Federal Probation

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JUNE 1984

Federal Probation is published by the Administrative Office of the United States Courts and is edited by the Probation Division of the Administrative Office.

All phases of preventive and correctional activities in delinquency and crime come within the fields of interest of FEDERAL PROBATION. The Quarterly wishes to share with its readers all constructively worthwhile points of view and welcomes the contributions of those engaged in the study of juvenile and adult offenders. Federal, state, and local organizations, institutions, and agencies — both public and private — are invited to submit any significant experience and findings related to the prevention and control of delinquency and crime.

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Subscriptions may be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, at an annual rate of 9.00 (domestic) and $11.25 (foreign). Single copies are available at $3.50 (domestic) and $4.40 (foreign).

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FEDERAL PROBATION QUARTERLY
Administrative Office of the United States Courts, Washington, D.C. 20544

SECOND-CLASS POSTAGE PAID AT WASHINGTON, D.C.
Publication Number: USPS 356-210

Federal Probation

A JOURNAL OF CORRECTIONAL PHILOSOPHY AND PRACTICE

Published by the Administrative Office of the United States Courts

VOLUME XXXXVIII — JUNE 1984 — NUMBER 2

This Issue in Brief

The Evolution of Probation: The Historical Contributions of the Volunteer.—In the second of a series of four articles on the evolution of probation, Lindner and Savarese trace the volunteer/professional conflict which emerged shortly after the birth of probation. The authors reveal that volunteers provided the courts with probation-like services even before the existence of statutory probation. Volunteers were also primarily responsible for the enactment of early probation laws. With the appointment of salaried officers, however, a movement towards professionalism emerged, signaling the end of volunteerism as a significant force in probation.

Don't throw the Parole Baby Out With the Justice Bath Water.—Allen Breed, former director of the National Institute of Corrections, reviews the question of parole abolition in light of the experience with determinate sentencing legislation in California, the current crisis of prison overcrowding, and the improvements that have been made in parole procedures in recent years. He concludes that the parole board—while it may currently not be politically fashionable—serves important "safety net" functions and retention of parole provides the fairest, most humane, and most cost-effective way of managing the convicted offender that is protective of public safety.

LEAA's Impact on a Nonurban County.—LEAA provided funds for the purpose of improving the justice system for 15 years. To date, relatively little effort has been made to evaluate the impact of LEAA on the delivery of justice. In this article, Professor Robert Sigler and Police Officer Rick Singleton evaluate the impact of LEAA funds on one nonurban county in Northwestern Alabama. Distribution of funds, retention and impact are assessed. While no attempt has been made to assess the dollar value of the change, the data indicate that the more than one million dollars spent in Lauderdale County did change the system.

Developments in Shock Probation.—Focusing on a widely used and frequently researched probation program, this paper by Professor Gennaro Vito examines research findings in an attempt to clearly identify the policy implications surrounding its continued use.

Family Therapy and the Drug-Using Offender: The Organization of Disability and Treatment in

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On the other hand, there is the danger that we could become too fragmented in our roles with respect to victims of crime. I wouldn't want the crime victim to feel caught in a bureaucratic maze. To the extent we talk among ourselves and recognize common goals, this may not occur. Perhaps that's the next step: a common reference. We need to see the problem differently than we have to date.

Medical Services in the Prisons

A Discriminatory Practice and Alternatives*

BY JAMES T. ZIEGENFUSS, JR., PH.D.**

THE PURPOSES of this paper are to consider the problem of the quality and quantity of prison medical care and the increasing involvement of litigation in the system. The paper identifies the legal system/service system conflict, including pressures for change in system structures and processes. Two examples of change directions are identified: provision of care by community organizations and an internal complaint mechanism.

There has long been a dispute over whether prison medical care is adequate and, if not, what to do about it. The discussion here includes general medical care as it actually is in prisons; i.e., inclusive of mental and addictions care—two common and much needed components of prison medical service. Both the courts and various citizen groups have been drawn into the dispute over service adequacy. For the courts, the question of involvement is a most difficult one, particularly as greater attention is paid to the civil rights of inmates. For example, in *United States ex rel. Yaris* v. *Shaughnessy*[1] the dilemma of the courts in the matter [of prison medical services] was outlined:

> It is hard to believe that persons . . . convicted of crime are at the mercy of the executive department and yet is unthinkable that the judiciary should take over the operation of the . . . prisons. There must be middle ground between these extremes. The courts have proceeded very slowly toward defining it.

The courts are now overcoming their reluctance and are beginning to exercise some control.

