLANNING*

My comments come from the perspective of an institutional administrator and stress the need for determined advocacy on behalf of appropriate medical care for prisoners. Institutional administrators generally receive the brunt of the criticism concerning lack of appropriate care yet I suggest that this type of criticism misses the point because administrators recognize the need for appropriate care and are often the most vocal advocates for improvements. Decision-making in an institutional environment is generally characterized by the crisis model because rational planning systems are difficult to implement in an area of social policy generally relegated to the bottom of public priorities. Prison administrators often hope for lawsuits in order to stimulate legislative and executive interest in projects that have been rejected year after year or which are never submitted because of the costs involved and lack of public support for spending adequate resources.

Correctional administrators are increasingly expressing their reluctance to knowingly operate health care systems which do not meet adequate standards and in this respect the AMA standards movement is one of the most productive endeavors in prison reform that has occurred in many years. Standards have been developed by reputable experts and have been available for use and adoption throughout the nation. Every administrator now has a reasonable set of standards that should be implemented in any correctional setting. One would hope that these standards would become mandatory either through state jail inspection guidelines or even legislation so that the administrator will not have to fight an almost always unsuccessful battle for marco level improvements rather than the small incremental changes that seem to characterize the correctional budget process.

Mandatory standards which can be enforced through state jail inspection teams would help establish an absolute minimum level of service capability and this would be immensely helpful in the budget process. Justification for expenditures would now come from written-enforceable guidelines rather than from mere policy suggestions. Every warden and superintendent who has battled the budget problem can attest to the value of standards that are enforced as part of mandatory guidelines. While we may question certain enforceable guideline proposals, medical care is so central to the humane treatment of offenders and pre-trial detainees that there should be no excuse for failing to implement a basic service delivery system. If a facility cannot provide such minimum services then it should not be permitted to operate.

Citizens do not question the legitimacy of rigid standards for other facilities such as senior citizen homes, nursing homes, hospitals and the like. We should accept nothing less for correctional institutions. Standards which are enforceable through courts or administrative agencies ensure that medical care would not change as a response to changes in personnel or public policy. Mandatory enforceable standards appear to be an appropriate alternative to the crisis model which characterizes correc-

* Presented by: Arthur M. Wallenstein, Director, Bucks County, Department of Corrections, Doylestown, Pennsylvania

tions today. The AMA is to be congratulated on establishing a position of national leadership in the field of prison reform through the development of is medical standards and procedural guideline books to help in the implementation of the standards. Let us hope that the AMA medical standards will be accepted as part of the standard operating institutional procedures in the future. Both inmates and administrators will benefit from such a situation.

MEDICAL AND ADMINISTRATIVE ASPECTS OF INMATE TRANSFERS AND TRANSPORTATION*

The Chicago Law Enforcement Study Group, the John Howard Association and the Illinois Prisons and Jails Project recently completed a brief report on problems in the transfer of inmate medical and time-served records from the Cook County Jail (formally called the Cook County Department of Corrections) to the Illinois Department of Corrections. While the report, made possible by a grant from the McDonald's Corporation, discusses the particulars of the situation in Cook County, both the problems and the recommendations for reform are sufficiently generic to be applicable in other jurisdictions.

Medical records for inmates at the Cook County Jail are maintained at Cermak Memorial Hospital, the Jail's medical facility. Cermak is given no advance notice by security personnel as to which prisoners will be transferred to a state facility on any given day. As a consequence, no medical information of any kind accompanies the prisoners at the time of transfer. Moreover, Cermak in the past provided state prison medical personnel with medical summaries for transferred inmates. Apparently due to a lack of funds, this practice has been abandoned.

Prison medical staff must, consequently, rely on two sources for initial information on medical histories of incoming prisoners. The most common source is the prisoners themselves. In many cases, this can be valuable. For example, most epileptics or diabetics are aware of their conditions, and can communicate this information to health care providers. Even simple physical observation can be an important first step. During the period of the study, a prisoner arrives at an Illinois correctional center suffering from paraplegia. Despite the lack of advance notice, medical personnel, of course, had no difficulty recognizing the situation for what it was. But in many instances, an inmate may be able to say no more than that he or she has been regularly receiving little white pills. Even when a prisoner claims to know the nature of his or her condition or previous treatment, medical staff can not, obviously, rely on the accuracy of that knowledge.

The second source of information relied upon is telephone communication with medical personnel at the County Jail. If Cermak staff are aware that an inmate with serious health problems is in transit to a state facility, they will sometimes call that facility to provide advance notice. This is, at best, a haphazard process, worsened by confusion among Cermak staff as to the appropriate channels for forwarding such information. Medical personnel at state prisons more frequently call Cermak for data concerning a prisoner with obvious health problems. This must, of necessity, take place only after some preliminary diagnosis of incoming inmates.

This rather erratic system of communication results in several difficulties. First, medical problems requiring prompt attention may not

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* Presented by: Paul Bigman, Project Coordinator, Chicago Law Enforcement Study Group, Chicago, Illinois

be readily apparent, making timely treatment impossible. This may also result in interruption of what should be continuous treatment. Second, problems such as paraplegia require special advance preparation by medical staff. Such advance preparation demands advance knowledge of the inmate's impending arrival. Finally, the lack of medical information even long after prisoners' arrival requires repetition of what may in some cases be a lengthy series of diagnostic tests. The Medical Services office of the Illinois Department of Corrections indicates that as much as six months may sometimes be required to replicate tests administered to a prisoner while at the Cook County Jail.

More serious still, unnecessary delays in the provision of medical treatment may have dire consequences for the health of the prisoner. As one official of the state Department of Corrections noted, "Someone could die."

In fact, someone did die, although he was not from Cook County. An inmate arrived at an Illinois prison suffering from familial periodic paralysis, a hereditary disease which creates a severe potassium deficiency. The prison doctor, lacking the inmate's jail medical records, is alleged in a pending law suit to have negligently diagnosed and treated the disease. For want of a record, a life was lost.

Illinois law, like that in many states, prohibits disclosure by a physician of medical information pertaining to his or her patients, except under certain specified circumstances. Transfer of a prisoner from one correctional facility to another is not, at this time, one of those exceptions. Under current law, it is not entirely clear that any medical information may be legally transferred from a county jail to a state prison, absent written authorization from the prisoner involved.

It is, however, possible that the failure to transfer vital medical information could result in a finding of liability for serious medical injury to a prisoner. The United States Supreme Court, in Estelle v. Gamble, 429 U.S. 97 (1976), held that "deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment...(and) states a cause of action" under 42 U.S.C. Section 1983 (429) U.S. at 104-105). The "deliberate indifference" standard is high, but conceivably could be applied to failure to notify a successor physician of a life-threatening situation.

The July, 1979 American Medical Association Standards for Health Services in Jails includes, as Standard 166, the following:

> Written policy and defined procedures regarding the transfer of health records and information requires that:
>
> Summaries or copies of the health record are routinely sent to the facility to which the inmate is transferred;
>
> Written authorization by the inmate is necessary for transfer of health record information unless otherwise provided by law or administrative regulation having the force and effect of law; and
>
> Health record information is also transmitted to specific and designated physicians or medical facilities in the community upon the written authorization of the inmate.
>
> Discussion: An inmate's health record or summary follows the inmate in order to assure continuity of care and to avoid the duplication of tests and examination.

The first two requirements of this standard make clear the necessity for a legal provision for the automatic transfer of prisoners' medical information without a formal written consent, unless such consent is to be obtained for each and every inmate. New York has already adopted such legislation. N.Y. Crim. Proc. Law Section 943 requires that, among other records, "any reports that may have been made as a result of a mental, psychiatric or physical examination" of an inmate to be transferred from a county jail to a state prison "shall accompany such person to the prison, reformatory, penitentiary or other penal institution in which he is to be confined." This information is to be delivered in a sealed envelope to the warden of the institution. Legislation similar to this is expected to be introduced in Illinois, shortly, with the provision that medical information be sent in a sealed envelope directly to medical personnel at state prisons.

Legislation of this type is crucial. Adoption of analagous law throughout the country would do much to solve the problems of transmittal of medical information. There are, however, several other steps which could be taken to alleviate the difficulties.

Medical personnel responsible for the care of jail inmates must be informed in advance of impending transfers, in order to provide time for preparation of medical records or a medical summary to accompany each prisoner. The files of inmates with significant medical problems should be easily identifiable, so that medical personnel can promptly segregate records for transferees requiring medical attention. State medical societies should work with correctional officials to develop standardized medical records forms, to facilitate communication of medical and treatment histories from one facility to another. Larger jails, such as that in Cook County, should computerize such information and establish shared computer systems with the state correctional department. Computerized medical records could then be retrieved instantaneously by state prison medical personnel, who should be the only correctional staff with access to such information. Finally, it is important that clear lines of communication be established among health care providers in jails and prisons throughout each state. This should also involve staff at public mental health facilities to which a defendant may be committed pending determination of fitness to stand trial. There is simply no excuse for jail officials to remain ignorant of proper channels for communication of needed medical information.

Timely and accurate transmittal of medical information if one of the less perplexing dilemas in corrections. The problems are relatively

easy to identify, the solutions relatively simple to implement. Yet the consequences of failure to transfer such information may involve substantial waste of increasingly scarce tax dollars and, more irreperably, severe damage to the health of men and women in public custody. It is incumbent upon all of us to ensure that a sentence to serve time in prison does not become a sentence to physical or mental deterioration, or death.

MEDICAL AND ADMINISTRATIVE ASPECTS OF INMATE TRANSFERS AND TRANSPORTATION *

The first panelist presented a description of the problems with continuity of care experienced by the Cook County Jail System when transferring inmates to the state prison system. Due to the enormous number of inmates handled, his observations primarily concerned those employed by large, unified systems.

As the second panelist, I endeavored to describe the steps taken within the North Carolina Division of Prisons to ensure continuity of care among transferring inmates. I tried to make the information applicable to small prison and jail systems. Even though North Carolina has a large number of inmates, they are distributed among seventy-seven field units and nine institutions. Due to the great number of separate units, we operate in the same manner as many small systems must. We experience approximately three hundred inmate transfers per week, the great majority of which are for administrative reasons and a few of which are for medical reasons.

On administrative transfers, the responsibility for the continuity of care rests solely with the administrators of the system. In order to protect the quality of medical care, the following standing orders are in effect:

1. Twelve hours notice is given to the sending unit thereby giving the unit clerical staff time to prepare the records.

2. Sending Unit

   A. The inmate's medical jacket must go with him on every transfer.

   B. The inmate's medication is placed inside the medical jacket.

   C. The jacket and the medications are then placed inside a plastic pouch to help prevent loss. (This step is planned but not yet implemented.)

   D. A transfer record sheet is always attached to the outside of the pouch and any special medical problems are written on that sheet.

3. Receiving Unit

   A. The officer-in-charge must make a quick review of the jacket for special instructions and medications. He then puts the jacket aside for the unit nurse.

   B. The unit nurse, who works four to six hours a day five days per week, makes a detailed review of the medical

* Summary Presentation by: Herbert A. Rosefield, Area Administrator, North Carolina Division of Prisons, Winston-Salem, North Carolina

jacket referring the inmate to the unit physician when necessary.

Medical transfers are done at the request of medical authorities for the purpose of additional treatment which may be administered either via in-house or outside medical facilities. In cases when an inmate is sick and medical personnel are not available, the officer-in-charge must determine whether or not to secure emergency medical services. They are under standing orders to always err on the side of liberalism. That is, if in doubt, go. Security precautions required in taking an inmate for emergency medical services never prevents the inmate obtaining treatment but are simply escalated based upon the inmate's custody grade.

In-house medical services include dental care, psychiatric/psychological care and specialized medical care. For the administrator, they would involve the necessity for scheduling, transporting, and ensuring that prescriptions are filled and follow-up care provided. For the system to work, the administrator must emphasize the importance of continuity of care. When an inmate being treated nears his release date, the North Carolina system makes every effort to ensure that continuity of care will take place. These procedures involve the following:

1. Medical/Dental

   We expect the unit nurse or unit physician to assist the inmate via referral to community health resources.

2. Mental Health

   It is the responsibility of the treating professional within the Department of Correction to initiate aftercare upon release via patient identification, referral and distribution of a treatment summary to the appropriate community health care resource. We have found that the key to success is a screening interview with the community health care resource prior to release as it is especially important for the inmate to know who he will be seeing and where they are located.

Although the North Carolina system is large and spread out, offering considerable opportunity for error, I feel we are making every effort to ensure that a high caliber of medical care is delivered. I hope that being informed of our methods will assist you in your planning.

MEDICAL QUALITY ASSURANCE REVIEW MODELS*

The problem we consider here today is how to provide health care and medical care, of good quality, to persons confined in jails. Some of the many factors bearing on the problem are well known to most of you, and you are also aware of the difficulty of both measuring and assuring the quality of the various segments of care that is being given by professionals of many disciplines: physicians, dentists, nurses, psychologists, social workers, aides, chaplains, and some corrections officers.

In our role as speakers, we were told to avoid repeating the obvious, but, in order to make my next point, I must say something obvious to most, if not all, of you. The jail inmate who comes to the clinic has both symptoms, subjective complaints, and signs, objective findings; his complaints may result from either functional or organic causes, or from both. Rather simply stated, the quality of health care, as determined by the relief of his complaints, can probably be measured in organic illnesses but probably cannot in functional illnesses. It is my impression from my experiences, that the majority of inmate complaints have no organic basis; therefore, the degree or relief or "cure" cannot be measured, the success in treatment cannot be measured, and the quality of care cannot be measured.

How, then, can one assure the quality of care? One, by making available to the jail the highest quality of health care professionals. Two, by periodic performance evaluations made by disinterested evaluators.

Item 1. I believe that the easiest and most direct approach is to begin by assuring that the person in charge is a high quality physician who can organize, supervise, operate and control the kind of health care program that will produce the highest quality care possible in the structural, functional, fiscal and philosophical conditions that prevail. The medical director having full knowledge of the conceptually stated ideal standards of care, and of the resources available to him as he works toward those standards, and by daily supervision and monitoring can be sure he is providing the highest quality care. In other words, if he knows what his job is and what he has to do it with, and sees that it is done, quality care is inevitable.

Item 2. In addition to his role as operator of the jail medical services, the medical director has important external responsibilities: liaison with other physicians, with other health care disciplines, and with the community. In the jails of our county, we have exploited the relationship of the jail medical director with his county medical association as a means of improving the jail medical care. The jail medical director is a regular and active attendee at the Hillsborough County Medical Association meetings. As a consequence of his being seen and active, the other members become aware that there is a county jail, that some inmates need medical care, and that such care is being provided. Dr. Chardkoff, the director, realized that the HCMA could be of

* Presented by: Joseph A. Baird, M.D., Associate Medical Director; Hillsborough County Criminal Board of Justice, Tampa, Florida.

real help to him and in 1973, he asked the Hillsborough County Medical Association President to appoint a jail committee. It was done. Since that time the committee meets at least twice a year over lunch in the jail dining room. The present members of the committee: two orthopedists, one plastic surgeon, one family practitioner, one urologist, one obstetrician/gynecologist, one ophthalmologist, one psychiatrist, and the jail medical director. They have visited the jail clinic, cells, offices and other activities. Being behind bars, even temporarily, improves empathy and understanding. They have made recommendations about the extent of laboratory, dental and radiographic work that should or should not be done in our jail and also about the kinds and amount of nurse/doctor care to be available. They have given specific guidance and help on such matters as specialists referrals, allocation of beds at the county hospitals and the problems of getting care at the Veterans Hospital for those inmates who are also veterans entitled to such care by law. The Hillsborough County Medical Association jail committee is essentially a peer review activity; an example of the way they function is as follows:

WALTER C. HEINRICH, SHERIFF
Hillsborough County
Tampa, Florida

INTER-OFFICE
MEMORANDUM

DATE: May 7, 1979

TO: Dr. M.E. Chardkoff, Medical Director - BCJ

FROM: Sheriff Walter C. Heinrich

RE: Medical System Survey

MESSAGE:

I would appreciate your calling a special meeting of your Medical Advisory Committee from the Hillsborough County Medical Society for the purpose of initiating a review of the medical program of the Board of Criminal Justice. In addition to any other areas of consideration in the survey, please have the Committee address the following questions:

1. Is the pharmaceutical inventory, control and dispensing of medicines in keeping with state law and the rules and regulations promulgated by the State Department of Corrections?

2. Is access to medical treatment adequate and in keeping with good medical practices?

3. Are our written administrative and medical procedures in keeping with community standards and state law; and do they establish a recognizable and workable system of the delivery of health care to inmates?

4. Are our medical records of treatment and our forms adequate and in keeping with medical community standards?

5. Do our medical personnel participate in continuing educational programs to maintain professional proficiency?

6. Is our dental services program adequate to provide emergency dental services?

7. Is our security and control of medical supplies adequate and in keeping with state correctional regulations and medical community standards?

Please give this matter your immediate attention. I shall look forward to a written report of the Committee's findings as soon as possible.

Sincerely,

Walter C. Heinrich,
Sheriff

The medical director and his associate informed the committee on all the matters in question and prepared the reply to the sheriff. The committee chairman made his report to the Hillsborough County Medical Association President.

The jail committee of the county medical association has been very helpful to the Hillsborough County Board of Criminal Justice in it's continuing efforts to improve the quality of health care in our jails. Perhaps it has worked well other places. It surely can be done anywhere there is a county medical organization.

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MEDICAL QUALITY ASSURANCE REVIEW MODELS *

During the past five years, the health care services provided for inmates of the federal correctional institutions in Canada have been undergoing a process of both quantative and qualitative development. It is my intention in the time at my disposal to present some descriptive aspects of the varied processes utilized and their modes of implementation.

Before proceeding into quality assurance models which we have developed, or are in the process of being developed in Canada, I think that perhaps a brief overview of the system to which I will be making reference will assist those not familiar with the present Canadian correctional system, to place my comments to follow in the appropriate context.

The federal government department responsible for inmates serving sentences of two years and over is the Ministry of the Solicitor General. All inmates serving terms under two years come under the authority of the ten autonomous provincial correctional services.

The Department of the Solicitor General has three components, the Royal Canadian Mounted Police, the National Parole Board and the Correctional Service. The latter, until approximately a year ago, was comprised of two separate services, the Penitentiary Service and the Parole Service. With the amalgamation of these into the Correctional Service of Canada, a whole new era of "image change" has come about. Several branches were involved in this recent re-organization process, and include such high profile areas as communications and policy and planning.

Although the Medical and Health Care Services Branch came into being within its own right only in 1974, (prior to this it had been included under an inmate programmes branch) it had fortunately developed to a point where it is now one of the most effectively managed programmes, and therefore, the first of the branches to undergo a thorough evaluation by the evaluation component of the service, the policy and planning branch. This will be elaborated upon later in this presentation.

Medical services have been provided to inmates of Canadian penitentaries from the beginning of the system. The quality of the service provided and, indeed, of the providers, was questionable. As the corrections system evolved, it became apparent that the medical services provided in the medium and maximum security institutions, required very serious review. At the same time, at the end of the sixties, concern was also being expressed over the psychiatric services being provided.

The new era for provision of medical and psychiatric services began in 1969 with the arrival of the present Director General, a psychiatrist. His task, as it became apparent, was to provide some order and professional direction to over twenty autonomous "sick bays" which were staffed by approximately two hundred hospital officers, of whom only three per cent were registered nurses.

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* Presented by Marjorie Carroll, R.N., B.Sc., M.Ed., Director of Nursing Operations, the Correctional Services of Canada, Ottawa, Canada.

The Director General chose his path wisely, as time has proven, and had appointed a number of advisory committees. These committees, comprised of designated representatives of the Canadian Medical, Nurses, Psychiatric and Dental Associations and the College of Family Practitioners, provided reports which, not only have been the basis for the organization of the branch but also for the philosophy of professionalization and its relevant policies. The reports are still being utilized by university programmes and professional study groups as guidelines for recommended change in health care services within some of the provincial correctional systems.

The basic policies now either implemented or in the process of implementation, relating to standards, which are directly attributable to either the McLean - Riddel Report, the Advisory Board of Psychiatric Consultants or the National Health Services Advisory Committee Reports include:

a. Appointment of a combination Nursing Advisory/Director of Nursing to the Director General.

b. Upgrading of hospital officers, (who are referred to as Health Care Officers since 1974) to either a nursing assistant or registered nurse level.

c. Appointment of regional nursing officers, with a basic qualification of B.Sc.N., as advisors and continuing education facilitators to the Health Care Officers.

d. Creation of Regional Psychiatric Centres, modelled on conventional psychiatric teaching hospital, which would be (and are) affiliated with universities.

e. Creation of an autonomous branch within the service. This came about in 1974 as the Medical and Health Care Services Branch. At this time the military terminology of "sick bays" gave way to "Health Care Centre".

f. Replacement of all Health Care Officers, through attrition, with registered nurses. (In five years there have been an increase of registered nurses from three to sixty percent).

g. Development of Guidelines Covering the Professional Conduct of Health Professionals in the Correctional Services of Canada. These evolved from a seminar at Queen's University in which medical and legal experts from throughout Canada participated.

These have subsequently been discussed with the ethics committee of the Canadian Medical Association and with modifications, have been adopted by the Canadian Psychiatric Association as guidelines for forensic psychiatrists.

This whole process of implementing recommendations is referred to as the professionalization process. How did these changes come about? Some happened with remarkable ease and rapidity, others with much foot dragging and pain. Some are still in the process toward full implementation. An example of this is the replacement of non-registered nurses with registered nurses. We have managed to have, by means of a special training position allotment, over twenty of the Health Care Officers graduate from diploma nursing programmes, returning to us as registered nurses. However, we have approximately one third of our Health Care Centre staff who, due to employment policies, will be replaced by attrition only.

I will not go into the difficulties inherent in introducing female registered nurses into what was a totally male environment. That is the subject of another paper alone.

Many of the recommendations of the two reports of the National Health Services Advisory Committee concerned the quantity of health care provided to the inmates. This included everything from the initial physical assessment to the discharge physical assessment. Many more of the recommendations were pertinent to dental and nursing care services. These were compiled in 1976, into a branch policy manual which is the overall policy guideline for all Health Care Centre and Regional Psychiatric Centre personnel. The manual undergoes an annual review and revision process with a prescribed ammendment procedure. This manual met with some opposition when intent to publish and distribute it was indicated. Of great satisfaction to the branch was the subsequent adoption of the branch manual approach to policy enunciation by other branches of the service. The initial service reticence to accept the policy manual approach was that it went against the traditional approach of directives and instructions which were all inclusive and where reference to health care policies could be found in innumerable separate directives and volumes.

Once one has stated policy and provided for the distribution of such a document, there comes the accountability for the implementation of the stated policy. Although the branch has a built-in regional structure, in the person of a Regional Manager, Health Care Services, which ensures this occurance, we have also been provided with several other means of monitoring policy compliance. More methods may well appear in the future but for the present, the following are providing this function.

Within the past year, as well as other changes in the overall structure of the service, an Inspector General of Corrections has been appointed with the overall purpose of providing an objective overseer who can bring areas of ineffective policy or lack of compliance with policy to various levels of management. Essentially, the Inspector General's management audit reviewing of compliance via on-site visits to institutions, with subsequent accountability sessions with the managers concerned, has served to prompt the branch to re-examine and tighten up some rather vague policy areas.

Secondly, we have also been fortunate in maintaining the counsel of several of the professional experts who served on both the Advisory Board of Psychiatric Consultants and the National Health Services Advisory Committee. Although both these groups had ceased to be by 1975, it became apparent that in order to maintain the impetus of the professionalization process, peer type review from our professional colleagues was essential. Therefore in 1978, the Medical Advisory Committee came into being with the primary purpose of monitoring the professionalization process. This has been achieved via scheduled meetings where reports are received from senior Medical and Health Care Services Branch officers and through on-site visits and provision of consultation services to the Inspector General and others as required. This monitoring body provides for the professional dimension so highly valued in our services.

The third means of monitoring our commitment of professional practice has arisen within our professional practitioners themselves. As one would find in any group of highly committed health care professionals, there is in evidence a peer appraisal system. This is provided via expressions of concern of professionals with regard to the quality of professional practice of individuals. Within the past year, through such expression of concern, subsequent reviews by the respective licencing bodies regarding quality of practice of both a dentist and a nurse, have been undertaken.

Perhaps one of the greatest undertakings over the past five years has been the standardization of practice. There have been times when we have wondered if our goal was achievable, much less if any part of it had been achieved. However, in retrospect, we have accomplished as much, and in some cases, more then we had hoped to in five years.

One of the first accomplishments was the standardization of all position descriptions for full time personnel. Those individual doctors, dentists and others who are on contract receive standardized contracts. The standardization is very important in the Canadian system as all positions are benchmarked at classification levels and open to audit at any time. In other words, a nurse in any one of the twenty-seven Health Care Centres must perform the same level type of functions as a jurse in all the others. The advantage is obvious in terms of consistency and recruitment.

The twenty-seven Health Care Centres just referred to are distributed throughout five regions in both medium and maximum security institutions. As mentioned previously, the professional guidance for the Health Care Centre personnel is the responsibility of the Regional Nursing Officer. These senior nurses provide a very important role in the branch structure. The innovative suggestions and real problem areas expressed by the health care personnel at the front line level, i.e., the Health Care Centre, are assimilated and brought to the national headquarters level by the Regional Nursing Officers for discussion at regularly scheduled meetings. From this evolves much of the policy concerning standards. Often, projects are undertaken by individual Regional Nursing Officers as ad hoc task committees of the senior nurse group.

Examples of this have been the nursing practice standards and the recruitment brochure for nursing personnel.