A related instititional case (a class action suit against the mental hospitals and institutions for the retarded of the State of Alabama) defined the need for a specified number of professionals to assure at least minimum staffing standards in institutions for the mentally disabled.[2] This precedent, defining some of the conditions of treatment, moved the judicial branch of government actively into organizational operations. Some commentators agree with Barr and Zounin[3] recommending that the administration of prisons be by the judiciary rather than the executive branch of government.

As the courts begin to hear more cases and to increase involvement, the legal basis will be further elaborated. Zalman[4] and others have discussed the prisoner's right to medical care with some writers indicating that lack of care may be discrimination. A special focus is on the separate but *unequal* services. However, the conflict in law may be avoided with the use of existing community services and an internal complaint mechanism. A brief note about the history and nature of the prison medical care problem is relevant.

Prison Medical Services—Problem Recognition

The English recognized the problem as early as 1922. In regard to medical services in English prisons, the Prison System Enquiry Committee[5] responding to the question of service adequacy stated that: "We must make the comment that only in an insignificant number of cases have ex-prisoners borne out the view that adequate medical attention is given . . ." In addition, the Committee listed at that time two principal defects as:

> 1—Medical officers of good calibre are rarely attracted to the prison service. The medical attention is frequently hurried and callous, and suspicion of malingering is very prevalent, and
>
> 2—The medical staff is not large enough to enable individual psychological study and treatment to be undertaken. Nor is it, as a general rule, competent for such duties.[6]

*This paper was first developed as a result of a tour of British programs at the invitation of the Department of Health and Social Security. Dr. Allen Sippert organized the tour, for which appreciation is extended. The author would like to thank David I. Lasky, Ph.D., Robert Little, M.D., Susan McGuire, Esq., and Violet Plantz, M.S.W., for reading the manuscript. Preparation of this paper was supported in part by a grant from the Pennsylvania Governor's Council on Drug and Alcohol Abuse, Contract Number ME-4904. The opinions expressed are solely those of the author.

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[1] *United States ex rel. Yaris* v. *Shaughnessy,* Vol. 112 F. Supp. p. 144 (S.D.N.Y. 1953).

[2] *Wyatt* v. *Stickney,* 344 F. Supp. 313, 379 (M.D.Ala. 1972).

[3] Barr, N. and Zounin, L., "Campus Prisons, Community Prisons and Judicial Administration." In L.M. Irvine and T.B. Brelje (Eds.) *Law Psychiatry and the Mentally Disturbed Offender,* Springfield, Ill., Charles Thomas, 1973.

[4] Zalman, Marvin. "Prisoners' Rights to Medical Care." *The J. of Criminal Law, Criminology and Police Science,* Vol. 63: 185-199, 1972.

[5] Prison System Enquiry Committee, *English Prisoners Today.* Stephen Hobhouse & Fenner, Brockway (Eds.), New York: Longmans, Green & Co., 1922, p. 261.

[6] *Ibid* p. 262.

In recognition of this problem, they used community consultation services as a solution to the problematic traditional prison medical system.

In America, Goldsmith, in a review of the literature on jailhouse medicine in 1972, concluded that: "Overall, the literature is disappointing in that it fails to provide substantial data on the process of medical care at correctional institutions or the quality and quantity of care available."[7] Goldsmith then reported on his evaluation of the quality and quantity of medical care available to inmates of the Orleans Parish Prison in New Orleans, Louisiana. Acting on Federal orders as a result of a class action suit, this correctional institution and the city of New Orleans contracted with a hospital to provide the inmates with medical care.

Generally, American medical care in prisons has not been extensively studied. In terms of psychiatric services, Roth and Ervin in 1971 felt that their study added to the meager information available regarding prisoners and psychiatric morbidity. They felt the research efforts were important in that "Characterizing a population in this manner may be a necessary step toward understanding the prison milieu, an area still virtually unexplored by psychiatry."[8] The authors also offered comment on the state of psychiatric practice in the prisons:

> Despite the fact that a large proportion of inmates (60 percent) have at some time been seen psychiatrically in conjunction with a criminal charge or during a prison term, most of these contacts occur at the pretrial or immediate posttrial stage. Very few inmates are ever seen again within a treatment context.[9]

In fact many of the articles relating to prison psychiatry deal with diagnosis and identifying personality types rather than the need for services or the actual delivery of such services.