Two years ago, the Nursing Operations Division produced a manual which provides relevant information for nursing personnel in both the Health Care Centres and the Regional Psychiatric Centres regarding the division's organization and structure, standards, guidelines and procedures. The standards for nursing service are well on the way to implementation. The standards on nursing practice are also in the process but at a much slower, more painful rate due primarily to the high proportion of non-registered nurse health care personnel who have no level of recognized professionally licensed practice. These officers are, in the main part, former custodial officers, who learned literally on the job prior to 1974.

Although we are substantially slowed down in this standards area, we have proceeded in the standardized nursing procedures area. The Regional Nursing Officers support groups, comprised of nurses from the Health Care Centres, who develop nursing procedures that will be utilized in the Health Care Centres of the particular region. It is the expressed intent of the Regional Nursing Officers that at the appropriate time the Procedures will be amalgamated and standardized nationally.

A highly significant accomplishment of the professional nurses within the Health Care Centres is the progress made in the difficult area of delegated medical acts. This project began through the concern of registered nurses over unauthorized practice of medical procedures, legally within the domain of the medical practitioner. The concern of potential malpractice suits grew as provincial licensing bodies became involved with the provision of malpractice insurance.

In Canada, any delegation of medical acts to nurse is done through the process of negotiation between provincial medical and nursing associations. Not all provinces have done this to date, but those that have done so within their individual provincial acts resulting in consistency. Thus, for a national service the problem of trying to please everyone once more had to be approached. We finally, after two years, at the point where we will be presenting our list of delegated medical acts, with the necessary policy statements for nursing practice within the Medical and Health Care Services of the Correctional Service, to both the Canadian Nurses Association for their sanction. This is only Phase I or the beginning step for the Task Committee comprised of four Regional Nursing Officers, one nurse in charge of a Health Care Centre and an institutional physician. The remaining phases are composed of procedure writing, certification process preparation, orientation of institutional physicians and Health Care Officers, and implementation which we project as happening around May of 1981.

One of the most gratifying factors that has occurred as a spin-off from the arduous work on delegated medical acts is the positive policy development regarding what were originally acts on the delegated list but

which were removed for separate action. Examples that are significant for the practice of professionals are the non-use of medical personnel (both nurses and doctors) for security procedures such as body cavity search, taking of blood samples for drug usage detection, the giving of injections of sedative drugs for security control purposes, and the provision of licensed physiotherapists to perform thermoelectric and ultrasound procedures.

From the beginning of the professionalization process, the importance of continuing education has been stressed. All Health Care Officers, be they registered nurses or not, are expected to obtain at least twenty hours of in-service or out-service continuing education each year. In Regional Psychiatric Centres, where there is an in-service coordinator, the minimal number of hours is fifty. All the nursing personnel have achieved, and in most cases surpassed this level since the requirement was instituted. Guidelines for orientation have been provided and are being implemented in accordance with the individual Health Care Centre facilities.

All the nurses in charge of Health Care Centres are expected to have management courses on appointment or within a year of appointment. There is provision for acquiring such courses for both nurses in charge and those desiring to obtain the required courses for promotion.

Attendance at professionally sponsored workshop is also encouraged. We are presently in the process of trying to remove some of the red tape inhibiting full utilization of continuing education activities for our health care personnel.

The major task that still lies ahead of us has proven, over the past several years, to present the greatest area of difficulty. That is the adoption of a realistic and workable standardized health care record. There has been a health care record in existence since 1974, which over the ensuring time has developed into a veritable octopus. There have evolved in each Health Care Centre what could be described as variations on a theme. Our Medical Records personnel refer to these as "bootleg" forms.

In analysis of data from a research project on determination of a staff/patient ratio for Health Care Centres that was carried out last year, it was evident that a disproportionate amount of time was being spent by health care personnel creating, maintaining and reporting data on services provided, amongst other record keeping. Our personnel had become a service of keepers of redundant records. In over half of the Health Care Centres, there was a clerk who helped in this. In the reminder, there was no clerk at all.

We are now in the midst of initiating a pilot project on a streamlined manual recording system in institutional Health Care Centres in one region. We are watching this with intense vested interest as our aspirations for nursing practice standards are in a large part dependent upon releasing nurses from unnecessary paper work, thus enabling them the time to utilize the holistic care skills we hired them for in the first place.

As mentioned at the beginning of this presentation, evaluation of the effectiveness of the Medical and Health Care Services Branch has begun. This is the first thorough review of the branch since its beginning. The evaluation will focus on all aspects of health care provision - preventive diagnostic, therapeutic, rehabilitative, as well as the enabling functions such as organization, administration, etc. The evaluation will be carried out over a period estimated as up to three years. The reasons why the branch is being evaluated are stated as follows:

1. Medical and Health Care Services is a costly Correctional Services Program with a $23 million annual direct cost ($2000 per inmate). It is a significant capital investment with 475-500 person-years involved.

2. It is now some 5 years since restructuring of Medical and Health Care Services. Is it working as intended? Does the Correctional Services provide a good health care service? Is the program good value for money?

3. As a constituent part of the Correctional Service program Medical and Health Care Services relates to most other Correctional Service activities.

Finally, a few words in regard to our future because we fully expect to still be in business after the aforementioned evaluation has occurred.

We have begun and are in the process of complying with the conventional health care delivery system standards as enunciated in Canada by the Canadian Council on Hospital Accreditation. The reason why we are going in this direction rather than use the AMA Standards, is our branch philosophy, based on the introductory statement of the first report on the National Health Services Advisory Committee. The philosophy statement is:

> "The Medical and Health Care Services Branch maintains that a humane health service, including medical, psychiatric, dental, nursing and allied health services, be provided for patient inmates in Canadian Correctional Institutions. This service should be provided by provincially registered professionals in good standing."

Within the last year we have had one of our Regional Psychiatric Centres accredited. It had already been certified as a hospital by the province. Considering that it is also classed as a maximum security institution, this was quite an accomplishment. Even more reassuring was the accreditation of a Health Care Centre. This was the result of much dedicated effort on the part of centre and regional health care services personnel to adapt to regid hospital unit criteria. This was due to the fact that CCHA had not yet progressed to the area of ambulatory care services.

When the Solicitor General became interested we knew our option of choice was limited. Therefore, we undertook, with the sanction of CCHA, to adapt the hospital guidelines to an ambulatory care service in a correctional milieu. This work has been completed and CCHA has now asked if it can use our adaptation of both the guidelines and the questionnaire for their ambulatory care facility accreditation criteria.

The questionnaire was tested in one Health Care Centre and then further streamlined. We are very shortly beginning an internal survey using our tools to identify all the strengths and weaknesses in our twenty-six unaccredited Health Care Centres. We plan to priorize all of these in terms of their readiness for official CCHA survey. This will also enable us to plan for facilities renovation and contracting of required services over the next five years.

Our goal in five years is to have as many Health Care Centres CCHA accredited as possible and to have all three Regional Psychiatric Centres fully accredited as psychiatric hospitals.

As you have noted by now, within the Correctional Service of Canada, the current underlying theme is accountability. The goal is the Medical and Health Care Services Branch has been equality of health care services within the community at large, which we have now essentially achieved, and a future shift in emphasis from a treatment model to one of health promotion and illness prevention.

The existing models presented, and perhaps some as yet unidentified models, are our attempt at providing quality assurance within a prison health care system.

MEDICAL QUALITY ASSURANCE REVIEW MODELS *

For those of you who are unaware of the AMA Standards for Health Services in Jails, you may wish to acquaint yourselves with the 69 standards.

Standard 109 states, "written policy defines the medical peer review program utilized by the facility". The discussion under standard 109 references the American Medical Association Resolution 121 (A-76) on quality assurance passed by the AMA House of Delegates 1976. The resolution reads, "resolved, that the American Medical Association endorsed the principle that correctional facilities provide adequate medical care to their inmates which is subject to physician peer review in each community".

Assuming that we accept the concept that quality assurance programs using the peer review approach are effective methods of assuring quality of medical care and that the quality of care within the correctional facility should be consistent with the care provided in the general surrounding community, our focus here, therefore, is to explore the techniques and resources for quality assurance programs.

Dr. Baird provided a model for quality assurance using the traditional peer review approach of specialty groups within a state medical society. Marjorie Carroll explained a national approach as implemented in Canada.

There are several approaches and designs that can be developed which can suit a particular correctional facility's needs. The key is to develop dialogue with recognized peer groups in the community setting; not just the physicians, but allied health professionals whose services are utilized in the facility - dentists, nutrionists, nurses, to name several.

There are now 22 state medical societies participating in the AMA technical assistance program for Health Care in Jails. Each of these medical societies has the appropriate staff to provide you assistance in developing a quality assurance program. The participating states are: California, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Texas, Washington, Wisconsin.

If your facility is not within these states and you also learn that the medical society in your state is not equipped to provide assistance, then another approach for technical assistance would be the PSRO.

PSRO stands for Professional Standards Review Organizations. They were mandated by Public Law 92-603 within the amended Social Security Act of 1972. Simply, PSROs are physician organizations whose main purposes are to develop peer review monitoring systems for medicare and medicaid patients in acute hospitals and long term care facilities. There are approximately 200 PSROs, nationally.

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* Presented by: Charles S. Amorosino, Jr., Executive Director; Commonwealth Institute of Medicine, Boston, Massachusetts

Although ambulatory care as practiced in correctional facilities is not a required activity of the PSROs, the professional staff in the PSROs should be able to provide some assistance in setting up a basic peer review system for your correctional facility. The PSROs should always be able to identify key physicians and allied health professionals in your community who are attuned to peer review concepts and approaches.

Each state medical society has on file an updated PSRO Project Directory which lists by state, the name, address and telephone number of the PSROs. You are welcomed to look at the copy I have with me.

MEDICAL RECORDS SYSTEMS: ADVANTAGES OF UNIFORMITY *

An overview of the medical record system for the state of Oklahoma, Department of Corrections was provided for the workshop participants. A flow chart of the medical record system was available for those participants who wished to have one.

Several opening comments concerning the overall medical record systems were:

1. Oklahoma maintains a "unit record system", whereby any record generated as the result of a previous incarceration, is pulled forward and made available in the current "active" jacket.

2. There is only one original medical record maintained on each correctional client. The record originates at the Lexington Assessment & Reception Center where a routine admission diagnostic work-up is completed on each correctional client in a 2-week period.

3. As the correctional client is transferred through the system, the medical record is transferred with the correctional client.

4. The Oklahoma Department of Corrections maintains a Problem Oriented Medical Record System (POMR).

The following components of the Oklahoma POMR system were identified and discussed: a) data base b) problem list c) initial plans/progress notes d) flow sheet.

The process utilized by the Oklahoma Corrections Department for implementing the new POMR system were identified as follows:

A. Applicants interviewing for employment were informed of the record system at the point of interview.

B. A participative approach was encouraged to invite the suggestions of the health care providers.

C. Individual institutional inservice sessions were held with the health service staff.

D. Individual (one-to-one) education.

E. Routine on-site visits to each institution on a monthly basis for health record system review.

F. Quarterly (system-wide) Correctional Medical Specialist inservice education sessions whereby a portion is designated for medical record issues.

* Summary Presentation by: Kathy Wiebe, R.R.A., Department of Corrections, Oklahoma City, Oklahoma

MEDICAL RECORDS SYSTEMS: ADVANTAGES OF UNIFORMITY *

The Department of Corrections of the State of Virginia is required by State law to do a complete physical examination and medical classification on each client committed to the care of the Department. Physicians employed by the agency have the authority to impose restrictions on assignments for medical reasons. The initial medical classification is given only after a complete physical examination. This physical examination and classification is conducted on all adults and juveniles received through detention centers, courts and those received through the Reception and Diagnostic Center.

Medical classification may be changed at any time by the facility's physician. Upon change, the appropriate forms are completed and sent to Central Classification. The facility's physician may request that an inmate be permanently assigned elsewhere for medical care. The Chief physician forwards the request, with his recommendation, to the Central Classification Office.

A coding system was designed to provide a means of medical classification (see appendix). This coding system accomplishes two purposes:

1. the medically approved activity level for the inmate, and,
2. presence of any physical defects, special condition or disease.

Letters are used to designate the activity level of the inmate. Numbers are used in conjunction with letters to note the special condition, defect or disease. All inmates designated as "B", "C" or "D" must have a number following their activity code, showing the reason for the restricted status. More than one number may be used when necessary. This classification also applies to dental problems. Special cases are designated a specific Correctional Center Infirmary. These special cases are:

1. Wheelchair case.

2. Suffering from severe medical disorders which indicate need for Infirmary care such as bowel and bladder problems, respiratory difficulties and orthopedic difficulties.

Any classification of this sort must involve medical personnel on the Classification Committee.

A change of medical classification can also be accomplished by the completion of a special form. This change of classification must be signed by a physician. Anyone placed in an "H" classification, which indicated a medical hold status, i.e., hospitalization, recovery or convalescent phase of illness or surgery, must be reviewed every thirty (30) days. The inmate will not be transferred to another until until the "hold status" has been removed.

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* Summary Presentation by: Lloyd Waggoner, Medical Administrator, Virginia Department of Corrections, Richmond, Virginia

APPENDIX

Medical Classification Codes

This new coding system is designed to provide two different types of information to the reader:

1. Medically approved activity level for subject, and,
2. Presence of any physical defect, special condition, or disease in subject.

Activity Levels

The activity level approved for each subject is designated by the capital letter A, B, C, or D. The letter E may be used after the first letter designation when indicated (ex: AE,BE). The letter H, whenever used, is to be placed behind the entire classification.

"A"..Any Activity - Subject is physically fit to perform any type of work, including road, quarry, heavy metals shop, and construction. Is also able to actively participate in strenuous sports such as football, basketball, wrestling, and weightlifting.

"B"..Moderate Activity - Restricted from work involving heavy lifting (maximum 50 lbs.); excessive running, climbing or walking; manual use of heavy machinery; or other tasks which demand prolonged physical exertion. Subject should be restricted from active "full-game-time" participation in sports such as football or basketball. Acceptable assignments include: moderate road work, housekeeping, kitchen, laundry, dairy, livestock care, gardening, grass cutting, litter, collection, bindery, cannery, and most manufacturing areas except heavy metals, and lighter phases of construction, such as electrician, painter, and finish carpenter.

"C"..Light Activity - Restricted from assignments requiring continued steady pace of activity. Subject should be allowed to work at own pace, should not be required to lift over 20 lbs. Acceptable assignments include: sweeper, runner, light gardening, food preparation and serving, warehouse inventory man, gatekeeper assistant, flagman, and clerical or other sedentary assignments. Recreational activities should be limited to walking, fishing, ping pong, pool, etc.

"D"..No Work Status - Used for those cases of severe heart disease, active pulmonary tuberculosis, terminal cancer, etc. Subject is in no condition to accept a work assignment under any circumstances. Physical condition is such that subject will limit other physical activity himself.

"E"..Nonhazardous - Due to significant visual or hearing impairment, epilepsy, or conditions causing frequent dizziness or vertigo, subject should not be assigned to work in dusty areas; on scaffolding or ladder, in or near open ditch; or use air compressors, air drills, or unguarded heavy machinery. Persons in this group should never be assigned to area where vehicle traffic is heavy.

"H"..Medical Hold Status - Temporary attachment to subject's medical classification. Is intended for use when: 1) inmate is undergoing special medical work-up or treatment which would be significantly disrupted if subject were transferred from facility, or, 2) inmate is in recovery or convalescent phase of illness or surgery. Unless under dire circumstances, inmate will not be transferred to another unit until hold status has been removed. The hold status must be reviewed and either reviewed and either renewed or dropped every 30 days.

* Note: If reason for hold status also requires a change in activity level, the entire classification must be changed. Accordingly, the entire classification must be reviewed every 30 days.

Special Conditions, Defects or Diseases

Whenever a special condition, effect, or disease is noted in a person, the corresponding number will follow the letter of activity code. More than one number may be used when necessary. While it is likely that many "A" classifications will not have a defect or condition to be noted, others will. All subjects classified as "B", "C", or "D" must have a number follow their activity code, as a reason for restricted assignments.

-1-	Age (60 or over)	- Persons in this age group may need activity limitation.
-2-	Neurological	- Includes epilepsy, muscular dystrophy, paralysis, etc.
-3-	Orthopedic	- Includes tendonitis, fractures, arthritis, torn ligaments, etc.
-4-	Visual	- Includes blindness, cataracts. glaucoma, etc.
-5-	Ear, Nose, Throat	- Includes deafness, perforated eardrums, deviated septum, chronic tonsillitis, cleft palate, etc.
-6-	Hernia	- Unrepaired ventral or inguinal
-7-	Hematological	- Includes leukemia, pernicious anemia, sickle cell, etc.
-8-	Mental	- Includes retardation, schizphrenia, depression, etc.

-9- Coronary/Circulatory - Includes coronary artery disease, congestive failure, hypertension, arteriosclerosis, etc.

-10- Respiratory - Includes asthma, chronic bronchitis, emphysema, tuberculosis, etc.

-11- Endocrine - Includes diabetes, hyperthyroidism, Addison's, etc.

-12- Gastrointestinal - Includes gastric ulcers, lye ingestion, colostomy, etc.

-13- Renal/Urological - Includes rental failure, hemodialysis, renal calculi, etc.

-14- Malignancy - To include any malignancy not covered by other numbers.

-15- Dermatological/Gross Disfigurement - Includes severe skin diseases, facial disfigurement due to burns, GSW to face, etc.

-16- Anaphylactic Reactions to Insect Bites or Stings - Documented allergy to bee or wasp stings, etc.

-17- Obstetrical/Gynocological- Pregnancy, prolapsed uterus, endometriosis, etc.

Dental Classification Codes

"A"----------Satisfactory condition, no dental work needed.

"AB"----------Minor defectes noted, immediate repair, not necessary.

"B"----------Needs dental treatment.

The letter "H" is to be used for a dental holding status in much the same way as in the medical classifications.

* Please note that any time a medical or dental classification is changed, or a hold status placed on or dropped from any classification, a "Change of Classification" form must be filled out and distributed to the appro priate places, as well as a notation made on the medical record or dental card.

MEETING THE HEALTH CARE NEEDS OF CONFINED JUVENILES *

The participants in this workshop attempted to present an overview of health care needs of confined juveniles as presented by Dr. Brown. Dr. Dochios discussed specific areas relating to health care needs and problem solving techniques in relating to children in short term detention facilities. Dr. Weber described experiences with a 200-bed intermediate to long term youth services "training school" facility.

The following is an outline of points suggested for consideration:

1. New medical and nursing health care providers to a juvenile facility must allow time to learn the traditions of their particular institution as those dictate the actual policies and procedures in effect.

2. The first impression of such a facility may be quite valuable and should not be discarded, although not immediately acted upon. As the health care provider works within a facility for a period of time, he/she becomes rapidly institutionalized and may no longer have untained insights.

3. It may become increasingly easy not to question long standing policies of an institution, even though they appear to have no rational basis.

4. One must develop the feeling of whose needs are being satisfied by various policies and procedures, e.g., Whose needs are being served by a large sick call?

5. One must decide who in the institution is most ready for changes, and which changes, e.g., Attempt to change smoking policy.

6. Methods which might be used to begin to change institutions' policies and procedures:
   a.) Establishment of an exploratory approach to all health care matters with broad based input and extensive discussion, helps to loosen up old traditions and identify individuals most threatened by change.

   b.) If new approaches are introduced as experimental, they may be less threatening.

   c.) Use of outside consultants from the community can also add to the acceptance of new policies.

   d.) The AMA Standards for Health Services in Correctional Institutions can serve as a useful guide.

* Summary Presentation by: F. Thomas Weber, M.A., University of Florida, Gainesville, Florida; Mary Dochios, M.D., Cook County Juvenile Detention Center, Chicago, Illinois; Richard Brown, M.D., University of California Berkeley, California

7. Medical care providers must adopt a sensitivity for the awesome problems of administration, program, and security personnel of their institution. Although the medical personnel should participate actively and cooperatively in the entire campus program, at times they may be required to hold fast to unpopular or difficult-to-accept medical priorities.

8. Health care providers may wish to design methods of contact with the medical system that are not "complaint oriented". Educational, recreational, or work contacts with health care providers within or outside of the health services area (clinic) may serve to diminish the need of individuals to malinger to obtain contacts with a health service team.

9. An important opportunity afforded to health care teams in longer term centers is the potential to teach their patients proper concepts of health care provider/patient relationships. Such areas to stress include: a.) trust on the part of both parties, b.) introduction of the concept of evaluation of a health problem and development of a diagnosis and treatment plan which will occur over time rather than an instantaneous process, and of the concept of follow-up, c.) a self-help approach to problems may also be introduced; such as methods to deal with stress-produced complaints.

   Longer term facilities and perhaps shorter term facilities should accept the responsibility for planning post-furlough health care follow-up. e.g. Young ladies may start contraceptive programs in an institution with specific follow-up health care plans.

10. An approach as to prevent staff "burn out" may include continuing education programs, two way communication with referral sources, reasonable staffing, and opportunities for introduction of innovative programs.

11. The establishment of good two way communications with referral sources from many institutions may require extremely great effort and time.

MEETING THE HEALTH CARE NEEDS OF CONFINED JUVENILES *

The Cook County Juvenile Temporary Detention Center, located at 1100 South Hamilton Avenue in Chicago, provides temporary secure housing for boys and girls up to the age of 17 years who are awaiting disposition of their cases by the Circuit Court of Cook County Juvenile Division.

The Detention Center also provides care for children who have been transferred from Juvenile Court jurisdiction to Criminal Court. These children otherwise would be incarcerated in the County Jail. The Detention Center is operated under the Cook County Board of Commissioners.

The Medical Services Department consisting of the General Pediatrics, the Dental and the Medical Laboratory sections, provide medical services for all children given temporary housing in the Detention Center.

The medical department is staffed by three board certified pediatricians, nursing personnel (7-8) who give around the clock services in three shifts, two laboratory technicians and a dentist. X-ray facilities are available for emergency use for possible body trauma and respiratory problems.

The infirmary has twenty six private rooms for care of illness and emergencies which may occur, with nursing around the clock. Provisions are also made for the transport of children to other institutions for emergency care beyond our scope, for treatment, and for specialist consultations and clinics.

Care for illness is provided on a twenty four hour basis and all children have access to the dispensary for treatment of medical complaints and injuries during this time.

All children are given a physical examination by a physician shortly after admission and their general health ascertained. This includes search for signs of communicable disease, physical abuse, trauma, pregnancy, venereal disease, signs of neurological disease, drug abuse and correctable health defects.

All children are given a dental examination shortly after admission. The dental department is equipped to care for routine and emergency dental problems. The operatory has an x-ray unit, air-driven rotary hand pieces, a power assisted contour chair, autoclave sterilizer and a comprehensive selection of instruments. Dental emergencies such as acute pulpitis or dental alveolar abscesses are given treatment priority. If surgical exodontia procedure of a more complicated nature and/or a general anesthetic is required, the patient

* Presented by: Mary Dochios, M.D., Chief Medical Officer, Cook County Juvenile Temporary Detention Center, Chicago, Illinois

is transferred to the Cook County Hospital Oral Surgery Department by the Detention Center. Dental prophylaxis is provided for all admissions and restorative treatment only if the patient is in the Detention Center for a sufficient period of time to allow these procedures to be performed.

The following laboratory studies are obtained on all admissions. CBC, urinalysis, serology, PKU test and nose and throat cultures. Vaginal smears and trichomonas tests are performed on all females and vaginal and urethral cultures on all suspected gonococcal cases.

Special hematology and chemistries are done when indicated by history and/or examinations. This includes fasting blood sugar for diabetes, mono spot test for suspected infectious mononucleosis. Sickle cell prep for possible sickle cell disease, liver profile for suspected hepatitis and urine tests for drugs and pregnancy.

All diagnosed cases of venereal disease are treated while in the institution and appropriate instruction and information given to the patient. If a patient is released prior to completion of laboratory tests and diagnoses, they are contacted through appropriate channels and advised on treatment as indicated.

All medication is given to the children in the Dispensary and under the supervision of the nursing personnel. Our drug inventory is extensive so as to meet the needs of the children's medical problems, such as infectious disease, venereal disease, skin infections, seizure disorders, allergies, respiratory infections, gastrointestinal disease and urinary tract infections. Children admitted with medications prescribed by their physician prior to admission for either a chronic or acute disorder are evaluated and their medicine continued as ordered.

Preventive medical services such as immunization program and contraception are not done, as it would not be feasible on a short term basis. Children seen on admission with a possible acute drug reaction are immediately referred to a hospital for emergency treatment as we are not equipped for conditions requiring acute intensive care and monitoring or for detoxifying procedures.

The dietary department is under the direction of a licensed dietician. Under her supervision the dietary department is responsible for preparing nutritious appetizing meals for the children and for special diets as required by diabetics, children with gastroenteritis or those with recent dental procedures.

The Temporary Detention Center Clinical Services program services the adolescents detained by the Juvenile Court. It is staffed by a registered clinical psychologist and a psychiatrist who services on a part time basis. They are advisors strictly for the Detention Center. Besides diagnostic services, there is an effort to define, clarify and improve the impact that even a brief period of detention may have on the individual. The clinical program capitalizes on techniques which can be successfully utilized in even a highly temporary situa-

tion. Making the child aware that he is responsible for his actions at all times in this setting, is called Personal Responsibility Training (PRT). The purpose is to assist the individual to function more adequately not only in the detention setting, but hopefully in the community, foster home or any court designated place. PRT is a form of reality therapy emphasizing the present situation, rejecting irresponsible actions and assisting individuals to become aware of their ability and responsibility to control the consequences of future actions.