To further substantiate this problem of prison medicine in regard to drug service, a report entitled *The Treatment of Drug Abuse in Pennsylvania* indicated that the ratio of prison inmates involved in drug treatment in the State of Pennsylvania (240) to the number incarcerated for drugs or drug-related offenses (an estimated half, or 3,048 of the 6,095 inmates within the eight State prisons as of June 14, 1972) exhibits a grossly inadequate provision of services.[10] Furthermore, in one Pennsylvania institution for female felons, staff states that 60 percent of 167 inmates were imprisoned on drug-related offenses, yet the institution had no drug treatment program.[11]

That there is a need for change has been recognized within the prisons also. Pertaining to the need for change in medical services, mental health serves as an example with Wolff commenting that "for many years now the prison authorities have been well aware that the biggest gap in their medical armoury lies in the field of psychiatric treatment."[12] The correction of this gap, however, is made exceedingly complex by competing functions of prison health service workers.

Many authors have recognized that the conflict between being a supplier of medical services and an agent of the system is most difficult. Some, however, would appear to be advocating an emphasis in a questionable direction—that of guard, not medical provider. Wilson and Pescor[13] appear to relegate the service function to secondary emphasis:

> . . . in the present state of our knowledge the prison psychiatrist serves his most useful function in helping to preserve discipline and morale.

In general, the reaction to these conditions and to similar views of the conflict have led to a drive for revitalization of medical services in prisons with a dual focus on the nature of the services and the organization of the service system.

Service Reorganization

Efforts to reorganize the service system have already been made. For example, in regard to psychiatry, the reorganization produces changes in the role of mental health professionals within the prison system. Role change responds to a feeling verbalized by Halleck that: "Psychiatric resources thus far have been spent in wrong directions . . . [furthermore] The usefulness of the psychiatric criminologist will ultimately depend upon his ability to find a rational means of integrating his individual-oriented philosophies and practices into a correctional system that is rarely sympathetic to individual needs."[14]

Systems change can result in renewed efforts in two directions. The first is described as a redefining of the service deliverer's role within the prison. The second could be described as the incorporation of community service providers into the treatment of prison clients and the changing of the prisoner service community.

[7] Goldsmith, S.B., "Jailhouse Medicine—Travesty of Justice?" *Health Services Report.*, Nov. 1972, Vol. 87, p. 767-774.
[8] Roth, Loren H. and Ervin, Frank R., "Psychiatric Care of Federal Prisoners." *Amer. J. Psychiatry*, Vol. 128(4), p. 426, Oct. 1971.
[9] *Ibid.* p. 429.
[10] Adler, Freda, et al., *The Treatment of Drug Abuse in Pennsylvania*, Pa. Dept. of Public Welfare & U.S. Steel Corporation. Nov., 1972, p. 105.
[11] *Ibid* p. 106.
[12] Wolff, Michael, *Prison*, London: Eyre & Spottiswoode, 1967, p. 171.
[13] Wilson, J.G. and Pescor, M.J., *Problems in Prison Psychiatry* Caldwell, Idaho: The Caxton Printers, Ltd., 1939, p. 31.
[14] Halleck, S.L., *Psychiatry and the Dilemmas of Crime*, New York: Harper and Row, 1967, p. 348.

In an effort to redefine the service deliverer's role, Fink, et al.,[15] describe a program in which the psychiatrist has been allowed freedom to move from the traditional role limited to diagnosis, classification and treatment of diagnostic disorders. Their new role for the psychatrist is of normalizing and making available to prisoners a therapeutic technique which is used on the outside. They found that: "Our experience has shown that psychiatry can play a primary role in the planning and directing of a total program for rehabilitation of the offender."[16]

While impacting on the target population with desired results, this attempt and other similar ones have unfortunately not considered a fundamental change in altering the provision of care system. They have sought to alter within the prison the structure of care and the function of the care-giving professionals but they have not considered the possibility of eliminating the notion of "prison care."

Most importantly, they have not considered that the provision of medical psychiatric, addiction and other related human services to prisoners in a fashion unlike normal community services tends to initiate and/or reinforce the notion of difference. For many incarcerated individuals, this is a reinforcement of a life-long pattern and one which does not serve a therapeutic purpose. In order to ready the individual for the resumption of normal life on the outside, it is necessary that prison environments parallel societal normality. The provision of separate services does not serve this need.

As mentioned above, reformers have most often examined prisons and their medical care delivery system with the purpose of making specific improvements in the quantity and quality of health care delivered in the prisons. A recent study in Pennsylvania does exactly that. Yet as we shall see, its recommendations may be more easily implemented by a fundamental change in the structure of the delivery system.