Health services discussed thus far apply to those available at our facility, the Cook County Juvenile Temporary Detention Center, which is a short stay facility. The medical and dental treatments are usually of short nature with diagnoses, immediate treatment and referral when indicated for immediate or continued care.

My discussion is purely from the medical point of view and does not take into consideration the expense and feasibility of implementing this program to fit all juvenile facilities.

Young people who find themselves in juvenile facilities constitute a group who traditionally have displayed a high frequency of health problems, physical and mental health. The conditions which necessitate removing them from their environment and placing them in institutions may aggravate or even cause physical and mental health problems.

For this reason health programs in juvenile court facilities must be broad and comprehensive. The extent of health care which should be offered to an individual will depend on the length of time he is in the institution, but every institution which confine juveniles should have a health program to meet his needs and promote physical and mental well being of its residents and contribute to their rehabilitation by appropriate diagnoses and treatment.

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MODELS FOR HEALTH CARE IN SMALL JAILS *

My presentation is based on the AMA Standards for Health Services in Jails and our experience in Pennsylvania, regarding their implementation.

SECTION A ADMINISTRATIVE

This first section on Administrative covers everything from who runs the health system to relationships between health providers and jail personnel plus paper handling relative to inmates. Where other aspects of the standards will probably function with similarity in various jails, some portions under Administrative have the greatest potential for variance.

Standard 101 - Responsible Health Authority

This standard is met through a variety of methods. The following models have been used in Pennsylvania and are not exclusive or more acceptable than others which exist.

1. Single Physician: A single physician such as a family practitioner is the most common model in Pennsylvania; we have jails ranging from an average daily population (ADP) of 6 to 240 using this model. In every instance, other health personnel are involved in the delivery of services, for example: Doctors with LPN, PA, RN, and Medical Assistant. This combination frees the doctor to concentrate on medical decisions, precisely what is required of him under Standard 101.

2. Physician Group Practice: This model is one of shared services between two doctors, i.e., partners, or associates in a group practice, or two doctors splitting time not in the same practice. In such cases, one doctor must be designated as the "responsible physician".

3. House Staff: This model uses a residency program director as the authority when residents are used to provide medical services. We have two jails using this model: one with an ADP of 180 uses a family practice program very successfully with the doctor coming into the jail as well as handling the details and the other jail (ADP-120) uses this model less successfully because the jail could not get one doctor to assume the "authority". This is the main problem with this model.

4. County Health Department: This model was the county health department which is particularly good for small jails. We have one jail now (ADP-30) which has real

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* Presented by: Donna Wenger, Jail Project Coordinator; Pennsylvania Medical Society, Lemoyne, Pennsylvania

problems; has gone through several doctors in the past years because of county commissioners. If the county authority could take over, that could help the political situation.

5. Community Hospital: This model seems less suitable for small jails, i.e., contracting for all services with a hospital. Although this may look attractive, especially if the hospital is going to assume liability etc., it is expensive. Small jails are better served to get some health personnel doing routine duties in jail rather than transport for everything. We have one jail (ADP-330) using a hospital because they can afford it. In their case, the hospital employs individuals to work in the jail.

Standard 102 - Medical Autonomy

This standard is straightforward. It assumes communication between jail and physician. We have had no problems with this standard being implemented in Pennsylvania.

Standard 104 - Administrative Reports

Most jails find the annual statistical report easier to do because figures are being kept monthly. One problem the small jails have is taking the time to summarize information for the annual report. The best way to solve this is to designate one person to be responsible for paper work, such as the nurse (approach in one jail (ADP-80) is to make this part of the nurse's assignment; or to have a corrections officer who works with health add this to his/her duties (used in jail ADP-180). Quarterly reports are another problem altogether because responsibility rests with the doctor or health authority. The best way to meet this report is to do it immediately and to the point. Remind jails that nothing elaborate is needed. Also tell the jails, these memos serve well to justify future financial requests of county commissioners or prison boards.

Standard 105 - Policies and Procedures

There is no need to spend time on individual policies. The main focus here is the need for formalizing procedures and policies through written approach. It is not enough to say everyone knows how it is done; it must be written down. Policies take many forms; they can be memos to officers for some standards, while others require specific carefully conceived policies, such as a "disaster plan". The distribution of policies is one important aspect. It is not enough to write it down, and then make the book inaccessible. It is not necessary to have a single manual although it is helpful. Also some policies may be cross-referenced and appear in several places; e.g. warden's manual, officers manual, and physician's manual. We found some jails that thought they had a policy because the item was mentioned in the doctor's job description.

In our opinion, this is not the same as the policy. If policies are meant to formalize and standardize health care, they do no good if no one knows about them. We had one jail where the jail administration (warden) had mental symptoms in his notebook and the health personnel did not know about it. Two other aspects; even if you aren't doing one of the standards, you still need a written policy of what you're doing and also 105 does not cover all written requirements, e.g. job descriptions.

Standard 115 - Health Trained Correctional Officers

There are three central concerns here: trained in a minimum of first-aid, in CPR, and in recognition of common illnesses. A big problem exists with first-aid in jails which have a turnover of officers. Some states have training programs run by the state in all phases of corrections, as does Pennsylvania. This may be enough, but check to make sure it meets the American Red Cross equivalency. Another solution we like, tried by one jail (ADP-200) is to get one officer certified as an instructor in first-aid. Then he can do courses for all officers on a rotating basis. A problem for small jails is not having the luxury of letting officers go for enough time to conduct training. If you can arrange with the local Red Cross or Heart Association, perhaps they will come in and do training on an on-going program within the jail. This is one good area in which to involve the local county medical society--if you can think of ways to interest them in such a project. Another group (medical) which may get into this would be state chapters of the Emergency Physicians. There is public relations (PR) value of local doctors training prison officers in first-aid. The replacement for one officer trained in CPR per shift can be met by having the shift commander trained, plus we recommend a back-up wherever possible. The Red Cross and the Heart Association offer CPR training, as do some fire and ambulance companies and some local education institutions (colleges and high schools) usually in the evenings. To get officers trained in the recognition of common illnesses, we recommend involving the doctor or nurse to prepare a list based on knowledge of the prison illnesses. This standard is not talking about diagnosis and treatment. (This concept really scares wardens who don't want their officers "practicing medicine".) However, officers do need to know what to do and training in recognition allows them to respond appropriately and know when to get medical personnel. This becomes especially important in a smaller jail which does not have a doctor or nurse on hand for more than a couple of hours. We have some jails where the doctor or nurse review the list of symptoms with officers. This can be handily combined with on-going officer training and instruction on other aspects of standards, e.g. recognition of mental problems, medication training, etc., that the doctor must give to the officers.

SECTION D PHARMACEUTICALS

Standard 163 includes many aspects of management practice. Foremost, this standard includes the requirement to adhere to state and federal laws. If the jail does not get answers from the state medical society, it can ask its state Health Department, the drug control people, or the Regional Office of HEW as to what regulations

apply. The burden is on jails to know what the law requires. Federal regulations on controlled substances relate to what drugs can be prescribed according to classes, to distribution of controlled substances, and to labeling requirements, reuse of drugs, and record keeping.

We have found the following problems for small jails in the following aspects of the Standard: 1) development of a formulary 2) use of medications and 3) security checks. In all these areas, the degree of involvement of officers play a significant role.

Developed Formulary: we take this to mean the drugs actually stored in the jail, whether prescription or not, and are the medications used within the facility. One problem for small jails is the belief that this list must be exhaustive. It does not have to be. Depending on who does your drug supplying, you may have the formulary problem solved. For example, we have small jails getting their drugs through a local pharmacy who may be persuaded to help develop a formulary list. Jails using family practice residencies may get the same help from the residency program. We have one jail which doubles up with the county home, and this shared services arrangement could be tapped to have a joint formulary. Another problem we have run into is the great resistance of doctors to have such a list developed. We find doctors feel restricted and it helps to explain that in extraordinary cases a doctor may certainly go outside the formulary. One answer we won't accept is that the PDR is "our formulary". (And we've gotten that one).

Use of Medications: one problem in one of our smalls is related to the outside authority wanting the inmates to be "calm". The doctor didn't want to use psychotropics for this purpose and eventually resigned over that and other similar issues where this practice of medicine was infringed upon. Unfortunately, we don't have a solution for such a deeply ingrained problem. It points out that medication is very much a part of the practice of medicine and must be physician controlled. We do know that some jails have a problem with an inmate admitted with nearly a dozen concurrent medications from a mental health clinic. The family doctor in the jail didn't want to take the inmate off those medications because he felt he didn't know enough. This points out the need for stop-orders. Jails should be reminded that certain classes of controlled substances may not be renewed after a certain length of time.

Another problem with the use of medications which occurred in one small jail was the desire to save money. Medicines prescribed for inmates who had left were being saved. In effect these became "stock" medications. First, such practice may very well be against state laws. Second, we advised the jail to 1) order medications for shorter time periods and 2) increase their stock bottles if they wanted to go that route. This does add to security aspects if "stock" includes controlled substances.

Another problem is who gives out medications. Officers may do the actual handing out if there is a proper recording means for each dose (such as a Kardex). One jail doesn't even record if an inmate refuses to take a medication. This jail found officers were sometimes taking that

unused medication. This is also dangerous and difficult to tell if the inmate got the proper care. Several jails don't have inmates sign a form if they refuse. Some jails have anticipated this problem by having the inmate sign a treatment release form when he's admitted, thus agreeing to get whatever medical treatment may be necessary during confinement. One major problem we find in small jails is the use of officers taking the drugs from bottles and dispensing it to the inmates, usually on the doctors' orders. While this may be OK for over-the-counter (OTC) drugs and going by standing orders (e.g. aspirin for headache--although even that can be a problem if an inmate has an undetected ulcer), it should probably not be a procedure for prescription drugs except on emergencies (extreme). In Pennsylvania, our pharmacy act describes that approach as "dispensing" and outside the law for an un-licensed person. A possible solution is to have an RN or PA prepare a tray of medications for the day, and trained officers give them out to the inmates. It helps to have prescriptions wherever possible for once or twice a day medication. For a three or four times a day medication, a script really complicates the distributing part.

Security Check: some jails may want to build in the weekly inventory as part of the nurse's duties. If this is not possible for smaller jails, a designated officer, possibly someone on a night shift, could be assigned to make a count of controlled substances in "stock" bottles as well as syringes and any surgical instruments. Care should be taken that the solution to the need for security checks not breach security itself; for example, we have one jail where disposable needles were used for syringes, supposedly eliminating the need for a weekly count. However, the jail had inmate trustees carrying out the trash with the disposable needles in it. It should be no surprise that the jail had needles turn up as contraband weapons. Some of the jails have machines which chop up used needles or some have them carried out in locked boxes. The concept of a count should be based on a positive ascertainment of the presence or absence of items. It is not enough to keep a running count of what is used and then subtract. This method gives us control but cannot detect if someone unauthorized gains access to these items and takes them. Security also presumes controlled substances and instruments are under lock when not in use "and not everyone should have a key."

SECTION E HEALTH RECORDS

The main issues of health records are content and location. Some small jails try to do a single receiving screening involving health questions which saves time and energy. This form is not included in the health record. It should be noted that the time spent filling out a separate health screening form, (which is kept with the health record) is well worth it should a lawsuit be filed. We find that the omission of a receiving screening form is the biggest problem in small jails. The Practical Guide has a very good sample receiving screening form and no small jail should have trouble using it as a guide.

Location is the other problem for small jails because of space constraints and filing staff. The temptation here is to keep health records with other records. Standard 165, point out that health records (in

some cases by law) must be kept confidential. Another part of this problem for small jails is that too many officers have access to health records even if they are kept separate. Once again, the access must be controlled by the responsible health authority. Some small jails also have problems keeping adequate records. Major omissions are laboratory findings, consent forms, release forms, and other items which may seem less crucial than the health history. To keep these files complete, the doctor and nurse in a small jail need to take a leadership role. Larger jails frequently have the luxury of a staff person whose responsibilities include checking on these items. This is definitely one place where a small jail has a disadvantage.

SECTION F MEDICAL LEGAL ISSUES

Standard 168 is not "essential" but very important. Earlier, we referred to a release form which an inmate may be asked to sign when entering the jail. Some jails have a form which is given to the inmate when he gets the handbook and the written sick call times. After comprehending those items, he is asked to sign that he received them and that he consents to necessary treatment. Some jails are relieved of the responsibility to get consent forms for all hospital situations, as are large jails. Common sense should prevail on this issue.

MODELS FOR HEALTH CARE IN SMALL JAILS *

The July 1979 edition of the AMA's Standards for Health Services in Jails includes 69 standards divided into sections A through F. Twenty-three standards are designated as "Essential". The minimum criteria for AMA accreditation of a jail's health delivery system is compliance with all 23 "essential" standards plus at least 70% of the remainder.

My remarks are directed to those standards under Section B titled "Personnel". It is my opinion that this section should be subtitled "Training" because of the 12 standards in this section, 10 require specialized training for individuals who deliver health services at levels varying from the doctor to the nurse to the correctional officer.

There are seven "essential" standards in Section B which I will discuss.

Standard 122 refers to licensure which simply means are the involved professionals authorized by the State to practice their specialities. Probably the simplest way to implement this standard is to write the appropriate state licensing boards, asking them to confirm the status of the jail's health care professionals. This must be done every year and the proof of registration kept on file in the jail.

Standard 123 covers job descriptions. For the doctor, a carefully-defined written agreement with the sheriff serves as the job description. There is a sample agreement in the AMA's "Practical Guide". This agreement is more appropriate for a large jail but it can be cut down to cover what the doctor is expected to do for a small jail.

There are also job descriptions in the "Practical Guide" for other health professionals practicing in the jail.

Standard 126 concerns health appraisal personnel. This standard addresses the level of training for those performing specific elements of the health appraisal required for all inmates by the 14th day of incarceration. Certain elements must be done by "qualified" persons, others may be done by "health trained" persons. A "qualified" person is defined as one who is licensed, certified, etc.

Usually, if the person is performing similar services in the community, they are qualified to deliver them in the jail, under the direction of the responsible physician.

Standard 127 requires training for jailers who distribute medications. The doctor and the sheriff are responsible for this training.

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* Presented by: Parks Reinhardt; Jail Project Coordinator, State Medical Society of Wisconsin, Madison, Wisconsin

Or they may designate someone who understands both medical and security problems inherent in the proper distribution of medications.

There are a number of ways this has been handled, each dependent on the sheriff and the doctor approving the plan.

1) There may be classes set up by the state bureau or the staff can be sent to in-service training classes at larger jail facilities.

2) The sheriff and responsible physician can (1) personally conduct in-service classes in the facility or (2) the sheriff might designate someone on his staff to handle the security aspects and the doctor might ask the nurse or a local pharmacist to teach the medical portion.

3) The manual for the National Institute of Corrections (NIC) "Jailer Training in Receiving Screening and Health Education" course includes a section on drug administration. This can be studied by officers prior to an in-service class with the doctor or nurse or pharmacist present to answer questions.

Standard 128 details the kind of training needed in five areas for a jailer to be able to respond appropriately to medical emergencies. These are:

1. Types of potential emergencies - awareness that an emergency can occur at any time.

2. Signs and symptoms of emergencies.

3. First Aid

4. Who to call for help, and

5. Procedures for transfer.

Usually no formal training has been given to cover the first two. Obviously this would be a serious gap in training; depending only on "common sense" can be dangerous.

Again, there may be classes set up by state agencies and in-service classes at larger jail facilities.

Within your own community a training session to expand on the usual first aid course could be taught by the doctor, the nurse, perhaps a qualified person on the rescue squad, or the person in charge of the hospital's emergency room. Resource material for the instructor is probably available locally, if not, the NIC course covers emergencies. Remember, the instructor should be asked specifically to cover the first two requirements.

Standard 130 is staff training in the recognition of mental illness and chemical dependency. Many sheriffs reported that the largest medical problem they have had in the jail is coping with the mentally ill. All jail staff, including matrons, who work with inmates need training to recognize these conditions so that proper referrals can be made to avoid potentially life-threatening situations.

If there is an alcoholism and drug abuse counseling service and a mental health clinic in your community, the professionals on their staffs would be well qualified to give in-service training. Hopefully, these people are delivering, or will deliver, services to inmates. A formal training session would be helpful not only to jailers but also would give the agency staff a chance to get to know the jailers' strengths and weaknesses in reporting signs and symptoms.

For backup written materials the AMA has monographs on the"Recognition of Jail Inmates with Mental Illness", and on "Chemical Dependency". Also, the NIC course mentioned previously has sections on mental illness and chemical dependency.

Standard 133 concerns inmate workers in the medical arena. Jail policy should state that inmates are not used in any phase of the health delivery services. If inmates clean the medical office-treatment room, they must be supervised.

There are two "non-essential" standards in Section B which I would like to mention - Standards 124 and 129.

Standard 124 is concerned with staff development and training. Because the turn over of jail staff is so high, a written plan should be developed to ensure that new correctional officers receive training, not only in security, but in health related duties.

Standard 129 requires first aid training. Most communities offer classes in first aid. However, in some cities, the Red Cross instructor has given an in-service class in order to emphasize handling emergencies more likely to arise in a jail than on the street - for example, attempted suicides. Incidentally, don't forget jail matrons and part timers when these classes are held.

Sometimes the sheriff and physician are totally stunned by the amount of training required for jailers - still others believe that the jailers already know all that is required from "on-the-job training". Something between these two extremes is more nearly accurate. Obviously, relying solely on "on-the-job training" by experienced jailers can lead to everyone using dangerous procedures.

When you start planning for training - get on the phone and check with everyone you can think of who might know about training courses or agencies which might be interested in developing programs. And don't rule out calling agencies whose staff in the past were "not interested" - there may have been personnel changes, and as in Wisconsin, there's a lot more "interest" today than in the past.

Contact all the local and county departments, especially the county nurse and/or the chairman of the County Board of Health Committee. Try the emergency rescue squad, crisis intervention agencies, etc. If they can't help, they probably will have ideas about local people who could serve as instructors and/or who have access to written resource materials.

We have found that getting professionals involved with the jail helps to "sell" the County Board on the need for funds to cover a medical program.

Contact the State Bureau of Corrections; talk to the jail inspectors if your state has them. Have any training courses already been developed? Perhaps your prisons offer in-service training you could tap. Contact your state universities and their extension departments; the emergency medical services department of your medical school; the School of Pharmacy. Do you have a state bureau dealing with alcoholism and drug abuse, mental illness?

Here are four examples which help to show the wide variety of agencies interested in a jailer training program:

a) In Georgia, the Medical Association helped prepare a manual and video tape on receiving health screening by jailers which is available for a very reasonable price. This was LEAA funded.

b) In Kentucky, the Division of Emergency Medicine of the University of Kentucky Medical Center has a manual and video tapes for training jailers to handle emergencies. This was prepared for the Kentucky Corrections Department.

c) In Mississippi, the Cooperative Extension Service at Mississippi State University is working on upgrading jailer training. Part of their funding is from the U.S. Department of Agriculture.

d) And in Wisconsin, the University of Wisconsin Extension, Department of Governmental Affairs, has developed a jailer training course which includes some health sections. They also prepared the NIC course previously mentioned. And each year our jail inspectors hold one or two jailer schools which include some health related material.

Perhaps all this "formal" schoolroom training cannot happen over night. But a goal should be set to eventually provide formal training of the jail's correctional officers.

You may find it necessary to start out with "home study" training of jailers. The responsible physician must approve the use and content of the training materials; the jailers must sign a statement that they have studied the material; and there must be some professional - doctor, nurse, physicians' assistant available to answer questions.

Training and continuing education are important in any profession. However, it should be considered essential for correctional officers, especially those in a small jail. A small jail usually means a small community and the nearest hospital or doctor may be 10 to 20 miles away. When a medical emergency occurs in a jail, it is vital that the officer has been trained to recognize common emergencies and trained to provide appropriate care until medical help arrives or the inmate can be transferred.

MODELS FOR HEALTH CARE IN SMALL JAILS *

Receiving Screening for Small Jails

It is the jail's responsibility to know the medical health situation of the inmates at intake and to act on that knowledge in the most appropriate manner. Based on this need, our physician's committee at the Medical Association of Georgia (MAG) developed a training program in receiving screening for jailers and booking officers. Small jails usually do not employ health personnel and many must use deputies and correctional officers to perform receiving screening duties. To answer this need, the training program was designed to develop skills for these officers.

We have available some handouts with a receiving screening form which are keyed to the manual we use in our training sessions. The manual is based on the outline which is included in the handout. In a few minutes we will 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.

Receiving Screening Workshops

Two workshops on receiving screening for jail personnel have been conducted by the MAG as part of the AMA Health Project to date, one in November 1977, and the second in February, 1978. A total of 26 jailers attended, representing eight pilot jails that were participating at the time in the AMA Jail Project. We encouraged the actual booking officers or jailers who perform book-in duties, rather than the sheriff or the jail administrator to come. However, it is useful to also train others who can be available on a regular basis to teach the program as needed by a jail.

The 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 with similar 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. Approximately a day and a half is required to teach this training.

An important feature of this course is that it was designed to be replicable on a local level, with the sponsoring agency supplying the instructor and some equipment and MAG providing the teaching materials and audiovisual aids. A vid ape playback unit and monitor are required for the audiovisuals, o the community must at least have these resources, as well as qualified individuals willing to teach (unless someone is contacted to teach on a consultant basis). We suggest that the local medical society be approached to identify the medical member of the teaching team and that a correctional officer assist. This format has worked well.

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* Presented by: Dorothy Parker; Jail Coordinator, Medical Association of Georgia, Atlanta, Georgia

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 this 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.

A video cassette was produced especially for this course. A 20-minute film, "Recognizing Abnormal Behavior," shows 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 the 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. This is available to be used in portions of future workshops. In the past year over twenty jails have contacted us to set up their own workshop, and we have sent manuals and duplicated the videocassette. If the jail will send us a 20-minute blank video cassette, we can duplicate it for less than $15.

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 come up with answers to questions that were raised. Role-playing is also used as a practice mechansim 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

After being able to cover emergencies, most experts on jail health care agree that health screening is the next most important for jails to do. Consequently, this training is essential, even in the smallest jails.

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 both question and observation, 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 also 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. Once 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.

Responsible receiving health screening will require some very special skills to be developed. Many booking officers have learned much from general experience with hundreds of prisoners. However, appropriate training 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 will now show you three fictitious cases of inmates being booked into a jail and let you practice making some physical assessments on your own.

MODELS FOR HEALTH CARE IN SMALL JAILS *

As I travel among the various county facilities in Illinois, I find they all have basically the same question: "Where do I find the resources to meet the AMA Standards?" Jail officials want to provide the necessary medical and dental services, train their personnel and comply with state laws, but few can find funding within their already limited budgets to deal with these requirements. Well, whether you're responsible for a small jail with only a dispatcher to handle calls, conduct intakes and cook the meals, or administer a large facility with a complete infirmary, there are resources within the community that potentially are available to you to fill the gaps in your medical care delivery system.

The accompanying chart briefly illustrates the possibliities within most counties. It lists governmental, private, professional and consumer agencies active in providing the types of services needed by correctional facilities. Use the chart as a starting point to identify those agencies active in your community. Then contact each to determine the extent of their services. Not all agencies provide the same services in every state, or every county for that matter. Usually, the local chapter has its own priorities or interests designed to meet the community's needs. In addition, there may be agencies which are not listed in this chart, but serve the same functions within your community.

The important point to stress is to look to your community. The jail should be seen as a component in the area's health care delivery system. Diseases identified and treated appropriately in the jail will prevent problems for the surrounding community. The jail holds local residents, most of whom will return to the area in a relatively short period of time. Therefore, it's appropriate for local agencies to extend their services to these people and deal with their health problems. In addition, the training of correctional officers enhances the ability of the jail to provide for itself, rather than inappropriately utilize medical resources.

Though it's unnecessary to go through the entire chart, let me mention some of the more important items.

Potentially, the county health department is by far the best resource available to the jail. Depending upon the county, the health department often is funded to provide medical and dental care, communicable disease detection, nutrition counseling, training programs and environmental services. Since county departments are supported by the same monies as the jail, county board members should be urged to utilize one county agency to service the other. To require jails to pay for health department services is like taking money from one pocket and placing it into the other. Again, it should be stressed that the health department is to serve community residents and the jail is populated by these same people. A close working relationship between the jail and the health department can change a non-existent health system into an accredited one.

*Presented by: Larry Boress, Jail Project Coordinator; Illinois State Medical Society, Chicago, Illinois

The involvement of students from medical, dental and nursing schools can provide the jail with interested, motivated individuals to handle the daily and routine medical, nursing and dental services. The jail offers a unique learning environment, giving the student an opportunity to treat conditions seldon seen in the typical medical or dental practice. Ideally, the head of a school department, i. e., Family Practice, becomes the jails' consultant, with the students providing the actual services. This arrangement offers advantages for both parties, though the responsibilities of each must be clear from the start.

Community colleges and universites may provide a valuable training ground for jail personnel, in offering medical, as well as correctional topics. For several reasons, school officials are looking for ways to serve the community and may be willing to develop courses or provide faculty to meet the specific requirements of the jail. In addition, student interns from Criminal Justice programs may be available to the jail to develop procedures, forms, etc., and all they ask is to be given course credit for these activities.

Military bases, and especially Veteran's Administration Hospitals, are potential sources of personnel and services. Though I don't know the details, I have been told that VA hospitals are encouraged to develop "sharing agreements" with the local community, to provide medical personnel, faculty and/or services as requested. Again, this is an area where local discussions are vital to determine the extent of assistance available.

Finally, I would like to encourage you to utilize the Regional Criminal Justice Planning Agencies as consultants in developing training programs for your staff. While their level of funding varies greatly, each RPA is required to have a local plan to assist correctional facilities, and your input is important.

I recommend that you take this chart home, review the potential resources in your county and determine the extent of interest which exists. Too often, jails spend unnecessary money to duplicate or purchase services which are available, sometimes for the asking, from other agencies in the area.

I encourage you to take that first step and develop the relationships which potentially offer continuing benefits to the jail and the community.

APPENDIX: AGENCIES IN THE COMMUNITY

LINKAGES WITH THE COMMUNITY

Agency/Organization

Service	Cit /Count Health De t.	Local Hos ital	Local Nursing Home	Count Nurse	School Nurse	County Medical Societ	Local Ph sicians/Clinics	Local Dentists/Clinics	Medical School	Nursing (RN/LPN) School	Dental School	Dental H ienists School	Community College/University (Interns in criminal ustice	Ambulance Company/Rescue Squad	Fire/Police De t.	Count Coroner's Office	Militar Base/VA Hos ital	HMOs/IPAs	American Heart Assoc.	American Cancer Societ	American Red Cross	Civil Defense	E ile s Foundation	Cooperative Extension Service	Local Mental Health Center	Local Drug Abuse Agencies	Detoxification Pro rams	Alcoholics Anonymous	Regional Criminal Justice Plannin A enc	Church Grou s	Auxiliaries	Civic Groups	Salvation Army	Family Planning Groups
Physician services/consultation on cases, pro?rams, olicies, forms	X																																	
Nursin? services/consultation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Dental services/consultation	X																																	
Lab & diagnostic tests for disease	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
EMT - A services																																		
Mental health services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Hospital services																																		
Detoxification																																		
Drug addiction services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
CPR trainin?-Basic/instructor	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
First aid training - Basic/ Advanced	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
EMT - A trainin?																																		
Receivin? screenin? trainin?	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Mental health/retardation assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Counselin?	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Clothin?	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Volunteers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Medical-le?al situations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Medication administration, trainin? and documentation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Professional ?ublications	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						
Health education materials	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X						

MODELS FOR HEALTH CARE IN SMALL JAILS *

My segment during this discussion on models for health care in small jails will devote attention to the important role and duties of a jail nurse.

Before attempting to design an actual health care delivery system, you should first analyze your current system i.e., what are the needs of the inmates; what services are provided or not provided, how can services be obtained; who will provide these services and where will those services be delivered?

Let me emphasize that the size of a jail should be no handicap in implementing an acceptable, adequate health service system, if there is dedication and purpose.

The Shiawassee County Jail in Corruna, Michigan has a rated capacity of 42 inmates, obviously a small jail by any standards. During the early 70's, this jail only provided first aid and a nurse came in to take blood samples and test for TB. A suicide in 1975 had a traumatic effect by awakening responsible community leaders and the general population; there were demonstrations at the jail protesting the lack of medical care and other grievances. Doctor John Lyons,DO, the county public health director brought this matter to the attention of the county board and in a short time he assigned a public health nurse to the jail.

Registered nurse Lois Storrer had never heen in a county jail and pondered about what she knew about caring for inmates; this was a new experience. Lois began her duties literally from scratch; no medical records to use as a guideline. As she tells it, she began keeping medical records - she calls them diaries - until the AMA Jails Project started with Dick Campau, the former Michigan Project Director, - visiting her jail. From then on, everything moved swiftly; Regular sick calls began (three mornings a week) attention to inmate's complaints and a system began to emerge which culminated in this jail receiving a two-year AMA Accreditation in 1978. In the afternoons, she returns to the Public Health Department for other department assignments.

If it isn't in your packet or materials, I recommend that you ask for the AMA monograph "Health Delivery System Models For The Care of Inmates Confined in Jails". Examples are given of seven different models of systems describing new alternate approaches. These examples cover situations from the very small jail which does not have a physician or a nurse on-site to a jail that employs a professional, certified EMT to jails that have registered nurses on duty around-the-clock. The flexibility of the standards were especially designed to allow a number of variations fitted to any size jail, its needs, and the available resources.

I asked Lois if she had any thoughts or words of wisdom I could bring to you today. She lamented that this kind of nursing was not in-

* Presented by: Herbert Mehler, Jail Project Coordinator; Michigan State Medical Society, East Lansing, Michigan

cluded in the curriculum at the nursing school she attended. Being a jail nurse is enjoyable, rewarding and fascinating. She thinks there should be some type of special training and/or in-service program for nurses who are or would like to be involved in improving inmates' medical care.

She made one other comment that had an impact on me and I hope on you. She said, that as a mother, if her son unfortunately had to spend time in a county jail, she would want that institution to have the capability of providing good quality health care.

When you return to your communities, give an extra look at your county jail; get involved by lending your expertise. A good community effort can achieve wonders and it can make a difference.

The Shiawassee jail did it and yours can too!

NUTRITIONAL NEEDS - ASSESSING SHORT AND LONG RANGE PLANS *

Food service is the most important department in any type of institution that has feeding. This is the only thing you and I have in common - we both have to eat.

What I have to say today you can use in any type of institution - any size. I don't care if you are feeding one person or 50,000 people, I have used this food control system recommended by the National Research Council for thirty-five years in corrections and it works. I have had only one disturbance and that was over Cinco de Mayo (May 5, 1970).

To have good food service you have to have someone in charge of the food service who cares. Food service is a profession of its own. It takes a different breed of person to work in a correctional institution.

The kind of person you need in a correctional food service is one that is honest with him/herself and the residents they work with. They have to like it. They have to live it and work at it 365 days a year and be willing to try new things. In a correctional institution you are not allowed to make mistakes. You see all of these hand-made weapons in front of you. You never know when you are going to be attacked! Yes, I have been scared many times. I would be lying to you if I said I hadn't.

For years you have heard so much about nutrition and a well-balanced diet. What is a nutritional diet? Do you know? I don't know, but I do know what I have been doing for the last thirty-five years is working. During this time I have had no one with scurvy or suffer from malnutrition or any food poisoning. Sometimes I think we try to make things harder than they are. Why feed or put something on a menu your customer won't eat. That costs you as taxpayers.

The biggest hangup on diets is that the inmate doesn't like to eat what is prescribed for him or her, so therefore, the nurse on duty should supervise the feeding so the inmate doesn't sell the food to someone else. Also, if an inmate is supposed to have a snack at night and the other inmates do not get one, the inmate that is to receive the snack will sell it.

My belief is that if a diet is prescribed by the doctor, it should be like a hospital on the outside i.e., the name of the inmate, number, type of diet and not over thirty days, etc.

So many times a doctor will give a special diet to the heavy weights because the inmate puts the pressure on the doctor to do so. I call it

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* Presented by: Al Richardson, Executive Director; American Correctional Food Services Association and Food Director, Utah State Prison, Midvale, Utah

a catering service to a select few. A way I recommend to handle the special diets is to do the following:

1. Diet from the doctor - I don't mean from anyone else, because most of the time others can be "conned" to.

2. The inmate is given a diet card to receive a meal. Make sure they eat on the diet line or pull his card until he sees the doctor about cheating on his diet.

3. If you have a large or small institution, let the inmate be assigned to your department so he can prepare his own diet under supervision. Then in case he has sugar diabetes, he will know how to prepare his own diet when he is released.

I would like to suggest to you if you are in charge of the food service or responsible for the food service to try the following things:

1. Get a copy of my Form 10. It tells you how much food to order and how much food each resident is allowed per day. It is broken down into sixteen details. As I stated before, I don't care if you feed one person or 50,000 people, it has the basic four food groups in it.

2. Use a menu planner. It will tell you how to prepare a good menu and how to garnish it. Make your menu up to six weeks in advance.

3. Get residents involved. Who is better qualified than the inmates or residents who eat your food? I either appoint or have elected one representative from each block, dorm or section on a food committee as an advisory board. Their duties are:

   a.) Make suggestions on menu planning.
   b.) Eat in the short line, then if there are any problems with the food such as too much seasoning, food cold, etc., they will then take the complaint to the inmate chef on duty. If they can't handle it, they go to the chef on duty. If they can't handle it, they come to me.

I have instructed all my paid staff not to put anything on the line they would not eat themselves - no exceptions. I have also told the resident that may have complained about the food and stated how good other states feed that if they would get me the menus from the other states for thirty days, I would feed it, but they couldn't skip

around and pick certain days. I have never been challenged in thirty-five years.

4. Celebrate different holidays and make a big thing of it. We celebrate:

   Cinco de Mayo (May 5)

   Soul Day (June 19)

   Pioneer Day (2 meals) (July 24)

   Thanksgiving (2 meals)

   Christmas (2 meals)

   New Years Day

5. Three times a year, (providing that the food service department has no "heat" on it), have a food service party. We invite the staff and their one guest and the residents and two invited guests, providing they are on the visiting list. Then I invite some of the top chefs and administrators from restaurants, hospitals and nursing homes and they tell the inmates about job opportunities. This helps to motivate the inmate as well as the staff.

6. Get your local health department involved.

7. Follow the American Correctional Food Service Standards for accreditation.

8. Get your food service staff certified by the American Correctional Food Service Association.

Here are a few things we are now trying: We are using decaffeinated coffee and it really has cut down on a lot of fights. I am also giving it to the staff. We are also working on giving whole wheat bread and sugar substitutes.

REALITIES OF THE EXPANDED ROLE OF THE PROFESSIONAL NURSE IN A CORRECTIONAL SETTING *

This workshop did not expect to develop final solutions to the problems inherent in expanding roles of health professionals. We could not adapt to the varying standards and regulations of the many state licensure authorities. We have not yet been able to cope with the problem of salary differentials associated with the expanded role of allied health professionals. The discrepant relationshops between length of training and salary scales among physician assistants, nurses and nurse practitioners clearly indicate that certain specifically defined skills have a higher value in the marketplace than others.

Relevance of the traditional role of the registered nurse (RN) in a prison walk-in clinic is limited. When a health care manager examines all of his options, utilization in this setting of RNs who have not been trained as primary encounter professionals raises serious questions of quality of care and cost effectiveness. In theory, the RN role can readily be expanded to that of primary encounter professional. These additional skills can be developed in motivated RNs by short and well designed programs. In practice, there are obstacles. These have been: nurse motivation; professional identity conflicts; and limited staffing i.e., nurses could not be spared for inservice training sessions.

In the Washington Corrections Division we undertook to provide in-service training for a group of former Navy corpsmen who had been employed for years in Corrections as primary encounter health professionals. MEDEX Northwest of the University of Washington, designed a curriculum (including 200 didactic hours) and a program which was approved by the State Board of Medical Examiners. Registered nurses and Licensed practical nurses (RNs and LPNs) were invited to participate. Most nurses chose not to. In this way, however, we generated a new category of health professional which we named correctional health specialist and for which an identity is now being sought.

In the program, the methodology of the problem oriented medical record was the basic framework in which statement of the problem and collection of data were the first steps. Emphasis was placed on recognition of the normal, exposure to commonly occurring episodic illnesses, and mastery of basic emergency procedures.

A more advanced role expansion of the registered nurse is that of nurse practitioner. At the Washington State Penitentiary we have validated the observation of Dr. Glen E. Hastings, that the certified family practice nurse is capable of definitive management of 90% of cases appearing in a walk-in clinic and which have historically been managed by physicians.

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* Summary of Presentations by: Edward Naugler, M.D., Medical Director, Adult Corrections Division, Olympia, Washington; and Joyce Lingerfelt, C.R.N., Director of Inservice Education, Olympia, Washington

Thus, positions for two full-time physicians have been abolished and one-half time physician and two nurse practitioners have been placed. Two additional midlevel professionals are needed for optimal service. The health care program has been greatly improved in the opinion both of the inmate population and of the physician consultants in the community. Record keeping has been improved, supervision of the primary encounter professionals is better, and utilization of specialty consultants more appropriate.

In our opinion, this rearrangement of utilization of professionals is a major step in avoidance of prison "burn-out". The physician, in particular, is used only for problems appropriate to his skills. But this is also true of the nurse practitioner who is motivated to further expand the skills of the primary encounter professional and so increase all around professional satisfaction.

It should be pointed out, and not parenthetically, that the nurse practitioners have been accepted as peers by the physicians of the community who serve the prison. The proper presentation of a clinical problem by one professional to another has repeatedly proved to be the beginning of a reciprocal learning peer relationship.

STANDARDS IMPLEMENTATION - HOW DO YOU DO IT? *

I am very pleased to be sharing this panel with Ms. Claire Evans and Dr. Sam Eichold. I am the Chief of Health Services for the North Carolina Division of Prisons and I will be talking about the implementation of correctional health care standards in a state prison system. Ms. Evans is a Jail Project Coordinator for the State of Maryland and serves on the Medical and Chirurgical Faculty of Maryland. She will be talking about the implementation of standards for a number of jails as a result of the AMA Jail Project. Dr. Sam Eichold is an associate professor at the University of South Alabama College of Medicine and serves as the health authority for the Mobile County Jail. Dr. Eichold will be talking about the implementation of standards in a specific jail.

When we talk about the implementation of standards we are obviously talking about implementing change. If we are presently providing health services in compliance with a specific standard, obviously that standard is already implemented. If a standard sets forth a certain procedure or policy which is different than that which we are presently doing, to implement the standard requires change. So what we will be talking about for the next few minutes is really the implementation of change in a correctional health care delivery system.

The instructions I received from Joe Rowan, initially were to keep "war stories" to an absolute minimum. At the same time, he emphasized that this conference should address "how to do it." What I am going to be doing for the next few minutes is trying to comply with one set of directions while disregarding the other.

I would like to share with you how we have been able to implement change to a degree within the North Carolina State correctional system as a result of two things. The first is the development of the correctional health care standards by the American Medical Association and second is the result of our participation in the Michigan Correctional Health Care System.

Our participation in the Michigan Program was probably the most positive thing that could have happened to us. We were able to send 22 staff members to a number of workshops at Ann Arbor and Lansing, Michigan during the fall of 1978. The participants in this project included 5 health administrators, 7 registered nurses, 3 psychologists, 3 physician extenders (that is physician assistants or family nurse practitioners), 1 pharmacist, and 1 dentist. At the conclusion of each workshop, the participants were debriefed. It was evident that their enthusiasm as a result of their participation in the workshop bordered on exuberance.

We conducted the final debriefing with all participants present on the 10th of January for the purpose of gathering input as to the changes we felt we could implement within the N.C. Divisions of Prisons as a result

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* Presented by: Richard A. Kiel, Chief of Health Services, North Carolina Division of Prisons, Raleigh, North Carolina.

of our workshop participation with little or no additional resources. After considerable interaction, we narrowed our scope down to seven specific areas and we established a task force to address each area. The task forces were composed of participants in the Michigan Program plus additional resource people that were available within our system.

Task force #1 addressed the issues of health records. It was our consensus that our records were inadequate, lacked standardization, and needed considerable improvement for them to become an effective clinical tool. That task force was charged with evaluating our current health record process to include our outpatient records, our inpatient hospital records, the inpatient mental health record, our putpatient mental health records, the dental records, and the records used in our skilled nursing facilities. It was the general consensus that a modified POMR would probably be the desired record. Standardization would be a key element and the record would be compatible with a management information system whenever we were able to develop one.

Task force #2 addressed a health care management information system. This task force was charged with the responsibility of developing the basic framework for a health care information system which would tie service delivery into cost data for specific services. It was evident that the data gathering must be designed so that the individual who gathers the data receives a positive return and in the process facilitates the delivery of their services. Considerable coordination between this task force the health record task force and the central pharmacy task force was evident. We were in the process of developing a central pharmacy service so it was obvious that one of the task forces should be concentrated in that area. The central pharmacy service task force was charged with the responsibility to evaluate our present service and develop specific procedures which would facilitate the central pharmacy operation. By the way, this is working very well and by the end of the year we will have all 86 state prisons under a central pharmacy operation. Procedures for the interface of the central pharmacy service with the management information service were also a mission of this particular task force. Task Force #4 addressed the development of protocols, algorithms, and standing orders. As you may know, about 70 of our prisons are very small and the health care staff consists of a part-time registered nurse who comes in and holds sick call and gets up medication and so forth. It was evident that standing orders were essential in the delivery of primary health care. Protocols are required in North Carolina between the physician assistant or a family nurse practitioner and the physician to whom they are registered. One of the goals of this task force was to identify standard protocols.

We have had a lot of trouble in North Carolina in insuring continuity of care. There is a tremendous amount of movement of inmates from unit to unit using a very complicated busing system. To get the inmate, his medical record, and his medication at the same place at the same time although it appears simple on the surface becomes tremendously complex. The continuity of care task force was charged with the responsibility to identify the specific problem areas which impede continuity of care and to recommend whatever action was necessary to insure the simultaneous arrival of an inmate, his records, and his medication when he moves from unit to unit. The sixth task force was in the area of continuing education. The thrust of that task force was to identify those areas where continuing education

of our correctional health care staff was most needed and to identify resources which could provide that continuing education. That task force also prepared recommendations for inmate health care education and self-help programs.

The last task force was composed of the chairmen of each of the other task forces and that addressed the development of the health care policies and procedures manual. This task force was to take the standards developed by the American Medical Association and use those standards as the basis upon which to write our health care policies and procedures manual. The standards would essentially become the policy and the method of implementation within the North Carolina Division of Prisons would become the procedure.

In May of 1979, we held a health care conference within our system attended by 150 correctional staff members. Fifty of these were health care providers, 50 were correctional officers or line commanders, and 50 were programs personnel. The theme of the conference was how can we do it better, and it stressed the team approach to correctional health care delivery. Input from the various workshops during that conference was funneled into the task forces so essentially we had the involvement of over 150 of our staff in the development of the policies and procedures for the delivery of health care. As we all know, implementation of change is facilitated when we involve the people who will actually be changing their behavior in the decision-making process which decides how their behavior is to be changed. Over 170 individuals had an opportunity for direct input into a new health care procedures manual and through that input I feel the implementation of the changes, were changes are required, will be facilitated.

After we had developed these task forces and set forth their mission, we wrote a grant proposal to our staff training office and requested that the task force meetings and the creation of the procedural manual be funded, under our training grant sponsored by LEAA. Rationale was that the health care procedures manual would be absolutely necessary to train our health care personnel and we were developing this training tool to insure that the new procedures would, in fact, be implemented. Each task force met three times over a period from March through September. The last meeting of the policies and procedures task force being the end of September. The end result was the creation of the first draft of our Health Care Procedures Manual. That manual has been staffed through the line commander and has been reviewed by the Advisory Council on Health Care in Corrections which is composed of representatives of the N. C. Medical Society, N.C. Nurses Society, N.C. Dental Society, and health disciplines from N.C. Department of Correction.

Obviously, getting it on paper is just the first step; however, it is a very essential step. Everyone needs to be playing off of the same sheet of music to have harmony in our song. And without a very definite procedural guide, each would be doing his own thing and chaos could well result.

I failed to mention that one of the components of the Michigan Correctional Health Care Program was the providing of technical assistance to the states. During the debriefing session in January, we decided that we would like to have technical assistance in the area of health care management information systems, in our central pharmacy service and our medical records system, and in the development of a continuing education training package for the correctional health care provider. We received technical assistance, very excellent technical assistance I might add, in these areas from the Michigan Correctional Health Care Program and we were able to use this TA as it fit into our task forces in the development of the new procedures.

It is recognized that we do have a large correctional system and we do have a significant number of correctional health care professionals representing all of the disciplines. Can a jail use this same approach? I think so. The bottom line is to get involvement of the people who are going to be affected by the change. If your jail health staff consists only of a nurse of two with a contractual physician, this type of approach could still be used by getting the involvement of as many people as possible in the development of your new direction. The route that we have chosen to take in North Carolina certainly isn't the only way, but I feel that it is going to work for us and I am anticipating a considerable improvement in our correctional health care delivery system as a result of this particular process which is geared toward implementation of the excellent standards that have been developed by the American Medical Association. Thank you.

STANDARDS IMPLEMENTATION - HOW DO YOU DO IT? *

At first, I would like to state that I was a novice regarding jail health care when I started with the program in 1976--one of six state project directors. The aims and goals of the program charged us with assisting jails in upgrading their medical program. Along with this, we worked with the National staff in developing and testing the Standards. In short, my qualifications are based on the experience gained over the past three years.

You might consider this unacceptable; but then, you might also realize that this lack of prior experience left me without bias. I approached the task with a total commitment to do a good job. Realizing now that I started at baseline zero, with a certain pride I would like to say that I may actually be able to give you some basic thoughts on "HOW TO DO IT?"

I realize that the document, which we call the "Standards", can be overwhelming at first glance. Many of the sheriffs in Maryland were discouraged from participation, there was so much documentation. So, please, follow this simple approach which I developed:

STEP ONE: Don't be overwhelmed. Read through each standard to find out the intent. (If it is not applicable to your facility, make a note of that.)

STEP TWO: Discuss and review the Standards with key members of your staff.

STEP THREE; Review your current system. Be objective in this.

STEP FOUR: Review all of your current documentation.

STEP FIVE: Develop an action plan to effect change.

After you have realistically evaluated how your current system compares to the Standards, you will find that there are areas which can be changed within the facility without too much trouble.

EXAMPLE:
FORMS
JOB DESCRIPTIONS
POLICIES
PROCEDURES

For this task, you may want to find one person to collect all current documentation to evaluate how they fit within the context of the Standards. You may be surprised how much is already available and how some minor changes can bring others into compliance.

Your responsible physician while providing care and overall direction in medical decisions will not have time to write the various policies and procedures governing the medical care delivery system. It will be necessary to delegate a support staff member to assist with this. Remember, it is most important to not only provide care but document such care.

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* Presented by: Claire P. Evans, Jail Project Coordinator, Medical and Chirurgical Faculty of Maryland, Baltimore, Maryland

It has been my experience when jail administrators and jail physicians work through all of the Standards from 101 to 109 slowly and systematically, they will be able to formalize the "health care manual" for the facility. It can be done regardless of your jail's size -- the overall approach remains the same. (But, don't forget: The "health care manual" is only as good as the services actually provided!)

I would like to state here: Don't be discouraged. Start step-by-step and success will follow.

Next you will need to list those areas where you will need assistance. Most of those will need involvement of agencies outside of your facility, to name a few, such as:

Medical Society
Health Department
Community Counseling
Referral Agencies
Training

Again, a conference with your key people within the facility will assist you in developing a realistic action plan outlining where you expect to see changes in: one month, three months, six months, or one year.

I would like to go back a step now and outline some of the referral contacts to help you with Standards Implementation.

Your STATE AND LOCAL MEDICAL SOCIETY will be able to provide you with information and assistance concerning the various issues of medical care as it is provided in your community. In addition, the American Medical Association has developed written material for your use. Ask your local medical society to appoint a jail health committee, and invite that committee to your jail. A mutually beneficial relationship will develop from this contact.

Ask your local HEALTH DEPARTMENT to provide you with testing for communicable diseases, such as tuberculosis, venereal disease, and others appropriate to your community. If they know your needs, and your effort to upgrade health care, I am sure they will respond.

COMMUNITY COUNSELING for both alcoholics and chemically dependent detainees should be extended into the jail environment. Get in touch with your local agency to develop a plan to fit both the agency and your jail.

In addition, contact with local MENTAL HEALTH AGENCIES should be developed to establish appropriate referral resources.

These are just a few suggestions to get you started. You will find that there are many more ways to get help, once you start. Most importantly, keep your community informed of your efforts. They need to know and understand your problems.

As you review the standards, it becomes clear that your correctional staff plays a major role in the health care delivery of your facility. They are the ones to observe and to act on emergencies, as well as every day health complaints. If you have a TRAINING ACADEMY in your state, develop contacts and discuss how that training can be expanded to provide knowledge in those areas involving receiving screening, handling sick call requests, recognizing mental illness, first aid, and CPR.

These suggestions are only given to get you started. I am sure that you will be able to add to them on your own.

As you can see, the implementation of standards is based on the combined effort of you, your staff, and your community. It can be done. If all of you work together toward improving jail medical care, it will result in eventual compliance with the Standards.

STANDARDS IMPLEMENTATION - HOW DO YOU DO IT?*

Accreditation for the Mobile County Jail was felt to be desirable in view of the need to meet minimum standards and evidence compliance with the decision of the Federal Courts in Montgomery and Mobile. The Medical Association of the State of Alabama has not been a participant in the program of the AMA and the eztablishment of standards for accreditation. Our own county jail has a deep appreciation of its responsibility for the delivery of health care to the inmate. Para-medical personnel are on duty in the jail and Physician's Cooperative, Inc. is under contractural arrangements with the sheriff to provide physician back-up.

A review was made of the standards for health care as developed by the AMA. The chief nurse initiated the idea of seeking accreditation. She developed the protocol for the delivery of health care at the Mobile County Jail and necessary forms that would meet the standards of the AMA. The Medical Association of the State of Alabama is one of twenty-eight associations which are not participating in the AMA standardation of health care in correctional institutions. Contact with the Medical Association of Georgia provided a sight visit team to inspect our facility. It was the opinion of the review team that our organization, our guidelines, the table of organization and the involved personnel were all appropriate for meeting the requirements of accreditation.

For inmates in a correctional institution there is no justifiable reason for the delivery of health care to be less than the standards of the American Medical Association. Accreditation is reasonable and justifiable.

*Summary of Presentation by: Samuel Eichold, M.D., Professor; Department of Medicine, University of South Alabama College of Medicine, Mobile, Alabama

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SUICIDE PREVENTION IN JAILS AND CORRECTIONAL FACILITIES (SEMINAR) *

In order to understand what brings about jail suicide and how to prevent it, it is necessary to understand what happens to a citizen who has been arrested. This experience is described as the Incarceration Process. It is also crucial to picture the broad spectrum of behavior which is both directly suicidal as well as self-destructive. Such behavior may be involved in the basic action of the crime, may precede it for any length of time or may occur in jail.