Organizational Alternatives to the Present System

That changes in the quality of medical care being provided were needed has long been recognized. Rector in 1929 in a study of prison medical services found that "In few of them are hospital facilities adequate for the amount of corrective medical and surgical work there is to be done. The present hospitals are greatly understaffed and in their present organizations many are really emergency, first-aid stations."[17]

Rector's list of recommendations covered the physical sick call, physical examinations and protective measures, dentist, eye examinations, tuberculosis, venereal disease, drug addicts, mental examinations, the insane and feeble minded, nutrition, recreation and health education.[18] It is heartening to note that recognition of this problem occurred years ago. Yet, apparently little progress has been made, considering that 43 years later a similar report is making similar recommendations.

In 1972, a Health Law Project[19] produced a report on the types and quality of health care provided in Pennsylvania prisons and on the conditions in these prisons. Significantly, the report was prepared under grants from the Council on Legal Education and Professional Responsibility and the Office of Economic Opportunity. It acknowledged the efforts of the Medical Committee for Human Rights and the Lawyers Committee for Civil Rights Under Law, demonstrating the legal energy and growing concern for medical care in a civil rights framework.

A most comprehensive report on health care in prisons, the report offers a detailed description of services, service environment and delivery process. In total, the report documents the incredible obstacles to be faced in first attempting to offer health care in prisons and second in any efforts to improve the dreadfully inadequate status quo. Importantly, the report can be used also to demonstrate the potential of an alternative system to the present institutional health care delivery.

The Health Law Project[20] made recommendations aimed at correcting abuses identified in this system. One set of recommendations related to personnel illustrates the range of needs for change. The recommendations were that:

(1) All personnel must work the hours [for which they are paid].
(2) Medical staffing should be available at all times.
(3) Staff salaries should be competitive with local salaries.
(4) Adequate malpractice coverage should be provided.
(5) Physicians should have a greater role in day-to-day treatment and care including rounds and supervision.
(6) Resident physician should be used only under close supervision.

[15] Fink, L., Derby, W.N. and Martin, J.P., "Psychiatry's New Role in Corrections." *American Journal of Psychiatry*, Vol. 126(4) p. 542-546, Oct. 1969.
[16] *Ibid* p. 546.
[17] Rector, Frank L., *Health & Medical Service in American Prisons and Reformatories*, New York, N.Y., The National Society of Penal Information, Inc., 1969, p. 21.
[18] *Ibid* p. 23-28.
[19] Health Law Project, *Health Care and Conditions in Pennsylvania's State Prisons*, U. of Pa. Law School, Dept. of Justice, Governor's Justice Commission, Nov. 1972.
[20] *Ibid* Section V, p. 40ff.

(7) Registered nurses should staff all institutions with inpatient services.
(8) Correctional infirmary supervisors should have formal training.
(9) Purchase of consultant services through group practice and hospital outpatient clinic should be explored.
(10) Explore with medical schools the possibility of joint programs.
(11) Review recruiting methods.
(12) The Bureau should provide for training convict personnel [who are providing medical care] including providing adequate pay and supervision.
(13) Prisons should seek to involve outside resources in developing training programs.

On examination, one finds that many of these recommendations are consistent with the administration and delivery of medical services *by the community.* Other writers have noted this possibility — Eyeman[21] for example.

In much of the medical service field, services are moving to a community base (see Bakal[22] and others). Community mental health centers, medical care clinics and drug and alcohol drop-in, day care and community residential facilities are all examples. Although far from fully developed, a comprehensive community services system should include provision for institutionalized persons. Under such a system, community services would handle institutions as one component of their responsibility. Certainly in their current daily operations, most viable community medical care units do not function with the long list of needs outlined above.

First, let us examine more closely one of these recommendation areas, personnel, keeping in mind what exactly would be different with community control. As a start, salaries would be not only competitive, they would be identical, as there would be no differentiation between prison and community medical services. Physicians, registered nurses and other qualified personnel would be hired as per standard hospital and community health care practice. Recruiting methods would also be eliminated as a problem since the prison medical system would not be competing with the community. The same would apply to programs for both resident and convict training. In short, we would likely see only those personnel deficiencies which also appear in the local community.

This staffing problem alone has been a major one for prisons. Bates commented on the difficulty of finding adequate staff: "One is obliged to be content either with some old, discouraged, broken-down veteran who is tired of actual practice, or some young and untrained man anxious to make his institutional experience serve as a stepping-stone to a lucrative practice."[23] A utilization of community personnel in prison units with a sharing of responsibility would be a major step in alleviating the staffing problem.