Both of these aspects of jail suicide will be discussed in this presentation along with some material regarding suicide prevention program development within the jail.

The Incarceration Process

Basically, there are two types of jail inmates. The most common one is the habitual or repeat offender. This inmate usually has a sociopathic personality, one which has distinguishable features. He easily lies, manipulates others, is pleasure oriented in terms of sexual appetite and substance abuse behavior and is dangerous. He has a high potential for violence, is rebellious and has a poorly developed or defective conscience. Confessional behavior usually gives away his criminal or antisocial behavior. His eye contact is poor and he cannot form a close, intimate and meaningful emotional relationship. Authority is thwarted by him and he usually sees that he is the victim of everyone and everything but himself. His suicidal behavior tends to be manipulative and attention getting in nature.

This type of inmate knows the criminal justice system. Frequently, he knows the jail staff and other inmates and his admission to jail has all the marks of a carnival occasion when he may exchange greetings with the staff and other inmates. He knows how to assess the skills of his lawyer, knows how to lie, how to build a defense and, like the predator he is, stalks the cell blocks in search of naive inmates whom he can exploit. This type of inmate is no serious suicide risk. He knows how to survive and take care of himself. Any suicidal behavior is manipulative. He is a definite security risk. Aside from being deprived of his freedom and need to do whatever he wishes, incarceration in jail will not be either traumatic or difficult for him.

The inmate who has emotional problems in connection with his arrest and confinement is the average, law-abiding citizen. His incarceration involves his initial arrest. It is for this person that the incarceration process becomes most difficult. Let's take a look at what happens.

From the time of his arrest until his admission directly to his cell block, this inmate passes through Phase 1. Throughout this period of time he experiences derealization, the feeling that this is happening but he is not part of it. It's like it's happening to some one else. The prisoner moves like a zombie, one drained of feeling. He displays a mild

*Presented by: Bruce L. Danto, M.D., Consultant and Lecturer on Suicide Prevention, Detroit, Michigan

confusion and appears like a lost puppy. Officers have to gently guide him into the patrol car, into the booking station and into his cell. In this stage the inmate says little. If he has been admitted to a single cell in a local lock up, prior to a transfer to the central jail or before the initial hearing is held in court he has the same experience. However, a feeling of shame strikes him immediately after his arrival in the cell. He thinks of what effect his arrest will have on his family or job or future. At this point he may decide to die and will either hang himself or asphyxiate himself with bedding or clothing. The jail or lock up staff are shocked as his arrest was either for a minor infraction of the law or was for his own protective custody if he had been drug or alcohol intoxicated.

In the central jail, however, when the inmate arrives and the door of the cell block is closed with a metallic clang, the inmate is startled into awareness and reality by unfamiliar noise and chatter or by dialogue from other inmates asking him why he is there, what is his name, whether he has cigarettes or managed to smuggle in either money or dope. He may never have even seen a movie about life in jail and persons who use words he hears are ones from another social world, one with which he never anticipated having contact on such an intimate basis.

Now he's in jail! He listens to jail house lawyers and gets advice. He pleads with his family, if there is one, to sell anything to make bail for him to leave the jail. He writes to relatives he has never cared about or thought about for a long time, asking for help and money. He is super polite and cooperative with jail staff and button holes and and all personnel entering and leaving his cell block. He writes to judges, talks to the social worker, begs to talk with his attorney whom he may only see a few minutes before a hearing and is absorbed and obsessed with doing anything he can to exit from jail.

This period of time from his initial arrival until the preliminary hearing in Phase 2. It's at the preliminary hearing that this phase ends because several things happen. Although he may have forgotten many of the details of his crime he hears what he did from witnesses. He sees what kind of case his attorney is going to have to try and get him out of. He hears the evidence presented by the people and he hears the judge and gets to size him up. He hears what kind of bail has been set and he learns that he cannot meet that amount and knows that he will remain in jail long enough for the trial or long enough until he is transferred to prison if convicted or if he pleas to a lesser charge.

His return to jail initiates the beginning of Phase 3. He's depressed, frightened, realized what kind of trouble he has bought because of his crime, hears confirmation of his poor chances from jail house lawyers and he comes immersed in panic and frustration. He feels alienated and abandoned by resources, possibly even from his family.

The tension builds to a point of explosion. He starts snarling at cell mates and staff. He responds to a feeling of powerlessness by becoming physical and assaultive. Soon he learns that he is not built to fight experienced street fighters or staff who have the authority and power

to place reasonable restraints upon him. Soon he realizes that physical protest and violence will get him no where. In an isolation cell this screaming, pounding, spitting, feces and urine hurling efforts change to surrendered whimpering in time. No one listens or cares about his threats, hurts or verbal assaultiveness.

Phase 3 ends with his recognition of hopelessness in being able to escape from being held responsible for his crime. Instead of learning to face those charges and the conviction and sentence which may follow and planning on the future for himself he opts to escape from further incarceration and frustration. He decides to die through suicide. This becomes his mechanism of escape from jail.

Jailers and cell mates should be able to recognize this suicide warning behavior. The inmate cries, sits silently, staring into nothing. He may be smoking more, complaining about not being able to sleep, has lost weight, has injured himself as a form of early warning, does not socialize and does not talk to anyone. In addition, if for unexplained reasons, he suddenly and unexpectedly changes from such a mood of despair to one of quiet relief and comfort and appears to be coming out of it, this too may be a warning sign. He may feel a boost in his mood because he has decided to kill himself and a weight has been lifted from his shoulders as he has decided he will have a way to leave jail and all that it means in terms of his feelings of having lost whatever little humaness he had acquired prior to his arrest.

Suicide in Jail

Those who might likely commit suicide in the central jail are males who have been charged with major felonies which involve considerable aggression, e.g., murder, rape, felonious assault, assault and battery and breaking and entering. In general, members of minority groups like American Indians, Blacks and Hispanics have the highest rate. In age, they fall between 21-35 years of age. Few are actively married and if so have a poor marital relationship. Their suicide plan involves the hours of 11 p.m. to 7 a.m., when supervision is light and other inmates are either trying to sleep or are internally preoccupied with personal troubles and aren't paying much attention to other inmates who might be quiet and withdrawn. Usually, they kill themselves with bedding or clothing, socks included, wrapped around their necks and either twisted with some secreted object like a spoon or pencil or attached to a horizontal locking bar. If attached to the bar, the inmate either quietly spreads eagle, crouches into a prayer kneeling position of hangs by tucking his legs underneath him to add extra dead weight to the end of the crudely fashioned noose. It takes about 15 minutes to induce total asphyxia, from start to finish, in terms of hooking it up and cutting off the blood supply to the head as well as the air supply. Sometimes toilet paper is wrapped around the body and ignited with lighter fluid or some other flammable agent. Sometimes an inmate will attempt drowning by up turning himself in a toilet and inserting his head into the bowl. Recently, there have been instances where an inmate housed in a strip cell managed to climb up toward a window, grabbing onto bars of the window and hurtling himself head first, smashing his skull into the tile floor. He was successful.

The profile of an inmate who gives off warnings of a pre-suicide nature has already been outlined. However, there are other features of clues which the inmate brings in with himself which may or may not be directly connected with his crime. These factors should be understood also because if the person survives a direct or indirect suicide attempt he may pose a suicide risk after his admission to jail. If his determination to die offers him some deep psychological benefit or meaning, then death may be more attractive than surviving his jail experience and this factor increases his risk of suicide. If his family makes him feel that it has abandoned him, his risk increases. If he feels deep shame and guilt about his crime that increases suicide risk and if he feels that a life sentence is likely, he may decide to end his life rather than spend the rest of it in prison, alienated from family, the social mainstream and important sources of gratification like love, sex, career and freedom.

Let's take a look at the types of suicidal behavior which may make up some of the background of the newly arrived inmate. All of the material which follows can be seen in such inmates but those known as Type 4., Autoerotic Suicide.

Types of Suicidal or Self-Destructive Behavior

Intentioned Suicide is that type of behavior which consciously and deliberately seeks death. The person has his or her own reasons, such as fatal illness, loss of a loved one, chronic ill health, or just plain loneliness. He chooses a method, commonly a firearm, and dies without much notice after his body has been found. In about 15 per cent of the cases, he may leave a note. He may have a history of suicide attempts along with insomnia, depression, and gradual loss of interest in work and pleasure.

Despite the deliberateness of this type of self-destructive behavior, we should not be either fooled or limited in our thinking that the entire aim of intentioned suicide is either death or extinction. For example, some persons commit suicide in order to achieve a transcendential shift in another world or form of living. They may view suicide as a method of accomplishing this shift, almost a form of transportation. Gary Gilmore saw death voluntarily sought out by the firing squad as a means of leaving prison and relocating in a better world. Some prisoners on the Island of Ceylon who study Buddhism approach being hanged for their capital crimes with such peace that for them, death is a means of purifying the soul so that they can be with Buddha in the next world. Some widows and children who opt for suicide see it as a means of joining dead loved ones.

Suicide may offer the one who takes that action an opportunity to end physical suffering as is seen with arthritis, diabetes, severe heart disease or cancer. It also offers a person a sense of revenge and triumph over a person if there has been great anger toward a loved one. It is like the last word in an argument. It leaves the survivors with something frightening to remember about the suicided person.

From these examples, it should be clear that for many who intentionally commit suicide, death is not viewed as an experience of extinction. Rather, it is a way of either ending economic, disease, or emotional suffering or relocation in another life system. However, there are still many who intentionally die because they really want extinction and finality to all life. They want out of it.

Suicide Attempt is that type of behavior which asks for help with a problem. Commonly, the attempter seeks sympathy or may try to manipulate an important relationship, as with a lover or parent, or even a psychiatrist. A child may try to negotiate with parents about an unwanted pregnancy or dropping out of school; the suicide attempt rallies everyone toward finding a solution to the particular problem. Then there are those persons who chronically attempt suicide and in time everyone expresses anger toward them, their behavior becomes too provocative and embarrassing for friends and family alike. Not infrequently, this type of person does commit suicide because he tries out his rescuers. Those dealing with the suicide attempter must recognize and be aware that the end result may well be suicide, and that in effect, the attempt is a dress rehearsal for death.

Related to attempted suicide is suicide threat. In the past, it has been a common practice to think about suicide threats as being unimportant and the working of an hysterical personality, an infant who really needs a spanking or lecture. Sometimes this is true, however, research shows that if such a threat is accompanied by insomnia, a previous suicide attempt, even a minor one, and clear evidence of emotional depression, the chances of a suicide occurring from such a threat within five years is 189/100,000. This extremely high figure contrasts markedly with the actual reported incidence of suicide in the United States of 12.7/100,000.

Subintentioned Suicide is an unconscious suicide. The victim is not aware of the significance of his behavior. He may be a patient with chronic long disease who cannot stop working hard, or a hypertensive patient who cannot lose weight. This type of behavior is seen in the citizen who leaves a bar at 2:00 a.m., forgets his glasses on a table next to some empty beer cans, and drives his car without a seat belt. His car has defective lights, steering, or brakes, and he heads south on a north-bound expressway traveling at 80 mph. Some will call him a bad driver and his record may be long or short. He may behave this way for 20 years, or die next Friday night and take you along with him.

Other examples are seen in persons who are sky divers but who have never taken adequate and precise care of their equipment; or soldiers and police officers who are reckless about protecting themselves in a dangerous situation. Such behavior may also account for the factory worker or construction worker who is always being injured on the job, and each injury becomes more serious and lethal.

In this category of behavior is the victim of precipitated homicide. The victim provokes another person into becoming his method of suicide. It may be a bar patron who eggs a highly dangerous patron of the bar into killing him, or a wife-abusing husband who dares his wife to kill him. It

might be a citizen who taunts the police officer to shoot and accuses the officer of not having enough guts for the job or shouts threats to shoot the policeman but shows either an empty gun or a toy gun. This type of death is becoming more common.

Autoerotic or Sexual Asphyxia Death is a type of death or suicidal behavior also known as Sexual Bondage Death or Sexual Asphyxia. It is seen almost always among young teen-aged boys or older homosexual males who are transvestites. There have been only two cases of females reported, to my knowledge.

There are two types: the most common one involves teen-aged boys who use a plastic bag over their heads in order to cut off oxygen intake so they become faint. As that near-blackout approaches, sexual excitement reaches a peak and they hope to ejaculate as they pass out. What happens is that they pass the point of no return and die because they have miscalculated their approach to a dangerous physiologic dificiency state of too little oxygen and too much carbon dioxide: Not infrequently at the death scene, exciting heterosexual pornographic material can be found, which is used to enhance sexual excitement.

The young man is found hanging, asphyxiated in a plastic bag or by ligature around his neck. The ligature has an escape device which has failed because of imperfect technique or moisture that tightens the noose, unbeknown to the man. Pornographic material is found nearby and frequently it shows a woman astride a man with a ligature around his neck, whipping and choking him at the same time. At the time of his death, he may be wearing articles of female undergarments such as pantyhose and he has a large ejaculum.

His hands may be bound by ligatures or handcuffs and a key to the cuffs may be grasped between his fingers, ready to unlock them. But this did not occur because asphyxiation worked too quickly to allow self-rescue. A decorated leather mask may be seen and cotton may be inserted in the nostrils to seal off oxygen being taken in during asphyxiation. Finally the scrotal sac may be bound by string or thread. This completes the emasculation the whole ritual dramatizes. What does happen in this type of lethal perversion is that the man achieves total emasculation, a dictate from earlier years from a mother who treated him that way. Revenge is unconsciously achieved toward his mother because it is the woman who symbolically dies when the deceased male is dressed in articles of female clothing. It is as if the man has killed the woman in retaliation for her maternal destruction of his masculinity.

The lesser type of autoerotic suicide or death involves more complicated behavior and psychodynamics.

Psychotic Depersonalization involves a form of schizophrenic behavior associated with extreme emotional withdrawal from others known as autistic behavior. The patient withdraws and hardly talks or relates meaningfully. He feels dead inside, as though his whole psychic structure has fallen asleep or is "unalive." In order to induce a feeling of aliveness, he may cut his wrist gently and superficially, not to manipulate others or mutilate himself, but rather to feel alive

through the fear of death. It's a little like rubbing your arm when it falls asleep to make it have feelings again. In this case the person cuts so as to feel reassured he is alive by feeling pain, seeing some blood, and feeling the warmth of blood on his skin.

Psychotic Mutilation, a serious type of behavior, always involves a deep psychosis associated with either schizophrenia or some type of organic brain disease like senile brain disease or brain damage from accidental injury. The person who injures himself feels much guilt because of masturbation, homosexual or even homicidal impulses coming from inside himself. He tries to prevent a release of such impulses through self-mutilation. He may try to amputate a hand with a power saw, or his penis with a sharp instrument. A woman may try to mutilate her vagina with a butcher knife or a pair of shears. This type of person may eviscerate an eyeball, cut off a nipple or breast, or set himself on fire and become a human torch. When he cuts his arm it looks as though he has passed it through a meat cutter. His behavior is no simple bid for attention; he is not attempting to feel alive. He wants to destroy a part of himself for irrational reasons.

Finally, Sensational Suicide is that form of suicide which is like a page-one or front page news or front page news dramatic type of death. This person's act of death is snapped by some photographer as he or she is about to leap from a bridge or expressway overpass -- like the robber who shot himself in front of a newspaper man and the television camera... like the newscaster in Florida who shot herself during a newscast on television -- a person who wants to die violently and have everybody remember the death scene. This type of person does not simply shoot himself; he may blow his head off with a cannon which he has strapped to his chest; he may commit suicide after a murder or use a vehicle in some spectacular manner, he may be a skyjacker, sniper, or assassin.

From this discussion and classification of suicidal behavior, it should be easier to see what is self-destructive and what needs to be done to bring about an effective intervention. It should be apparent that a crisis intervention approach might be useful.

Suicide Prevention in Jails

The first line of defense against suicide in jail is knowledge and sensitivity about what it means, what kinds of people do it and what makes it happen to those who remain in jail for crimes they have commited.

The second prevention measure concerns proper screening of all inmates. Questionnaires should be filled out on all new arrivals in terms of a psychiatric history. Have they been emotionally disturbed, treated for it, hospitalized for it and whether they have ever thought about or attempted suicide. They should be observed for obvious signs of previous suicide attempts such as cuts on their arms or neck, especially if the cuts have been sutured and if the cuts are upward from the wrists toward the neck.

The remaining prevention measures are found on the cell block itself. If the inmate starts to stay by himself, is crying, lacks interest

in anything, can't joke around and just seems to be crawling up inside himself, the jailer needs to target that person for contact. He or she needs to talk about the sad behavior observed and what can be done about it. Questions about thoughts of suicide need to be asked of that inmate. Assurance by the jailer that he feels it's good that the inmate can level with him offers support to the inmate that someone cares. Having staff roam the catwalks, especially at night when jail activities slow down is a must as it increases surveillance to prevent a death and increases the chances for a suicide candidate to be spotted, talked to and referred to the next most important defense against suicide, a mental health staff.

Such a staff needs psychiatric, psychological and social work capacity to diagnose, talk to and treat the depressed and desperate inmate. He needs to be able to identify the psychotic or severely mentally disturbed inmate so that effective tranquilizer therapy can be started. Relationships with the jailers and inmates for the mental health staff require skillful appreciation of their stresses and skills as well as the support they need from the mental health staff.

The entire jail staff and inmate population can work toward an effective suicide prevention program if all parties can achieve an understanding of and agreement about the need to preserve all lives. Jailer career hopes may be helped by developing skills to render suicide prevention services to inmates. The jail administrative staff can maintain a better public image if the community and county board of supervisors knows that the lives of all inmates will be protected at the jail. Suicide prevention helps the jailer realize the goal he sought by choosing law enforcement, namely, helping others and saving lives. This type of caring attitude may be enough to help the new offender achieve a turn around of a life which otherwise might have headed in the wrong direction.

SUICIDE PREVENTION IN JAILS AND CORRECTIONAL FACILITIES (SEMINAR)*

Deaths in jails are common to both past and present cultures. This past April, I completed a descriptive study of jail deaths that occurred in two Michigan counties, as compared to jail deaths in 42 states. All of these deaths occurred during the period of 1970-1977.

Even though this study focused on all types of inmate deaths -- suicide, natural, accidental, homicide and those of undetermined nature -- suicide was the main cause of death for both groups, accounting for fifty-seven percent of total deaths. Suicide deaths may be due to a combination of factors; structural and individual. These problems include: inadequate screening of individuals when admitting them to jail; over-populated and under staffed jails as well as, untrained staff.

A theory I find to be useful in describing suicide deaths is the theory of alienation. Although the concept of alienation may not describe all the factors involved in suicide deaths, it is believed that some theories of alienation may provide insight into understanding these events.

Alienation has been applied to those who are rejected (or who feel rejected) by society and it refers primarily to undesirable social and moral conditions (Marx, 1964; Durkheim, 1951). Becker (1967) maintained that individual alienation may be an outgrowth of an individual's inability to cope with contemporary social and cultural demands. Still others have contributed insights into alienation, such as personal disintegration or identify diffusion and inability to make appropriate choices regarding one's life (Mannheim, 1940; Fromm, 1955; Seeman, 1959).

Persons behind bars involuntarily may feel like they belong to someone else other than themselves. They may be alienated in the sense that they are separated from familiar surroundings and people they know. Inmates are subjected to a vast body of rules and commands which tend to control their activity in minute detail, leaving them no way to respond independently (Sykes, 1958).

Historically, alienation may be viewed from two major schools of thought; the sociological and psychological. The sociological point of view sees alienation as a social problem -- a reaction to the stresses, inconsistencies and injustices of the social system such as the jail. The alienated person in jail is said to be the victim of his society; his alienation is imposed upon him by an unjust social order. The psychological theory of alienation views it as developmental in nature, and traces its root cause to "personal" pathology. The alienation of the individual is said to be self-chosen and serves as a refuge from painful interpersonal relationships. Both these schools of though are working simultaneously; social reality shapes individuals lives, as do the experiences of one's daily life.

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* Presented by: Janice B. Howard; Staff Associate, American Medical Association Correctional Programs, Chicago, Illinois

Sociological Alienation: From a sociological perspective Durkheim coined the term "anomie" to refer to the normlessness or disturbance in a collective order. In our present time, anomie denotes a situation in which the social norms regulating individual conduct have broken down or are no longer effective as rules for behavior. Alienation may be conceived here by understanding the normlessness within society, because a lack of consensus exists for goals and behaviors of its members.

The structure of social interaction patterns in the jail setting increases the probability that persons detained may become anomic. It is not unlikely that the individual anomie which accompanies social disintegration could develop, along with feelings of normlessness, powerlessness, meaningless, etc. Such feelings may frequently lead to suicide (Durkheim, 1951).

Psychological Alienation: In theories assessing psychological alienation (Riesman, 1953; Fromm, Frankl 1968; Maslow, 1968) the emphasis is placed upon the individual's feelings about himself. The loss of self-identity and identification with a rejecting majority may lead to a loss of self-worth. This may be typical of inmates who commit suicide while in jail.

Individuals in jail who are said to be self-alienated may be ashamed of anyone finding out and may feel that being in jail registers on them as a discredit. Therefore, they may despise themselves; feel contemptible, worthless and unlovable. It has been said that the most conspicuous and inevitable consequence of going to jail is publicity of the event (Martin and Webster, 1971).

There are many in jail who are troubled and have past histories of drunkenness, drugs or mental disorders. Several deaths have occurred in jail to individuals who suffered from such disorders (Dye, 1971; Brush, 1971; Filiatreau, 1972; Newman and Price, 1977).

The suicide rate seems to be higher among alcoholics and depression is the basic dynamic in the individual's life. Inmates in jail typically may present a facade of defenses against the acknowledgement that they are in deep trouble.

In the final analysis, to be self-alienated means to be something less than one might ideally be if the circumstances in society were otherwise. I would like to discuss some recommendations that might in the future help inmates who are unable to cope with the demands and conditions of the jail system and with their own crisis situation.

1. More detailed information regarding inmates should be collected upon admission. Information of this nature may reveal facts that may prevent a death.

2. More trained staff are needed to meet the needs of those detained such as for: transferring inmates from the facility, recognizing signs and symptoms of illness, chemical dependency, and supervising a planned program of exercise.

3. More uniformity is needed in retaining the same type of records for inmates in all jails.

4. Establish a program that will educate the public as to the operation of the jail and its relation to the entire Criminal Justice System. At present, those detained in jail are isolated; greater public awareness may result in a call for changes in detention procedures or at least force a re-evaluation.

Presently, we can say that greater public awareness of the jail health care operation is evident as you are among many that elected to come to this Third National Conference and stand up and be counted for a cause that purports to deal with the social structure.

References

Becker, H.S., ed. The Other Side. New York: The Free Press (1964).

Brush, M. Jail Victim Drifted. Kansas City Star. (Mo.) November 9, 1971, (300: F 3)*

Durkheim, E. Suicide: A Study In Sociology (Trans. by J.A. Spaulding and G. Simpson, Eds. Glencoe, Illinois: Free Press (1951).

Dye, R.M., Four Troubled; Empty Lives in Jail Cell Suicides Kansas City Star. (Mo.) September 18, 1971, (270: C 4). *

Filiatreau, J. Dead In A Jail Cell. Courier Journal. (Louisville), December 24, 1972, (186: D 11-12). *

Frankl, V.E. Meaninglessness: A Challenge To Psychologist. 231-238 in T. Million, ed. Theories of Psychopathology and Personality. Philadelphia: W.B. Saunders Company (1973).

Fromm, E. The Sane Society. New York: Rinehart (1955).

Howard, J.B. Inmate Deaths In Kalamazoo County, Berrien County and 42 States: A Comparative Analysis For The Years 1970-1977; Thesis: Western Michigan University, Kalamazoo, Michigan (1979).

Mannheim, K. Man And Society In An Age of Reconstruction. New York: Harcourt, Brace (1940).

Marx, K. Selected Writings In Sociology and Social Philosophy. London: C.A. Watts; New York: McGraw Hill (1964).

Martin, J.P. and D. Webster The Social Consequences of Conviction. London: Heine (1971).

References (continued)

Maslow, A.H. Toward A Psychology Of Being. New York: Van Nostrand Reinhold Company (1968).

Newman, C.L. and B. Price Jails and Drug Treatment. Beverly Hills, Calif: Sage Publications (1977).

Riesman, D. The Lonely Crowd. New York: Doubleday Anchor Books (1953).

Seeman, M. On The Meaning Of Alienation American Sociological Review. 24: 783-791 (1959).

Sykes, G. The Society of Captives. Princeton: Princeton University (1958).

* Newsbank, Inc., Stamford, Connecticut.

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SUICIDE PREVENTION IN JAILS AND CORRECTIONAL FACILITIES (SEMINAR) *

Prisons pose substantial challenges and threats. The man in prison is separated from family, denied status and autonomy, viewed with distaste and alarm in the larger community. Imprisonment is a stressful experience for even the hardened criminal; for younger offenders, the experience can prove traumatic.

I shall summarize research on the nature of prison trauma experienced by adolescent prisoners. The research is based on interviews with 325 suicidal adolescent and adult prisoners in selected New York State jails and prisons. The interview schedule used with crisis-prone inmates called for systematic reconstruction by each subject of the events, feelings, and concerns leading to the self-destructive act or acts. This material was then content analyzed using a typology developed to encompass the motives and meanings associated with self-destructive conduct. The typology is quite complex, involving 16 separate themes that vary in terms of three psychological dimensions (impotence, fear, and dependency) and three levels or types of crisis (situational, neurotic, and psychotic). The interested reader can find a detailed account of the typology elsewhere.[1] For our purposes it is sufficient to note that young offenders differed reliably from their adult counterparts on three major themes of the typology: youths were disproportionately prone to crisis that reflected the inability to maintain self-control and composure in solitary confinement (Isolation Panic, a situational fear theme); to crisis that signalled last-ditch efforts to revitalize flagging social supports (Self-Certification, a neurotic dependency theme); and to crisis that marked a declaration of psychological bankruptcy in the face of social pressures and threats (Fate Avoidance, a neurotic fear theme). Stated otherwise, youths displayed distinctive patterns of psychological breakdown related to concrete coping tests posed in the prison environment, and to self-esteem problems posed when imprisonment strained interpersonal links of undermined feelings of social competence.

Settings That Suffocate: Segregation is a prison within a prison. It is a setting in which the person is very much alone. He is also paralyzed and shut in. Activity is confined to a 6 by 8 cell and is limited to solitary diversion. Most youths describe their confinement as irritating and boring, as an unpleasant interruption of their prison routine. For some of these young men, however, the conditions of isolation undermine coping efforts and promote psychological breakdown.

Segregation proves unmanageable for some youths because of the social isolation such confinement entails. Persons with strong needs for social contact and support may find involuntary periods of segregation an alien and disheartening experience. Among the more brittle and dependent youths, social isolation can spark a need for tangible support and re-assurance from significant others that reaches psychotic proportions.

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* Presented by: Robert Johnson, Ph.D., Associate Professor, School of Justice, the American University, Washington, D.C.

1 Hans Toch (with contributions by John T. Gibbs, Robert Johnson, and James G. Fox) Men in Crisis: Human Breakdowns in Prison (Chicago: Aldine) 1975.

Confinement to segregation disrupts normal coping sequences, which are typically patterned in terms of ongoing social relations within the prison. For persons for whom adjustment to prison has been won at the expense of considerable time and effort, segregation may be viewed as a major setback. Some liken the experience to the shock of arrest and confinement. Segregation abruptly separates the person from his social supports and may place in doubt his ability to reestablish needed social links.

The conditions of solitary confinement can directly undermine preferred coping strategies. Some adolescents rely heavily on activity as a mode of adaptation. Their goal is to immerse themselves in prison life and to ignore disquieting outside concerns. Activity, for them, is a prop for denial and a substitute for introspection and problem solving. When activity is sharply restricted, as in segregation, they may find themselves deluged with unmanageable problems.

For some youths, the need for activity reaches extremes. They describe a compulsive need for involvement to hold their feelings in check. They diagnose themselves as prone to tension, subject to outbursts, controlled by urges. In activity they find temporary release; in constant activity there is a kind of equilibrium. When segregated, such persons feel caged and helplessly explosive.

The stress of isolation can also create problems having to do with larger losses sustained through imprisonment. Individuals able to suppress concerns about family or future during normal confinement may find an empty segregation cell a context for unwanted reflection. Not uncommonly, the person dwells on the various benefits of life in the free world now denied him and experiences intense feelings of loneliness and deprivation.

Segregation, as we have seen, is particularly troublesome for some adolescent prisoners. Salient needs for social contact and support, and for environments that support short-term, action-oriented problem solving, make youths vulnerable to the pressures of isolation. Unlike their adult counterparts, youthful offenders may posses more limited and specialized coping repertoires; if settings fail to meet their survival requirements, as is often the case in segregation, they may become helplessly self-destructive.

Segregation is often cited by critics as the ultimate tool of callous prison administrators and the hallmark of destructive penal milieux. Barbaric physical conditions and extended social deprivation are routinely noted as key features of solitary confinement. In most prisons, however, including the ones studied here, such confinement includes basic amenities, limited recreation, and is deployed for sharply reduced periods of time, often no more than five days. The point is that segregation hurts, not so much because of its objective deprivations, though these are admittedly unpleasant, but because it exposes men to special environmental challenges and calls for special psychological resources. Those unable to marshall appropriate responses are abandoned to defeat and left to ponder, alone and unaided, the nature and import of their failure.

Breakdown of Social Supports: Many adolescents find incarceration an extremely stressful experience. Some feel an intense need for support from significant others to cope with the alien pressures of confinement. They depict their links to family as their dominant support system and describe periods of suffering that result when the family lifeline proves unreliable. For those whose lives have been inextricably tied to family, the separation from loved ones can prove traumatic. The gap between the family world and the prison world, for them, seems wide and unbridgeable.

Loneliness, of course, is a dilemma for many prisoners, irrespective of age. And there are adults who, like their youthful counterparts, have led sheltered lives and feel unequipped to deal with an impersonal prison environment. A key problem for many adolescents, however, is that their relationships lack depth and maturity. Ties to family are often substantially weakened (even dissolved) by histories of one-way involvements, in which the person has manipulated, abused, or taken loved ones for granted. When support (predictably) fails to materialize in prison, these men feel helpless. Self-destructive conduct may represent a dramatic bid to gain an unearned response from significant others.

This pattern frequently has parallels in childhood crisis, a fact suggestive of chronic interpersonal difficulties and of reliance on pragmatic, stated gestures to compensate for social inadequacies. Such persons feel they can't cope without support. When support is not forthcoming after routine requests, self-mutilation is a backup means of securing assistance. But such self-destructive conduct is not undertaken dispassionately. The need for support is painfully real. The person knows he has alienated loved ones; self-injury represents an extreme move designed to communicate genuine distress and establish one's legitimacy as a candidate for help.

Crises that reflect degenerating relationships seem particularly likely to arise among those who maintained the support of family or friends in the free world through manipulative, one-way relationships. Such persons are egocentric, and expect the world to be at their beck and call. The fact that they have caused others pain is of no consequence to them. They find it impossible to understand that they may have forfeited the affection of significant others. When loved ones fail to make superhuman efforts to resolve their prison problems, even though they have done so many times in the past, these men feel rejected and abused. Their resentment can culminate in self-destructive conduct.

Persons who attempt to use crises to resuscitate family bonds tend to view themselves as unimpressive. They feel that people will not recognize or respond to them unless they advertise their needs or coerce support. Some youths trace this assumption to their family experience. They feel they were never really loved, and consequently were forced to "act out" in order to be noticed. Low self-esteem may make the premise that one is not loved difficult to disprove, reassurances notwithstanding. Another problem lies in the fact that repeated efforts to gain care and attention may alienate precisely those persons from whom the individual wishes to secure love. When such behavior results in repeated incarceration, it may strain family bonds to the breaking point. The person who desperately seeks love may then find himself abandoned when he most needs family support.

The need for support is not always clear-cut, however. Youths tend to be sensitive to the double-edged connotations of dependency. Thus while assistance from significant others may be desperately desired, the need implies dependence and unmanliness. The resulting ambivalence can spawn demands for support on one's own terms, demands that often translate into such messages as "I don't really need .... but don't let me go." The problem is that such messages are, at best, ambiguous. And there is the very real danger they may be taken at face value as bids for independence. The person who thus stridently proclaims emancipation from family may feel abandoned and helpless when he is treated accordingly.

Encounters with prison staff sometimes reflect concerns analogous to those that underlie family-related problems. Some youths feel particularly threatened by the impersonal routine of prison, which they feel does not allow for sufficient attention to their special problems or needs. When normal channels of communication fail to produce desired results, breakdowns may be used as a tool to force a favorable response. For others, self-mutilation is used to secure support from staff without having to admit dependency. Here again we see persons who wish to prove they are important and worthy of note and concern, in the face of evidence to the contrary.

Crises designed to ameliorate interpersonal problems sometimes result in short-term payoff. Guilty parents or lovers may respond to such overtures, and prison staff may placate the man who demands a hearing. As often as not, however, the message falls on deaf ears. More importantly, these cirses do not reduce the pains of inadequacy the youths feel. Rather, they reinforce the person's suspicion that he cannot command respect on his own merits. To get results, he must resort to extreme measures.

Marginality and its Consequences: The power-oriented games of prison are situations with which some inmates are unequipped to cope. Such persons are marginal both in the sociological usage of the term, in that they must live on the fringe of the larger group, and in the psychological sense, because they must pay the price of ostracism. Marginality in prison, however it is assessed, proves costly. It entails loneliness, self-denigration, fear. The experience can be disabling one, especially for naive or inexperienced offenders, who may be locked into victim roles by status-hungry peers. And given the self-doubt such encounters breed, the prespective victim is likely to play out his asisgned role with some conviction, thus sealing his fate.

Some adolescents class themselves as victims before they begin their prison careers. They have an image of prison that is shaped by inexperience. As they see it, men like themselves are open game in prison. Pressure for sex, which they feel is commonplace, looms in a major focus for fears. Personal crises mark a declaration of impotence; the youths know prison will pose tests they are unable to counter.

Panic, for most inmates, occurs in response to tests. Among the more vulnerable, peer games, comprised of teasing and obstracism, may prove unmanageable. The simple fact of exposure to prison living may be an overwhelming experience for sheltered youths.

The difficulties susceptible adolescents face are apt to emerge early in the incarceration process. There is an informal "testing period" in which incoming prisoners are selectively evaluated in terms of their victim potential. Inmates who are frail, shy, or visibly fearful may come in for excessive pressure before they have a chance to acclimate themselves to prison life.

The ritual of testing exposes inmates to enormous pressure. There is the added problem that the rules of the game are imperfectly known by prospective victims, making it difficult for them to respond effectively to challenges. Should one man attack a gang of predators or seek out lone targets? How many confrontations are required to obtain security? Will fighting backfire, provoking aggressors? And beyond these difficult questions may lie the fear that what one does is irrelevant, since one's foes have a monopoly on power and are free to victimize others at will.

The problem of peer victimization, for the most part, reflects the inability of many young men to play the roles required to obtain immunity from prison pressure. Avoiding peer confrontations requires considerable street sophistication and poise. Some young inmates seem particularly ill-equipped to fend off predatory moves. They attempt to buy peace of mind by placating aggressors, a strategy viewed in prison (and in slum streets) as a sign of weakness and vulnerability. Others, who have been traumatized by confinement, do not counter peer pressure at all. They become immobilized with fear because they meet threats against which they feel defenseless.

The losers of predatory prison games have a desperate need for social support. They know they cannot survive alone and seek allies against a rejecting world. More often than not, however, their bids for support go unrecognized and unmet. Peers tend to be insensitive to the victim's plight, and staff are prone to view personal dilemmas in classification and management terms. The inmate in trouble has few viable options. He may seek to buttress his defenses in self-insulation or in escape to segregation, but such responses are likely to feed self-doubt and leave the person feeling more vulnerable than ever. If significant others prove unreliable--the person's last line of defense -- he may feel himself completely worthless and alone. His crisis may thus escalate from one of panic, where intervention is possible, to one of hopelessness, where helping efforts are least likely to bear fruit.

Conclusion: Prison creates special problems for young offenders. Many youths need social support, shared activity, acceptance. They are engaged in the difficult job of forging an identity, of marking out a place for themselves in which there is a modicum of status and recognition, and in which stable, nurturing relationships can grow. Prison both disrupts and shapes their developmental tasks, It is an arid human environment, presenting obstacles to adaptation and threats to self-esteem. It symbolizes community rejection, closes off opportunity, and stunts interpersonal growth. Those who survive must distort their needs. The survivor must be insular, distrustful, and willing to exploit others. He must adopt a power-oriented view of himself and others. To be sure, prison has its winners, but they exist at the expense of their

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fellowmen, those who have been abused or neglected or ignored.

The victims of prison, those who by their shortcomings and failures make the success of others possible, become victims of crisis. They succumb to rigid, unresponsive settings, rejecting families, abusive peers. Staff, who might defuse such sequences, seem largely unable to play constructive roles in the management of stress. Too often the man in crisis becomes a management problem and a candidate for custodial care. We can do more. At a minimum, we can modulate the environments of susceptible men, build mature links between them and their loved ones, and assuage their fears. Ideally, we can work to foster a human community within the prison, in which differing predispositions and needs mark variations in lifestyle rather than deficiencies in coping.

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THE IMPORTANCE OF HEALTH CARE DATA COLLECTION AND RESEARCH *

My colleagues Dr. Robert Derro and Mr. Bruce Kuennen and I are here with you today to discuss the importance of health care data collection/research. We are quite honored to share our observations and findings with you as all of us are convinced that such data collection/research is crucial to effective and efficient delivery of health care services. Mr. Kuennen will give you an insight into how health data assisted him at a small jail and Dr. Derro will give us insight into his research on health at the Ramsey County Jail in St. Paul, Minnesota.

Before we get to them, however, I would like to make some observations on the importance of data collection/research from an outsider's point of view. Perhaps I should start by explaining what the General Accounting Office is, its purpose and finally why we believe such health data is important.

The U.S. General Accounting Office

The U.S. General Accounting Office (GAO) is a non-political, nonpartisan agency created by the Congress to act in its behalf by:

- examining into the manner in which nearly all U.S. government departments and agencies using public funds, discharge their financial, legal, and management responsibilities;

- reporting at all times its findings on matters in need of attention to the Congress or the Federal agencies; and,

- recommending ways in which the executive departments and agencies can carry out programs and operations more efficiently and economically.

In short, GAO provides the committees and members of the Congress with independent reports on the financial and management operations of the executive branch. It often is called congress' "watch dog" over government spending. The basic objective of its audit work is to promote constructive improvements in government operations.

GAO reviews some activities based on statutory mandates or at the specific request of committees or members of Congress. However, it reviews many activities at its own initiative.

The General Accounting Office has its headquarters in Washington, but its organization is dispersed so widely that it can always "go wherever the action is" to fulfill its responsibilities.

GAO auditors are stationed permanently in some 50 departments and agencies of the government in the Washington area. There are 16 GAO regional offices and 30 suboffices throughout the United States, and overseas offices in Frankfurt, Honolulu, Manila, and New Delhi.

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* Presented by: Frank Reynolds, Audit Manager; Detroit Regional Office, United States General Accounting Office, Detroit, Michigan

The operating staff includes approximately 2,300 auditors and accountants, about 100 lawyers, and a growing number of specialists in management, engineering, statistical and automatic data processing fields.

This carefully selected staff has become highly expert in making recommendations to achieve greater effectiveness in the application of public funds and has earned a high reputation for the objectivity of its work.

The Comptroller General or his representatives often are called upon to testify before congressional committees to provide them information in connection with reports which GAO has submitted to the Congress, or matters considered within the special competence of the office.

An important additional service GAO provides to the Congress consists of furnishing comments on proposed legislation. GAO analyzes all bills introduced in the Congress to ascertain whether its past or current accounting, auditing, investigative, or legal work has disclosed information that might be useful to committees in their consideration of the bills.

GAO Interest In Criminal Justice Including Inmate Care

The Criminal Justice system is one of our major national concerns and involves expenditures in the billions. For this reason, GAO spends considerable resources in evaluating the Federal Criminal Justice System and the effectiveness of federal assistance to state and local government systems. Our work addresses the courts, law enforcement, and the corrections systems. A number of significant reports have resulted from this work-- each to some extent has influenced federal legislation and appropriations. For example, a recent report of ours on the adequacy of medical and dental care in prisons and jails (GGD 78-96 December 22, 1979) prompted the senate committee on the judiciary to recommend an increase in medical staffs assigned at some federal prisons. Also, the U.S. Marshals were given more funds to improve health care at local jails that house federal prisoners. Moreover, a number of federal agencies such as LEAA and HEW have taken steps to encourage states to improve prisons and jails.

Obviously, our reports have not been a cure-all for all the problems in correctional systems. Nor can we realistically expect all of them to be cured in the near future. The problems are immense -- among them - a lack of resources and a long-standing public apathy toward providing adequate care for inmates.

But one thing is certain, more effective management could improve inmate health care--notwithstanding funding limitations and personnel shortages. By effective management, I mean sound information on inmates' needs, adequate records, effective monitoring and evaluation of programs, and independent reviews and research of programs. To varying degrees, administration in prison and jail systems lacked these needed elements. Briefly put:

-- Information on the overall extent and type of health problems in inmate populations was usually not being compiled.

-- Records of treatment actions and needs were often incomplete or disorganized, and pertinent information was not forwarded when inmates were transferred.

Correcting these management shortfalls is essential for ensuring that managers make the best use of exsiting resources. Improvements in these areas would also enhance staff's ability to provide effective treatment and care for inmates and would help minimize duplicate efforts.

Reasons For Lack Of Health Care Data Collection/Research

The correctional administrators need to systematically determine the medical and dental needs of inmates so they can analyze them to determine (1) The level of care needed and (2) The type and amount of resources required. From this analysis, they can design an effective, efficient health care delivery system -- one that meets inmates' needs through an appropriate mix of institutional and community resources.

The health care delivery systems in the agencies we examined generally did not have the resources for providing adequate care. Officials frequently told us they lacked the necessary funding to make improvements. However, given the likelihood that correctional institutions will generally continue to be underfunded, it is critical that they examine ways of improving their utilization of all existing health care resources.

The AMA and other professionals we interviewed agreed that medical and dental programs should be tailored to meet the needs of the population served. For example, young people may have different problems than old people and people of one race may have problems different than those of another--sickle-cell anemia being one example. Only after corrections administrators learn what type of care is needed and what is actually being delivered in the institutions under their direction, can they make effective decisions about staffing, facilities, equipment, and, possibly most important, which health care services can be provided by both institutional and community resources.

The health problems of people entering correctional institutions and the problems they develop while there, are largely unknown. Consequently, assessing the efficiency of the existing allocation of treatment resources is rendered very difficult or impossible.

We found little demographic data on medical and dental needs of inmates entering prisons and jails. While everyone generally agreed that inmates entering their systems were in poorer health than people in the community, few had any statistical research data to support their viewpoint.

In our inquiries into the use of medical records data, we found that only 3 of the 10 states we visited consolidated some data from the records for planning and control pruposes.

New York used LEAA funds to establish a state-wide computerized medical/dental records system. This system is based on medical complaints made by inmates during the daily sick call routine. New York officials said the system was useful in various important ways.

-- It helps them determine the volume and type of services provided. Reports on monthly visits, broken down by prison and by categories of medical staff members providing the care--doctors, dentists, or other allied staff--are a part of the information the system compiles. The data enhances planning for each prison, because it reveals such things as overall health problems, and staff shortages.

-- The system also helps officials assess the under-utilization of medical care by those inmates who need treatment and observation for serious illnesses. It does so by means of a monthly chronic disease report, which lists inmates with important chronic conditions (such as hypertension and diabetes) and the frequency of their encounters with the health care system, is valuable.

-- Finally, the system helps them audit the quality of care, using explicit criteria for assessment and management of specified diseases. It lists all inmates with specific diseases and enables each individual medical record to be located and examined in relation to the criteria.

The second state--Michigan--was manually preparing quarterly reports using similar information gathered at each prison. Among other things, these reports were used to make budget projections, analyze staffing levels, compare cost data, and monitor sick call activities. A state official told us the system was working so well that he was considering switching from a quarterly to a monthly basis.

The third state--North Carolina--was developing a system to determine overall health needs by compiling information from inmates' physical examinations. This data will allow officials to know the problems of inmates entering the system. At the time of our visit, they had not reached the point where they could tell which health needs had been treated and which had not been. Officials hoped to expand their system to enable them to evaluate additional staffing needs.

Although other states were not using medical/dental record data for planning or control purposes, officials could see the need for and the benefit of such data. They realized that without such data they could not (1) assess overall changes in health status, (2) assure efficient use and allocation of resources, or (3) demonstrate overall improvements in health care. Officials in one state believed that with total operational health needs and related staffing needs statistically predicted -- that would assist greatly in preparing budget projections and allocating resources.

Of the 30 jails in the AMA in-depth study, 3 of the 10 small jails and 5 of the 12 medium-sized jails did not keep any management records which reflected medical activities. In other words, 26.6 percent of the jails did not keep track of the number and types of drugs being dispensed, the number of inmates receiving health care, etc.

Of the seven small jails keeping management records, three only logged medications, while the other four logged any health treatment given. In six of the jails, these records were kept by the corrections officer, while in the other jail, both the correctional officer and the physician made entries as needed.

The medium-sized jails keeping management records and all of the large jails tended to keep full tallies of medical activities. These records were usually completed by a correctional officer, a nurse, or both, with occasional physician input.

Health care professionals place much emphasis on good medical and dental records--ones which adequately document the conditions of patients and the care provided them at each encounter with health care staff. The ACA standards require that medical and dental personnel maintain complete records of treatment given inmates to ensure continuity of care.

To maintain confidentiality of information, the responsible physician should control access to records, particularly inmates' access.

What should the medical record contain? The AMA's Department of Practice Management, in its seminar for new physicians, stresses that the content of individual medical records is totally up to individual physicians. Because of the current malpractice climate however, physicians are well advised to include as much information as possible, as well as notations showing the place, time and date of medical encounters, and the identity of the health care provider involved. The AMA and other professionals believe all significant clinical information pertaining to a patient should be incorporated in the patient's medical record. In fact, the record should be sufficiently detailed to:

(1) Enable the practitioner to give effective continuing care to the patient, as well as enable him/her to determine at a future date what the patient's condition was at a specific time and what procedures were performed.

(2) Enable a consultant to give an opinion after his/her examination of the record; and

(3) Enable another practitioner to assume the care of the patient at any time with informed knowledge of the treatment that had been given.

We believe these requirements should be applicable to the records of a correctional institution's medical unit.

A medical/dental record for all inmates should be opened at the time of their arrival in the correctional system. It should, record at a minimum inmates' medical history, physical examination and prediagnostic tests. Each contact of an inmate with the medical/dental services should be entered, as appropriate, in the form of progress notes, nursing notes, laboratory reports, consultants' opinions, diagnoses, orders, and treatment plans.

Federal Bureau of Prisons policy requires that physical examinations be reported on standard federal medical and dental examination and history forms. All sick call visits are to be recorded on a standard chronological record of medical care listing the date, nature of complaint given, physical findings, diagnoses, and treatment prescribed. An additional report of injuries is supposed to be filled out on any injury requiring first aid. All standards of the Joint Commission on Accreditation of Hospitals (JCAH) are to be followed.

We examined medical records in five of the six federal institutions we visited and obtained copies of regional inspection reports on all six. In the one institution where we did not examine medical records, a recent regional inspection report revealed that medications issued to inmates were not always recorded in their medical records. The report also noted that records for three inpatients in the hospital were deficient.

To be specific:

-- The entrance physical examination form was grossly inadequate and had not been signed in any of the three cases.

-- Many medical reports were unsigned and undated, making it impossible to tell a.) whether an opinion was expressed by a physician or someone other than a physician and b.) when the opinion was expressed.

-- Dental cavities were noted on several entry examinations with no notations on dental consultations.

-- Records did not always indicate that treatments were fully carried out. In one case, involving an inmate who injured his face; X-rays were requested, but results were not recorded. Another inmate had

evidence of infectious hepatitis, but no blood tests were recorded in the file.

In examining 40 medical records at one state prison hospital, our medical consultant found incomplete records because prisons did not send the hospital all the data on the inmates they transferred to it for treatment or evaluation. For example, initial histories and physician examinations were not part of the hospital records.

In a second state, our medical consultant went to three prisons and found this:

1. Twenty files, randomly selected at one prison, contained brief notes of outpatient visits, many of them almost illegible. She also requested specifically records of inmate having epilepsy, diabetes, heart problems, or asthma. These also contained many brief notes that were almost illegible. The files did not contain sufficient information to assess the care given. She also asked for a few old charts, and found these too were in very bad shape.

2. Of 40 charts reviewed at a second prison, neither those picked at random nor those picked because they involved epilepsy, diabetes, heart disease, or asthma contained sufficient information. Many of the entries were illegible.

3. At the third prison, records were even less satisfactory than those of the other two.

In another state, the Medical Association was asked to review a prison hospital. The chairman of the survey committee reported that the prison's medical records were inadequate in terms of content, continuity, currentness, and legibility. Medical record procedures were estimated to be at least 20 years behind the time. Often, a discharge summary was substituted for the documents required in an adequate medical record, and frequently the initial history and physicals were not included.

While we were not premitted to examine medical records in two states, our conversations with prison officials indicated that they were not well maintained. The medical director for one state correctional system told us the records were in a disastrous condition and he had not had the opportunity to develop the necessary written policies and procedures to correct the problems nor did he have the money to hire the needed personnel.

Conclusion

In summation, little emphasis has been given to maintaining adequate records of either inmate needs or treatment. This information is fundamental for adequate planning because it provides a basis for

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Conclusion

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measuring the extent and types of services that should be established. Finally, it can be used to assist managers in determining and supporting requests for resources. Finally, adequate records can be used to document treatment given to inmates where prisons come under the scrutiny of the courts.

THE IMPORTANCE OF HEALTH CARE DATA COLLECTION AND RESEARCH *

One thing that stands in the way of many jails that would like to set up a health care program is the almost total lack of data. Frequently, jail managers do not have easy access to even the most basic information regarding the persons who are confined in their jails. This presentation is designed to identify the areas of data collection which are minimally required to predict the manpower, time, and money that are likely to be needed to provide systematic health care to prisoners. The implementation strategies of Washington State and Whitman County will be discussed.

The American Medical Association, and now the State of Washington, have adopted minimum standards for the delivery of health care services in jails. These standards require written agreements between the governing unit and a responsible physician, written policies and procedures, training of jail staff, receiving screening (at booking), regular sick call, provision of emergency and non-emergency care, routine health appraisal, proper management of pharmaceuticals, and adequate medical records. Many jails presently provide care on a purely "as needed" basis, often transporting prisoners to private physicians and emergency rooms.

Washington's standards became mandatory on October 1, 1979. The chief means of assessing compliance is yearly on-site inspections which explore most aspects of jail operations on a standard-by-standard basis. Orders of compliance are issued on a time-phased basis for those areas found not to be in compliance. Appeals of these orders are possible to the full Jail Commission which has been appointed by the Governor. Cooperation and technical assistance are the primary emphasis of the process, but the Commission is empowered to order closure of jails that do not meet mandatory standards.

Physical conditions, particularly overcrowding, also have an effect on prisoners' health and on health care delivery. The Jail Commission has been authorized to distribute $106 million in State bond monies to local jurisdictions for construction of city and county jail facilities. The funding process is now underway, and new construction (and remodeling) will begin in the near future. Operating costs will continue to be borne by local jurisdictions.

Before concrete and steel can be put in place, basic information such as number of persons held and population projects must be obtained. The same kind of information is needed before a jail health care program can be initiated. Information on a jail's average daily population, although usually available in some form, is surprisingly variable in definition, and sometimes simply inaccurate. Common definitions and reliable reporting systems are essential.

Accurate information is useful in the following areas: (1) Length of stay (number of persons), (2) average length of stay (amount of time),

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* Presented by: Bruce Kuennen; Jails Standards Compliance Specialist; Washington State Jail Commission, Olympia, Washington

(3) incidence of health problems, (4) number of trips to health care providers and emergency rooms, and (5) cost data.

Although many jails can easily supply a figure for average length of stay--for example, 2.3 days--few can readily break this information down into the number of persons held beyond a certain length of time. A breakdown which has been found to be useful for planning purposes is number of persons held: (1) less than 72 hours, (2) from 72 hours to 7 days, (3) from 7 to 14 days, and (4) 14 days or more. More appropriate breakdowns may be established for individual facilities, but these are useful for many situations. Standards require that every person confined in a jail be screened for basic, immediate health problems. Washington standards also require a more thorough appraisal by "medically trained or qualified medical personnel" on all persons held 14 days or more. The reason for the 7-day cut-off is that research in some jails has shown that a large majority of persons who remain in jail after 7 days are still in jail after the thirtieth day. Thus, persons reaching their seventh day of incarceration could be scheduled for examination by health professionals within the next week, without a great deal of unnecessary schedulings or wasted professional time. Compilation of this data could be easily extended to number of screenings, number of appraisals, and approximate time required to assess the health problems of the jail.

An additional useful refinement of the above data is to break the overall average length of stay mentioned above into the average of those more than 7 days and the average of those more than 14 days. Again, the cut-off times can be adjusted to fit the requirements of individual jurisdictions.

Once a rudimentary screening system has been established, data can be routinely gathered on the incidence of health problems common to, and important to jails. Those which must be screened in Washington are: (1) venereal disease, (2) infestations, (3) other communicable, (4) mental illness, and (5) other frequent complaints (to be designated by the responsible physician). All problems can be screened by an appropriate combination of self-reporting, laboratory tests, and possibly standardized tests. The author has initiated research in the use of the Psychological Screening Inventory in a small jail to predict prisoners in need of further psychological evaluation. Others have used depression indices and other scales as a possible predictor of suicide risk. In often liability-conscious jails, refusal to respond to screening questions can be taken as indicative of the need to observe more closely and to refer to specialized professionals.

Cost data is often fragmented in jail budgets and other records. If available, the number of trips to private physicians and emergency rooms is a useful piece of information to compare before and after the initiation of a health care system. Most of the predictive data described above can be expressed in time required and in cost/hour and divided according to the level of health professional expected to provide the service. Providing this data to interested health care providers can allow them to make reasonable estimates of their expected charges. This may allow correctional administrators to compare services and costs of those services among potential providers.

Implementing a medical system in the Whitman County Jail actually reduced the explicit cost (per prisoner) of providing medical care. Problems which previously required additional security personnel, transportation, and high emergency room charges, could now often be handled at routine sick call visits by the county health doctor. In this instance, no funds were actually exchanged between the sheriff's office and the health department, since both were agencies of the county and both were willing to cooperate on that basis.

This kind of reduction of costs should probably not be expected in other situations, particularly where little care is presently provided to prisoners. No comparative data has as yet been gathered statewide by the Jail Commission. A uniform reporting system is planned, however, and is hoped to be in operation before 1981.

Implementation strategies in various jails in Washington will vary, but all intend to comply with the basic minimum standards described in general above. The systematic gathering of this kind of basic, minimal population and health problem incidence data can make the difficult job of correctional planners and administrators a lot easier. Then, the systematic provision of health care services in jails can follow, resulting in significantly better, and more efficient, health care delivery in our jails.

THE IMPORTANCE OF HEALTH CARE DATA COLLECTION AND RESEARCH*

Standards for health care in correctional institutions have been formulated by the American Medical Association, the American Public Health Association and the National Institute of Law Enforcement and Criminal Justice. These efforts have been a response to legal directives and heightened professional concern regarding the rights of incarcerated persons to adequate health care.

Goldsmith has emphasized the importance of acquiring basic clinical data in planning prison health services. Such data should include a compilation of common medical problems that are present on admission or that occur during incarceration, or both. Previous reports have provided such information for specific settings, but many of these studies have methodological limitations that are inherent in the study of transient inmate populations. These limitations have restricted comparability and applicability of the data in the widely diverse correctional institutions of this country.

In August, 1974, I initiated a study of inmate health care needs at St. Paul-Ramsey County Workhouse. The Workhouse is a minimum security correctional center for male offenders. The average daily census in 1974 was 121 (range 93-155). Inmates served sentences from a few days up to one year for mostly non-violent offenses. Misdemeanors and gross misdemeanors accounted for 94.5% of these offenses. Regular jobs are held by 15-20% of the inmates under the work-release program while serving their sentences. The other inmates work approximately six hours a day in assigned work areas.

The objectives of this study were to determine the health status of inmates on admission to the institution and to establish the types and frequencies of health problems encountered during their periods of incarceration. Further, we hoped to determine whether relationships existed between results of the admission health evaluation, health problems subsequently encountered, and health care-seeking behavior of the inmates.

We felt that it was important to design a protocol which was practical, realistic, and effective. The protocol so designed minimized disruption of daily routines in the facility, recognized differing levels of responsibility for health care of inmates incarcerated for variable periods of time, and assured review of all data for accuracy by the chief investigator. It was our intention that the data so obtained would underly guidelines for admission screening and health care services in this facility. Finally, it was our hope that the research protocol would be applicable to other institutions and inmate populations.

Four hundred and ninety-one inmates underwent admission health evaluation, which included the administration of health history and self-rating depression scale questionnaires, physical examination, and limited laboratory investigation. The 11-item admission health questionnaire,

*Presented by: Robert Derro, M.D., Associate Director, Department of Family Practice, St. Paul Ramsey Medical Center, St. Paul, Minn.

emphasized the inmate's recent and present health. The self-rating depression scale questionnaire was easily administered to and understood by inmates. For physical and laboratory examinations a summary form was used. We did not routinely include funduscopic, rectal, and neurological examinations in the otherwise complete physical examination. Laboratory investigation comprised hemoglobin and/or hematocrit, urinalsis, VDRL, intermediate strength PPD, and in Blacks a test for sickle cell trait. All tuberculin reactors underwent chest x-ray examination, except where they related having had an x-ray within the past year. The results of each component of the admission health evaluation was entered on a coded summary form. These summary forms were submitted for computer compilation and analysis at the conclusion of the study. Computer printouts provided data on each component of the health evaluation, correlations between individual items under history, physical examination, and laboratory. Some of the conclusions and applications of this part of the study are listed in Table 1. (see appendix)

In the second part of the study, we recorded all health problems encountered subsequent to admission on a diagnosis check-off form. This form incorporated code numbers and contained blank spaces for "write-in" diagnoses. In addition, we differentiated first encounter from repeat encounters for each problem.

Computer analysis of these forms provided data on rates of clinical utilization, types of problems, frequency of problem encounters, and number of hospital referrals (see Table 2). In addition, multiple correlations were demonstrated between age, rates of clinic utilization, certain problems or categories of problems encountered, negative or positive depression score, and results of admission health evaluation. Table 3 (see appendix) shows some of the conclusions and applications of this part of the study.

In the course of this presentation, I have alluded to some of the pitfalls encountered in clinical research studies. I have listed these and others in Table 4 (see appendix). Assuring the accuracy of data requires limiting the number of individuals collecting and reviewing the data. Also in this regard, the use of self-administered questionnaires necessitates a certain level of participation by the inmates. This in turn requires that the questionnaires be easily understood and that their completion by inmates be monitored. In my view, the keys to avoiding pitfalls 3, 4 and 5 (see Table 4) are the recruitment of research technicians who are skilled in the collection and analysis of data, and the automated compilation and analysis of data by computers. I would like to emphasize that a computer capability need not be a complex and incomprehensible component of such a study, and that the fairly simple (for computers) data analyses described in this study can be easily incorporated into research protocols. Finally, the ability to apply the results of your research will depend on the degree to which you have involved and informed staff personnel in the study, more specifically those individuals who will have the responsibility for implementing new or revised health care procedures. Early involvement of these individuals in decisions relating to the study will enhance the development of a commitment not only to the proper conduct of the study but as well to changes rendered necessary by the data obtained.

APPENDIX 1

TABLE 1. CONCLUSIONS AND APPLICATIONS - PART 1

1. Considerable utilization of medical care services prior to admission.

2. Usefulness and effectiveness of health history questionnaire.

3. Marked prevalence of dental/gingival disease.

4. Marked prevalence of depression as measured by a self-rating questionnaire.

5. Comparison of prevalence rates at the Workhouse with those in the general community for epilepsy (higher), positive PD (higher), hypertension (comparable), and sickle cell trait (comparable).

6. Results of several screening components, individually and taken together, correlated significantly with age of inmates.

7. Utilization of physician-extenders to perform routine admission health evaluation is reasonable.

APPENDIX 2

TABLE 2. SUBSEQUENT INMATE VISITS AND PROBLEM ENCOUNTERS - PART II

491 Inmates

179	- Not seen
312 (63.5%)	- Seen at least once
239 (48.7% of total)	- Seen in first month
186	- Workhouse only
112	- Workhouse and hospital
14	- Hospital only

1257 Visits
2.4* visits/inmate/sentence
7.7* visits/inmate/year

1549 Problem encounters
1.23 problems/visit

14 Hospitalizations
9 hospitalization/100 inmates/year

*Excluding dental visits

APPENDIX 3

TABLE 3. CONCLUSIONS AND APPLICATIONS - PART II

1. Overutilization of ambulatory health care services.
2. Persisting proneness to trauma.
3. Exaggerated concern with bodily image.
4. Correlation of depression with number of visits, number of problem encounters, and several commonly encountered problems.
5. Important determinants of hospital referrals were part-time status of nurses and physicians, and lack of x-ray equipment and dental facilities.
6. Injuries, dental caries, skin complaints, and pain of various sites were the most commonly encountered problems.
7. Utilization of algorithms, standing orders, and physician-extenders to deal with many of the common medical problems and complaints is appropriate.

APPENDIX 4

TABLE 4. PITFALLS TO BE AVOIDED IN RESEARCH STUDIES

1. Disruption of daily routines in the institution.
2. Collection of inaccurate data.
3. Collection of excessive data.
4. Insufficient help in collecting, collating, and analyzing data.
5. Necessity of manually re-working data.
6. Insufficient funds.
7. Failure to apply results of study.

References

Abeles H., Feibes H., Mandel E., et al. The large city prison: a reservoir of tuberculosis. Am Rev Respir Dis 1970; 101: 706-9.

American Medical Association, Program to Improve Medical Care and Health Services in Correctional Institutions. Standards for health services in jails. Chicago: American Medical Association, 1979.

Derro RA., Admission health evaluation of inmates of a city-county workhouse. Minn Med 1978; 61:333-7.

Derro RA., Health problems in a city-county workhouse. Public Health Rep 1978; 93: 379-85.

Goldsmith SB., Prison health: travesty of justice. New York: PRODIST (Neale Watson Academic Publications, Inc.), 1975.

Gunn J., Fenton G., Epilepsy in prisons: a diagnostic survey. Brit Med J 1969; 4:326-8.

King LN, Young QD, Increased prevalence of seizure disorders among prisoners. JAMA 1978; 239: 2674-5.

King LN, Geis G., Tuberculosis transmission in a large urban jail. JAMA 1977; 237: 791-2.

Novick LF, DellaPenna R, Schwartz MS, et al. Health status of the New York City prison population. Med Care 1977; 15:205-16.

Rundle F., The dilemma of a prison doctor. Hastings Cent Rep 1972; 2: 7-9.

Stead WW., Undetected tuberculosis in prisons: source of infection for community at large. JAMA 1978; 240: 2544-7.

Twaddle AC., Utilization of medical services by a captive population: an analysis of sick call in a state prison. J Health Soc Behav 1976; 17: 236-48.

Zung WWK., A self-rating depression scale. Arch Gen Psychiatry 1965; 12:63-70.

TRAINING NON-PROFESSIONALS TO ADMINISTER MEDICATIONS *

The noted author, Kurt Vonnegut, several years ago observed that "unexpected invitations to travel are dancing lessons from God". It is with much these same feelings that I return to Chicago to address you all today.

I am certain that most of us have experienced the vexing and often wearisome task of providing safe and effective health care to those persons detained or incarcerated. On these occasions, we may begin to feel the need for a choreographer to assist us in making the right steps as we move hesitantly into unchartered territory. To provide such assistance is the purpose of this conference and of this particular presentation.

"The trouble with our age,' noted L. Kronenberger, "is all signposts and no destination". While this homily may somewhat overstate the case, many of us would agree that we do, in fact, live in times of government by indicator. Does the Gross National Product really indicate how well care was being provided by your staff? Notably over the past decade, court decisions have attempted to establish signposts indicative of a less definable destination; safe, effective and humane care for institutionalized persons.

Federal, state, local and professional standards have been adopted to protect basic human rights, historically not given high priority in many institutions. One such right is for the provision of adequate health care in correctional institutions. An element of this right concerns the administration of drugs. It is to this specific topic that my presentation today is directed.

The constipated inmate on bisacodyl may not tell the physician that he is consuming several non-prescription antacids concomitantly. The cardiac patient, on a low sodium diet, seldom tells the doctor that he is taking one or two alka-seltzer tablets after meals. Yet the sodium content of such preparations may very well exceed that which is safe for cardiac patients. Cold remedies contain cholinergic agents that are contraindicated in certain types of glaucoma. The use of laxatives, antacids and anti-hemmoroidal preparations may easily mask a more serious problem; a problem seemingly controlled or made invisible through improper self-administration. Unknowledgeable persons may labor under the misconception that if two pills are good, four must be twice as good. Much damage can potentially result from such instances.

It should be obvious to all of us that the administration or the delivery of pharmacologic agents cannot properly be seen when divorced from the context of a continuity of health care. I believe this principle applies irrespective of the setting in which drugs are administered. Even so, there exists a well-intentioned but dangerously uninformed cadre of persons who believe that anyone should be allowed to pass out medications.

* Presented by: Robert A. Hamilton; Education Coordinator, Minnesota Department of Health, Minneapolis, Minnesota

Few health professionals have a realistic concept of the quantity of over-the-counter medications bought by the general public for general consumption. Perhaps more importantly, the public doesn't consider these so-called "safe" drugs in the same sense as they consider those legend medications prescribed by a physician and dispensed by a licensed pharmacist.

While we may not wish to go so far as did Plato, who, writing in 400 B.C., noted that "diseases, unless they are very dangerous, should not be irritated by medicines"; while we may be reluctant to generalize to such an extent, we must surely note that our society is largely dependent on medications to mitigate even the slightest unpleasant condition. This dependence by a large group causes us to fail in a proper individual respect for drugs.

If one were to look beyond the less complex tasks of simple pill delivery (and I believe we are obligated to do so), one is confronted with the more complex issue of assuring a proper continuity of healthcare. Is the medication achieving the desired effect? What untoward effects are observed? Are these significant? What should be done about them? What client education should be given? Who should give it? What documentation is needed? How are drugs stored, handled and discarded? These are not easy questions to answer. In fact, it has been only within the past few years that we have even asked them in any rigorous manner. As John W. Turk recently observed, "there are no easy answers or simple solutions after kindergarten."

Is it enough to assert, as did one gentleman to me recently, that his facility had never made a medication error in that no inmate had yet died from a drug-overdose? Is it enough to refuse training for the licensed staff for fear that with training they may begin to question the professional health staff? Do we avoid medico-legal entanglements merely by pleading ignorance of the law or of good professional practice? Are we fulfilling our collective responsibilities by simply distributing "one blue and three red" tablets at noon? These and similar questions must be answered in every community, in every institution and by every individual responsible for preserving and protecting the health and safety of persons committed to public care.

The continuity of that care begins and ends with the recipient. Gone are the days when the client permitted him/herself to be viewed as a patient; that passive, compliant open vessel simply waiting to be cured by some external laying-on of hands. Today, the situation is much different. Accountability is both a watchword and a challenge. Today, we increasingly find ourselves in imbroglios bounded on the one side by the public demanding cost-containment; the most bang for the buck. On another side, we are hemmed by vocal clients demanding that we respect all their rights, both actual and perceived. On the third side, we find the governmental agencies; often as perplexed as we in attempting to decide how best to meet their obligations. And on the fourth side, we find the watchful guardians of medico-legal obligations

attempting to assure a safe and effective duty of care. Is it any reason we feel boxed-in? And yet we must do something, but what?

In Minneosta, the State Departments of Health and Corrections began in 1976, to produce jointly participatory standards which would govern, among other things, how drugs were to be stored, handled and discarded in certain correctional facilities. In the spring of 1978, these standards were officially adopted by the Department of Corrections. One standaed embodied in these rules called for the completion of a training program in medicine delivery approved by the Minnesota Department of Health. This program was to be completed by all unlicensed personnel before said persons were authorized by their facility to deliver drugs under the ultimate supervision of a licensed physician.

The complex task of developing such a training program can be summed in one query: What would correctional workers need to know in order to deliver medicines safely and effectively? Although on the surface this question appears simple, it is indeed rather complex. In order to properly answer it, one would need to determine:

1. What correctional workers already know.

2. What is meant by "delivering medicines" as contrasted with "administering medications."

3. How the constructs "safely" and"effectively" are to be defined and assured.

I shall not at this time detail our deliberations on any of these issues. What I shall do is to overview the answers as they are presently revealed to us.

1. Correctional workers appear to have no consistent body of knowledge as related to the safe and effective handling of pharmaceuticals. Ergo, the training program may be viewed as an entry level course.

2. Delivering medicines appears to involve a different clientele than is usually associated with the administration of medications. Those to whom medicines are to be delivered appear to be ambulatory, not acutely ill and generally in possession of their mental faculties. The techniques of administration, the gamut of possible side-effects, documentation requirements and delegation of authority seem more similar than different between the two "systems".

3. "Safety" can be defined by the set of practices consistent with the recognition and preservation of the "Five-Rights" (i.e., the right drug to the right patient in the right dose at the right time via the right route).

"Effectively" alludes to therapeutic efficacy; did the drug accomplish what it was supposed to accomplish what it was supposed to accomplish with minimal, or at least acceptable risk? This is the concept of "balance of benefit and risk" and further highlights the crucial role of a team effort in providing an appropriate continuity of care.

In order to prepare the naive population of correctional/detentional workers to deliver medicines, it was necessary to specify what they absolutely needed to know as differentiated from what would be nice for them to know. This winnowing process was accomplished over a period of some months and given to a review committee for comment and critique.

In brief, we feel all those administering drugs should have a basic knowledge of

1. the laws under which they must operate; federal, state, local and policies of their individual facility.

2. health-related terminology.

3. use of reference sources, including their own formulary and a standard reference, such as the PHYSICIANS' DESK REFERENCE. (P.D.R.)

4. the desired and undesired major effects of drugs administered.

5. charting, documentating, recording and reporting procedures and practices.

6. the actual procedures involved in delivery of drugs, including supervised practice to competency both in the educational setting and by the facility physician (or designee) in the participant's own institution.

Each of these topics, taken separately and en toto, is directed toward fulfillment of the care-givers imperative; to see to it that the patient receives the drug exactly as ordered by the physician and that no harm comes to that patient as a result of any act of commission or omission. The physician has the right to expect that those rendering care will be able to recognize and report in a timely manner any condition which might adversely affect the patient's welfare. Conversely, the unlicensed staff has the right to expect that the physician will neither delegate nor allow them to perform any task beyond their training and experience. These are not easy responsibilities; they are co-dependent, one cannot facilitate resident welfare should it be divorced from the other. Even though I tend to agree with Oscar Wilde

that "nothing worth learning can be taught", I now propose to share with you certain discoveries which may aid you as you develop a training program in medicine delivery. I have stated these in the context of axioms, although I do realize that their nature of self-truth will be recognized only by others through actual experience. With this limitation in mind, I offer the following for your consideration.

1. We do not arrive at truth through deductive logic. In the real world, truth evolves and cannot be revealed by any simple unfolding of pre-determined elements. Rather, truth is inferred from particulars. That is to say, inductive logic better assists us in our search for truth than does deductive logic. An induction requires experience. It therefore follows that you will not be able to determine the nature and extent of your own training requirements from a recumbant, armchair-bound position. Directed activity is necessary, but not sufficient. This brings me to my second point.

2. You will not be able to develop an appropriate and equitable training program by yourself. Conversely, a group of people will not be able to develop one either. The answer lies in a middle road. Collect around yourself all those with wisdom and all those who are properly involved in the impacts of such a program. Encourage diversity; eschew similarity in viewpoints. Establish mechanisms so that all have the opportunity of being heard, their points debated and addressed.

3. Determine who is in charge. This individual must have a vision consistent with the truth or at least have a vision which is consistent with administrative notions of truth. To this person must be delegated full administrative responsibility and authority.

4. Determine what every participant would minimally need to know in order to be able to deliver/administer medicines safely and effectively. Be particularly watchful not to allow practice to determine principle.

5. Identify and investigate alternative delivery modes. Frequently those alternatives which can be most expediently "costed out" are found to have the highest cost over the long haul. You may remember Will Roger's maxim that "Today's solutions are tomorrow's problems".

6. Field-test your selected alternative. Ask yourself "how can this alternative be packaged for mass-consumption?" and "what additional problems will probably be encountered in translating the alternative from pilot

to real-world applications?"

7. Implement the selected option. Regularly monitor progress.

8. Establish and honor a "date certain" at which time the entire project will be reviewed and revised as necessary.

All these suggestions may seem at once overly complex and overly generalized. This is an accurate perception, but a necessary limitation in such a brief presentation as this.

If I were to leave you with but a single thought to guide you in forthcoming deliberations, I could do no more than to provide a focus for all interventions into the lives of others. This focus is from Emerson: "Every man is a divinity in disguise; a god playing the fool".

To be sure, some appear more foolish than others. But the devine flicker is there. Its preservation and nurturance become our challenge and our charge. Can we in good conscience do less?

Synopsis of Question Topics Posed

Q: How many persons have been trained in Minnesota's Medication administration Program?

A: We have four such Programs operating: a 36-hour course for nursing home staff; a 40-hour course for staff from facilities for the mentally retarded; a 48-hour course for chemical dependency facility personnel; and the corrections course of 16 hours. Nearly 7000 persons have been graduated from all four courses.

Q: Who teaches these courses and where are they taught?

A: The courses are taught by registered nurses, each of whom is licensed by the State Department of Education. Back-up is provided through the establishment of local advisory committees having pharmacist and medical doctor representation. Courses are taught through vocational schools, community colleges and at certain state hospitals. Under certain conditions, classes may be conducted off-campus by an approved instructor.

Q: How is testing handled?

A: The State Department of Health issues tests for each program every 6 months. The testing involves oral, written and practical applications. Following successful completion, as defined in course objectives contained in student manuals, participants return to their employing facility where the licensed physician or his designee performs a clinical assessment using

a series of check lists developed and provided by the Department. In most instances, the physician delegates this assessment to the registered nurse who supervises the participant on a day-to-day basis.

Q: What is the content of the 16-hour course?

A: The content has been overviewed in the foregoing presentation. A comprehensive outline of the full 16-hours may be obtained at no charge from the author: 717 Delaware St. S.E., Minneapolis, Minnesota, 55440. Expense prohibits our supplying the student texts. The 275-page texts are available from: Documents Section, Department of Administration, room 140, Centennial Building, St. Paul, Minnesota, 55155. Request code number 8-11, 'Medicine Delivery Program for Law Enforcement Staff'. As of mid'November, the exact cost had yet to be established.

Q: How long should the course be?

A: This is similar to a question of prunes: Are three enough? Are six too many? Perhaps more aptly, we might ask "How long is a piece of string?" The answer depends on what you expect it to cover. It is far better to establish the desired content and let the number of hours evolve as a function of that content than to establish some magic number and try to pad or cram the content to validate your original position.

TRAINING NON-PROFESSIONALS TO ADMINISTER MEDICATIONS *

The manual that I've used in training non-professionals to administer medication is entitled "Training of Jailers in Receiving Screening and Health Education". The material was developed by the Department of Governmental Affairs, University of Wisconsin Extension. It was prepared for the State Medical Society of Wisconsin and the American Medical Association.

The instructional material is contained in two manuals, one for the instructor and one for the student. The section that pertains to medication administration is only one unit out of eight units that make up the course content. Other units relate to reception health decisions, receiving screening, vital signs and gross testing, recognizing signs of ill health and first aid.

The material is presented in a combination of lecture, discussion and demonstration of technique. Visual aids are provided in the form of transparencies.

The course material is presented with the understanding that the dispensing has been done by the qualified health professional and adequate labels are attached to each medication bottle or envelope.

The presenter should have thorough knowledge of the material and the system. Persons qualified to do this are pharmacists, registered nurses and health educators. The presenter should become familiar with the institutional or jail setting prior to presentation. It is important to know the size of the facility, type of population, whether it is a transfer site or receiving direct admissions from the streets or courts.

Information should be available as to the approximate number of prescriptions and over-the-counter medications that are administered during a given time. One needs to know how the medication is packaged prior to administration. Information given in instruction will vary if packaging is in the form of bottles, envelopes or unit dose. You should check in advance the availability of professional consultation.

It is helpful to know the regulations and standards that exist in the areas of medication dispensing and administration. Pharmaceutical dispensing laws may vary from state to state. Administration standards should be checked. Is there mention in the job description for the non-professional, anything that relates to medication administration and training?

The actual training course time for the medication training administration unit is 90 minutes but allowing three hours given adequate time for questions and answers and also allows time to relate to specific situations.

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* Presented by: Mary Holtshopple, R.N., Nursing Coordinator, Bureau of Institutional Health Services, Oregon, Wisconsin

The objectives of the course for the medication unit requires that each student will upon completion:

1. Be aware of some general aspects of medication and medication prescriptions, including: labeling requirements, methods of taking medication, timing of dosages and special orders, stop orders, warning of side effects, and allergic reactions.

2. Understand the importance of verification of medication brought into the jail or institution and know how to obtain such verification. Resource reference books such as the Physician's Desk Reference are used and encouragement is given to directly contacting the health provider that has been involved in the patient's care plan. This could include the pharmacist, physician and/or nurse.

3. Understand the importance of secure control of all medication in the facility. This relates to both prescription and over-the-counter medication. Also become familiar in how to deal in situations where patients take medication with them for self administration when involved in off-grounds work or study programs.

4. Know and understand basic procedures of medication administration in the jail or institution. Recognize the importance of inmate identification, following label directions as to amounts and distribution time.

5. Understand the importance of not stopping or stopping an inmate's medication (prescription and non-prescription) within the facility. Recognize importance of documentation of observations and alerting health providers.

6. Understand the importance of careful documentation of the administration of all medication.

7. Know the recommended components of a medication log sheet.

The following are certain things the course is not designed to do.

1. It is not designed to train you to be an emergency medical technician, nurse, or physician's assistant.

2. It is not designed to teach you to diagnose illnesses and decide appropriate treatment; that is the job of the physician, physician's assistant or nurse practitioner.

There are two appendixes included, (1) general warnings and common side effects for some common classes of drugs and (2) comparative units of measurement.

The manuals (instructor and student) are presently in the process of being printed by the Government Printing Office. Inquiries as to availability can be addressed to Nate Caldwell, Correctional Program Specialist, National Institute of Corrections, Jail Center, P. O. Box 9130, Boulder, Colo. 80301

TREATMENT OF THE VIOLENT AND/OR PSYCHOTIC INMATE *

Those who would provide treatment for residents of correctional institutions must recognize the reality of constraint placed on the provision of such services. The American Correctional Association's Manual of Standards for Adult Correctional Institutions (Standard 4380) specifically addresses the reality that inmates have the right to refuse offered treatment. Courts have shown an increasing concern for the use of psychoactive medication; they have seriously questioned the use of these medications for the treatment of various behavior problems in the absence of diagnosed mental illness. The use of psychoactive medications under such circumstances has been interpreted as possibly violating the Eight and Fourteenth Amendments to the United States Constitution.

Civil commitment has a place in providing psychiatric treatment for the seriously mentally disordered, incarcerated individual. In view of the reality of the right to refuse treatment, it would seem only reasonable that the judicial system be included in the behavior scientist's effort at providing treatment for those few individuals desperately in need of treatment, yet unable to meaningfully participate in consent procedures. Civil commitment may well be utilized at the end of a criminal commitment. On occasion, the court, through civil commitment proceedings, can be asked to appoint a guardian for the purposes of assisting in the treatment process.

Treatment interventions can be applied "inside the walls". Severely antisocial individuals can be more effectively "treated" in a prison setting than in a psychiatric hospital, including a secure psychiatric hospital. Effective management techniques which incorporate behavior science consultation frequently produce better results with the severely behaviorally disordered person. Such individuals do not respond well to use of psychiatric medications. In reality, their utilization in the absence of serious mental illness is questionable and borders on "legalized drug abuse". Effective treatment inside the walls requires close scrutiny over the utilization of all types of psychoactive medications in a prison setting. Little reason exists for the utilization of so-called "minor" tranquilizers and sedatives. Barbiturates serve little purpose except for the treatment of specific conditions such as convulsive disorders. In light of current knowledge, no medical service in a prison setting should be using Darvon.

On occasion, some residents of correctional institutions require treatment in a psychiatric hospital. The Iowa Security Medical Facility at Oakdale, Iowa is an 81-bed psychiatric hospital accredited by the Joint Commission for Accreditation of Psychiatric Facilities. Effective treatment in a psychiatric hospital requires intervention from many sources. A violent individual, psychotic or not, must be approached in a fashion so as to reduce danger to himself, others, and property. Verbal responses are frequently sufficient at controlling aggressiveness. Milieu expec-

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* Summary of Presentation by: Paul Loeffelholz, M. D., Superintendent Clinical Director, Iowa Security Medical Facility, Oakdale, Iowa

tations have a major impact. Loss of privileges can influence behavior.

Constructive penalties have a place in reducing violent behavior. Restraints and segregation are important in the control of violent behavior. It is essential that a program be developed which promotes adaptive living skills. Simply eliminating maladaptive behavior is inadequate treatment. Medication has a limited place in the management of violent behavior. It should be limited to the treatment of a specific mental disorder which has relevance to the violent behavior in question.

Documentation is critical in the management of individuals who are violent and/or psychotic. The Problem-Oriented Medical Recordkeeping system is ideally suited to this process of maintaining documentation of care provided. All utilization of restraints and segregation should be documented so as to be able to answer questions which can, and do, develop surrounding their use.

The behavior scientist is frequently asked to express an opinion concerning release of the mentally disordered individual, especially the violent mentally disordered. Some practical criteria is available to possibly assist individuals in this decision-making process.

UNIQUE HEALTH CARE PROBLEMS OF THE FEMALE OFFENDER *

Becoming a resident in prison to some is:

1. A way of life - an accepted fact.
2. An adventure.
3. A great shock.

Each person reacts differently depending on her make-up. Recently I talked at length to a number of residents about their feelings on coming to prison and most said: "I never thought it could happen to me", "my lawyer said.....", but unfortunately, "the judge said .....".

One of the residents told me, "I didn't know I was in prison until my door closed at the Intake Unit and I looked around my room and said, 'Where am I'?". Another resident said she had a great sense of fear; the stories she had read, the movies she watched, had given her an idea of what prison was going to be. She said she felt a great personal loss - her freedom? On arrival, she felt dehumanized, she was there with nothing, she wanted to cry, but contained herself. She had many questions, but was afraid to ask.

The Admission Office was a busy place; the staff had a job to do and no time for her questions. By the time she got to the Intake Unit, she felt she had done a day's work. Actually, she had just sat in a chair and answered volumes of questions.

Observing became the number one concern in most residents' lives; they observed both people and things around them, looking more closely than they had ever done before.

The residents noted at the Intake Unit, that people talked more to other people, even to themselves, and for them, life became a little more relaxed when they realized they were here "until further notice".

As we all know, residents come in all shapes and sizes and from all phases of life and each has her own special problems and needs - medical, psycological and physical - and her own way in which to handle the problems. Due to the changes in her new life, illness may become a big part of everyday living. Attendance at sick call is a way of communication, a way of meeting other people, a way of getting something taken care of for herself, sometimes not even relating to medical needs or illness. It gives some residents a feeling of being needed or that someone is showing concern or attention.

A resident may request medication for a headache, shortly after request further medication, this time perhaps for "cramps" or other complaints. Upon questioning the resident, you find out the problem is not the headache, the "cramps", etc. but a lot of unanswered questions.

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* Presented by: Bridget Lame, R.N., Hospital Administrator, Dwight Correctional Facility, Dwight, Illinois

The questions range from the family she left in the care of a favorite Aunt or Grandmother or maybe there is a phone call at the end of the conversation needed to overcome the loneliness.

Being locked up gives one a very different look at other people, especially those working around you and with the residents and especially with the medical staff. Residents get the same kind of illness as people in the free community, though sometimes expressed very differently.

Most of the population in a prison is usually young and healthy and find the medical unit a place to visit, meeting their friends and exchanging the latest "gripes" while waiting to see the medical staff. The medical unit does not only serve as a place to receive medical attention but a place to ask questions, and is used as a means to this end.

Unfortunately, some of the residents have spent an awful lot of time going from clinic to clinic on the streets, never completing a course of medication or treatment, either because the complaint started to clear up, or it didn't clear up quickly enough for their expectations. Education to meet their needs in the medical department must be an ongoing process and repeated many times to meet their understanding.

In a prison, there is a special need to take care of the older resident. I have asked myself, "Who is the older resident? Who is the older patient?" In such an environment, the person who comes in with a debilitating illness is usually an older person. How old is old? Of course, deteriorating illnesses can come to young or old. There are all sorts of problems and age groups to contend with in an institution. There is of course, the young person who becomes old in your midst. Time has gone on, and suddenly she is becoming ill as a result of the aging process. This patient is more apt to become depressed with the realization of her illness as the longer time spent in the prison setting.

The resident with the deteriorating illness needs the same care as the resident on the outside but more often it is found that she does not understand what is happening to her or just gives up and behaves contrary to her needs. Unfortunately, in a closed environment motivation is often lacking on the residents' part and very often they express the desire "to get out of here before something serious happens to me".

I have noticed the patient with a debilitating illness does not feel obliged to make the effort to make life worthwhile. Younger residents will always be drawn to the older residents and therefore, the older resident will often become the pampered person and enjoy the role of the invalid. Even in prison, the older person just like the baby, can become the center of activity for better or for worse. The healthy older person for the most part is a revered person and her voice can carry a lot of weight. Her word becomes law and everyone listens. She can be helpful to the staff and residents alike if channeled in the right direction. She will help the younger ill patient accept responsibility for her own care, help her to enjoy the company of other residents; she will include older residents in activities. Both age groups will gain from the experience.

The resident who is growing older in the population has a different outlook on life than the older resident first coming into the institution. The growing old resident has experienced the "ways and means" of the various departments in the unit. She becomes well versed in the medical unit and informs others how to act. Although she also has learned to handle the headache, pain in the foot, etc., becoming old and ill in a prison to the resident can become a very frightening experience. She probably feels very abandoned and will want to be at sick call every single day. To her this will be her assurance and make her feel cared for. Your communication with her will help her to meet and accept the growing change; her medical complaints will become your problems. She will need to spend more time with you and the physician for constant explanations.

On discharge from the institution to the free community, the resident should be advised specifically regarding any health problems, given complete information regarding the various clinics close to their home in order to make them aware of continuing care and availability of the services provided for them in the community.

Hopefully, the residents will have learned by their mistakes and not return to the institution. We further hope that our instructions on proper medical care will be adhered to by each resident who is in our facility and for those who may in the future be in this facility.

UNIQUE HEALTH CARE PROBLEMS OF THE FEMALE OFFENDER*

I will be talking to you this morning about stress as it relates to the psychosomatic complaints of women offenders.

It has been the experience of the South Carolina Department of Corrections (SCDC) that medically managing the female offender is more difficult than the medical management of male offenders. The difficulties faced by staff members assigned to female correctional centers are not due to physiological differences between male and females, but to the behavior of female offenders in their interaction with medical staff members. The female offender displays greater degrees of manipulation, complaining, and aggressive type behavior than the male. This response to illness could be attributed to several factors.

1. Females traditional roles as nurturers of life and as the practical ones who cope with the daily problems of existence.

2. Stress encountered by the female offender due to separation of the mother-figure from the family.

When individual's experience need frustration, they are likely to react in one or more defensive ways. Some of these defensive measures are aimed at preventing further frustration; others are simply subconscious tactics for "getting even". The medical staff must be able to recognize these behaviors as defensive reactions and attempt to eliminate the cause of the need frustration where possible. Many of the problems we experience in South Carolina can be attributed to stress - related incidents and the female offender's inability to cope with this stress. There is a definite relationship between constant stress and a high incidence of psychosomatic illness.

I will be reviewing with you the physiological reactions, the physical effects, and the psychological reaction of stress on bodily functions. As I talk about these characteristics, you may think about your particular situation, and see if you recognize any of these manifestations in the behavior of both the staff and women offenders in your care. Then, I would like to recommend some therapies and strategies for reducing stress in a prison environment.

Many diseases are thought to be caused by stress, the list is almost endless and includes asthma, allergies, ulcers, colitis, migrane headaches and others. Health professionals acknowledge that stress is a contributing factor in making a disease worse in terms of symptoms and total impact upon a person's life. However, it is difficult to establish stress as the critical event in the natural history of the diseases, but we do know that "stress makes things worse".

The book Life Stress and Illness (Gunderson and Raye, 1974) places particular emphasis on the fact that stressful life events in an individual's recent past can be used to predict the onset of psychological or physical disorders.

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* Presented by: Pat Satterfield, R.N., B.S., Director of Nursing, South Carolina Department of Corrections, Columbia, South Carolina

We are aware that when danger threatens our life the body responds in a certain manner. There are certain noticable physiological reactions that enables the body to prepare for "fight or flight". Let's focus on the physiology of stress and explore what happens to you internally under stressful situations.

Physiological Reactions

1. Dilation of pupil.
2. Decreased salivation.
3. Elevated heart rate.
4. Increased blood supply to the muscles.
5. Dilation of trachea and bronchi.
6. Conversion of glycogen to glucose.
7. Decreased activity of stomach and intestines.
8. Increased productions of adrenalin.
9. Increase in lactate build up.

These reactions are not damaging as long as the source of stress is identifiable, the challenge is met, and the body experiences a relaxation rebound before returning to normal functioning. However, most of our daily threats are ambiguous, and this prevents a sufficient recovery from the stress - alarm reaction which they induce.

This build up of stress without any relief mechanism is instrumental in the development of psychosomatic illness. First, a baseline level of tolerable stress is escalated to a level of excessive stress. Then, when this high stress level is prolonged and unabated, it produces alterations in neurophysiological functioning which can create the preconditions for the development of a disorder.

Prolonged unabated stress will actually damage the body. The mechanics of this damage are complex, but the principal effects include:

1. Releases fatty acids in the blood (cholesterol - heart attacks)
2. Increases hydrochloric acid level in gastro intestinal tract - peptic ulcers & colitis.
3. Inhibits immune response - more susceptive to disease.
4. Urinary difficulties.
5. Sexual dysfunctions.
6. Circulatory difficulties - migrane headaches - tachycardia.

Several studies have shown that a stressful, anxiety - producing work environment promotes emotional distress and increase the incidence of psychosomatic illness, accidents and interpersonal conflicts. Also, an angry, unloving home environment promotes emotional distress and destructive behavior in the family members.

As Toffler points out in his book Future Shock, man is a "bio-system" with only a limited capacity for over stimulation and if thrust into an overloaded environment he can react with a variety of symptoms which range from "anxiety, hostility to helpful authority, and seemingly senseless violence, to physical illness, depression and apathy".

Any alteration in an individual's life requires him to adjust, and when these adjustments must be made too frequently in a brief period of time, tension and stress are the results. Prolonged stress will wear out the body and lower its resistance. Excessive stress keeps you in a keyed-up, hyper - emotional state, and interfers with your rest, even when you are asleep. You may experience a whole range of abnormal emotional states from anxiety, tension, and irritability to fatigue and depression. These symptoms certainly inhibits ones ability to function well in any environment.

Lets take a look at some psychological effects of stress:

1. Irritability
   a. Restlessness
   b. Anxiety

2. Disturbed sleep
   a. Decreased R.E.M.
   .(Rapid eye movements are highly associated with dreaming.)

3. Narrowed perception

Many of the complaints at the Women's Center in S.C. could be associated with the psychological reactions just described. Most women offenders experience insomnia, nerve problems, migraine headaches, fatigue, and other stress - related symptoms. The pressure of prison living can cause prolonged, excessive stress, not necessarily at extremely high levels, but enough to accelerate the aging process, sap vitality, and increase susceptibility to serious illness. The emotional consequences of excessive stress are as harmful as the physical ones. In fact, they may be even more dangerous because they inhibit your coping ability and reinforce the stress response. The Womens Center has a census of 272 and 18% of the population reported either having received admittance to a state psychiatric hospital prior to or during incarceration. (This is certainly an indication that their coping skills are minimum and how unsuccessful they have been in handling stressful situations.)

I think we can all see the relevance of considering stress when planning for health care in a correctional setting. Prisons are incubators for stress. Most are over crowded, rigid, boring, and isolated from the community. They offer many stressors and provide few outlet's for this stress. Women offenders experience many frustrations and guilt feelings. Most have left small children at home, being divorced, pregnant, or have financial worries. Incarceration is hard on the mind and the body which affects the behavior, degrees of health and illness of an individual.

The strategies for reducing stress are very simple techniques which enable the female offender to take charge of her own health and well-being, to learn simple steps for achieving physical fitness, and to take advantage of her own natural healing abilities. I will be discussing the importance of stress awareness for the staff and women offenders; relaxation techniques, exercise program, and environmental changes that decrease stress.

When we analyze a problem we must look at our contribution to the problem, therefore, my first suggestion is to provide inservice for the medical staff to review stress symptoms and the importance of stress as it relates to psychosomatic complaints. The staff must be made aware of their own stress and how this stress affects their behavior and attitude toward the female offender.

At the University of Washington School of Medicine, Holmes and Raye have done some research in assessing your own level of psychosocial stress. They developed a systematized method of correlating life events with illness and tested their hypothesis with more than 5,000 patients. They also used this predictor scale with other groups of people. To use the chart (See Appendix) you should check off events which have happened to you within the past year and then total up the score by adding up the assigned values of these events.

A score of 150 based on the past year would make ones' chances of developing an illness or a health change roughly 50-50. A score of 300 would increase that chance up to 90%. Conclusion: As the score increases the chance of one developing an illness or a health change is greater.

The main point is for the medical staff to become aware of their stress level and seek ways of decreasing this stress. When you begin to "lose your cool", there are several physiological changes that occur. For instance, your heartbeats and breathing rates increase, the pupils dilate, perspiration increases, and muscles become tense. If you can reverse these physical signs, then your "up-tightness" decreases.

Prudent heart living is a life-style that minimized the risk of future heart disease, and there are also some principles if applied to daily living will minimize stress. There are twelve principals to get your life under control and be helpful in managing daily stress.

1. Modify perfectionistic attitude.
2. Adjust scope of responsibilities to those you can control.
3. Structure your life (planning) "one thing at a time."
4. Don't fight the clock.
5. Don't kill the child. (T.A.) Balance work and play.
6. Don't engage in self-medication.
7. Speak up for yourself.
8. Try to work in a quiet environment.
9. Reduce talking when it is throwing fuel on the fire.
10. Observe the 10 o'clock principle (do dreaded tasks before 10:00).
11. Let the means justify the ends (Presentness).
12. Develop a feeling of control. Helplessness turns stress into distress.

Secondly, the women offenders should be educated regarding stress and encouraged to participate in a program to enable them to identify stressors and develop methods for coping with this stress. Most people are sensitive to their own psychological status and if behavior can be truly shown to have a direct casual relationship to disease, the potential for prevention is enormous.

In this workshop you will be introduced to two practices very useful in coping with stress. One is called prescribed breathing and the other is called deep muscle relaxation. These exercises will prove very helpful in combating the constant build-up of stress.

While we generally breathe properly when sleeping, we breathe improperly when under stress disturbing our natural rhythm and causing hyperventilation. Or we may breathe too slowly, or inefficiently, and set up a condition known as hypoxia.

I have some handouts on the table which gives you step-by-step for performing prescribed breathing. Proper breathing is a way of reducing anxiety if you practice this exercise daily. Group exercise is an effective way to begin with the women and then let them individually schedule their own time for practicing this technique.

The second exercise is deep muscle relaxation. Again this is a cookbook type receipe that must be practiced daily to be effective in reducing tension. Progressive relaxation training consists of learning to tense and release various muscle groups throughout the body. An essential part of learning how to relax involves learning to pay close attention to the feelings of tension and relaxation in your body. This exercise is a very effective method for treating tension headaches. Relaxation therapy was utilized at the Women's Center for a group of women who complained with frequent headaches. The results was not as dramatic as we had anticipated, but we plan to initiate another group in the near future. Enthusiasm and commitment by the medical staff will be stronger with this next group. Handouts are available for the deep muscle exercise.

Recently, I read in the "Harvard Medical School Health Letter" the following regarding the role of regular exercise in reducing stress.

"For years we have emphasized the potential physical benefits of regular exercise while largely ignoring its possible emotional benefits - a sense of control over one's body, a feeling of accomplishment, a release for pent-up frustration, etc. More recently, however, there has been increasing emphasis on the role of regular exercise as an effective treatment for emotional problems. And some intriguing bio-chemical research suggests that regular exercise may increase the levels of brain chemicals (endorphins) that result in good feelings. (In fact, some have proposed that persons who seemingly become addicted to exercise might literally have become addicted to an increase of such body chemicals.)"

Most physical exercise requires very little space to perform and can be scheduled at the inmates leisure. Again, positive results will depend on the promotion and enthusiasm displayed by the staff when presenting the program to the inmates.

Lastly, environmental changes can do much to enhance your program to decrease stress within a correctional setting. In South Carolina, the lock-up cottage was a drab and very non-stimulating housing unit. Most of the women housed in this unit are behavioral problems, and abuse medical services. Security and treatment services joined forces and recommended the following changes:

1. Uniform changed from a basic sack-like dress to blue jeans and colored plaid top.
2. Grey curtains on the windows were changed to colorful floral pattern.
3. Music is played over the intercom system and closed circuit T.V. is available for the inmates.
4. The walls are white and the doors are painted black. It has been suggested that we paint the door different colors in warm tones such as reds, oranges, yellows. These colors are stimulating and will aid in combatting the disruptive behavior displayed by the women.

The results have been positive in that the behavior has improved and the medical staff are not harassed as in the past. We feel this approach has been a step in the right direction, and will continue to scrutinize the surroundings for possible trouble areas and act as quickly as possible to bring this change.

I hope that this general review of stress has been helpful and will make you more alert to stress symptoms and its effect on bodily functions and behavior. Stress level regarding staff and offenders should be assessed and recognized as a legitimate concern but one which is potentially manageable. Rather than reacting defensively, in turn, to the inmates defensive reactions, the wise nurse will see these behaviors as symptoms of a larger problem. He/she will then attempt to identify that problem and to correct the situation causing it. It has been estimated that 50 - 70% of illness is stress related, therefore, emphasis on decreasing stress should be given high priority in planning health care for a correctional setting.

References

Benson, Relaxation Responses (1977)

Bloomfield, Harold, The Holistic Way to Health and Happiness, (1978)

Pelletier, Kenneth, Mind as Healer, Mind as Stayer, (1977)

Toffler, Alvin, Future Shock, (1971)

"Harvard Medical School Health Letters," Volume 4, Number 12 (October 1979)

APPENDIX - STRESS PREDICTOR SCALE

Item No.	Item Value	Happened (X)	Your Score	Life Event
1	100	_____	_____	Death of spouse
2	73	_____	_____	Divorce
3	65	_____	_____	Marital separation
4	63	_____	_____	Jail term
5	63	_____	_____	Death of close family member
6	53	_____	_____	Personal injury or illness
7	50	_____	_____	Marriage
8	47	_____	_____	Fired at work
9	45	_____	_____	Marital reconciliation
10	45	_____	_____	Retirement
11	44	_____	_____	Change in health of family member
12	40	_____	_____	Pregnancy
13	39	_____	_____	Sex difficulties
14	39	_____	_____	Gain of new family member
15	39	_____	_____	Business readjustment
16	38	_____	_____	Change in financial state
17	37	_____	_____	Death of close friend
18	36	_____	_____	Change to different line of work
19	35	_____	_____	Change in number of arguments with spouse
20	31	_____	_____	Mortgage over $10,000
21	30	_____	_____	Foreclosure of mortgage or loan
22	29	_____	_____	Change in responsibilities at work
23	29	_____	_____	Son or daughter leaving home
24	29	_____	_____	Trouble with in-laws
25	28	_____	_____	Outstanding personal achievement
26	26	_____	_____	Mate begin or stop work
27	26	_____	_____	Begin or end school
28	25	_____	_____	Change in living conditions
29	24	_____	_____	Revision of personal habits
30	23	_____	_____	Trouble with boss
31	20	_____	_____	Change in work hours or conditions
32	20	_____	_____	Change in residence
33	20	_____	_____	Change in schools
34	19	_____	_____	Change in recreation
35	19	_____	_____	Change in church activities
36	18	_____	_____	Change in social activities
37	17	_____	_____	Mortgage or loan less than $10,000
38	16	_____	_____	Change in sleeping habits
39	15	_____	_____	Change in number of family get togethers
40	15	_____	_____	Change in eating habits
41	13	_____	_____	Vacation
42	12	_____	_____	Christmas
43	11	_____	_____	Minor violations of the law

INSTRUCTIONS:

1. Total your scores for the past twelve months.
2. Check the range of scores which includes your score:
   - Less than 150 _____ no crisis likely at present
   - 159 - 199 _____ mild crisis likely at present
   - 200 - 299 _____ moderate life crisis
   - 300+ _____ major life crisis

END