Second, in addition to personnel, another group of recommendations within the Health Law Project Report relates to the available services including: surgery, inpatient nursing services, psychiatry, pharmacy, laboratory services, radiology, obstetrics-gynecology, dentistry, rehabilitation services and supplies, special diets, and medical social services. Let us examine some of these recommendations in light of a system in which community staff perform the required prison medical services.

Under surgery, the report recommends the establishment of standards for surgical procedures, the renovation of operating rooms, and the provision of counselors for those contemplating plastic surgery.[24] The recommendations for standards and counselors would be met if existing standards in community hospitals and clinics were to be used. There might be an increase in staff required and in some instances operating rooms would have to be renovated. However, since many medical facilities are now experiencing under utilization, such facilities could be used without the need for duplication.

Among their recommendations under inpatient nursing services, the Health Law Project called for upgrading standards along with more qualified staff, the formation of patient care plans, training, and evaluation by local hospitals.[25] Again, many of these services need not be duplicated in prisons, as they are currently being supplied by existing hospitals for the community. In place of duplication and the time-consuming tasks of developing parallel standards and systems, the operating system of the community could be contracted for services as indicated by Goldsmith[26] for the Orleans Parish Prison.

A third example are the recommendations for the upgrading of psychiatric services. These include reviewing services to insure availability, organization of an advisory committee, establishment of standards, integration of psychiatric and medical services, exploring the availability of volunteer psychiatric help from professionals, medical schools, hospitals and

[21] Eyman, Joy S., *Prisons for Women: A Practical Guide to Administrative Problems*, Springfield, Illinois: Charles C. Thomas, 1971, p. 94.
[22] Bakal, Yitshak (Ed.) *Closing Correctional Institutions*, Lexington, Mass.: Lexington Books, D.C. Heath & Co., 1973.
[23] Bates, Sanford, *Prisons & Beyond*, New York: The MacMillan Co., 1939, p. 154.
[24] Health Law Project. *op. cit.* p. 104ff.
[25] *Ibid* p. 110ff.
[26] Goldsmith, S.B. *op. cit.*

mental health centers and limiting the use of restraints.[27] These recommendations also could be implemented through existing community mental health programs.

Fourth, the provision of drug services to prisoners provides us with a final example of the dual prison-community system and how it develops. In response to the question of whether narcotics addicts have a right to treatment for their addiction while in prison, Rudovsky (for the American Civil Liberties Union) states that: "Courts have held that when current medical practice indicates a particular course of treatment, denial of such treatment constitutes cruel and unusual punishment."[28] They further suggest that "Courts may soon hold that forcing prisoners to undergo unalleviated drug withdrawal constitutes cruel and unusual punishment as a denial of needed medical treatment."[29] In line with this direction, methadone detoxification is now available in American prisons. A dual system requires that standards be established for prison methadone programs and for general administration of addiction services such as are now being supplied by the community.

Although this step is applauded (perhaps only as a short-term goal), what are the implications in regard to future prison addiction program expansion? Will it now mean that all drug and alcohol services will eventually have to be made available in the prisons? In that event, the problem will parallel that of general medical services; i.e., institution vs. community-based services and the whole standard of care issue.

Summary

The history of traditional prison services has shown that there is first a period of welcome relief that these services are now available to the prisoner. However, through evaluation of existing programs, it seems practically inevitable that we will find the services to be second class or lower due again to a myriad of reasons including appropriations, etc. Moreover, we will still be confronted with the problem of whether funding should be at a level parallel to those services supplied to the general population and, if not, will there be further court actions.

There are two directions to pursue in addressing the problem: community-based service provision; and the development of medical care grievance programs much like patient representative programs in general hospitals. Much of what has been mentioned in this paper relates to a variety of prison medical services including psychiatry and drug and alcohol services. Drug and alcohol professionals, however, are in a somewhat unique situation as their programs are newer on a national scale basis. Addictions service providers could take this opportunity to lead the way by insuring that drug and alcohol services are available and equal in quality whether in prisons or in the community. By offering comprehensive drug and alcohol services to prisoners on a contractual basis through the community, the process of ending a glaringly discriminatory practice would begin. This paper was part of the initial planning in one community that took this approach.

Considering what has been written regarding the quantity and quality of all medical services in prisons, what has been suggested in the past is that the notoriously poor services be upgraded. However, should this be the response to an already openly discriminatory practice? To upgrade medical services or to develop new drug and alcohol services in prisons will only serve to continue the practice of duplicating services which already exist in the community, and worse, duplicating them in an inferior fashion.

The response to separate but unequal provision of medical services must be the incorporation of community services in prison systems. There are no delusions as to the difficulties involved in operationalizing this notion. Problems in trust, in accepting outside intervention, in general cooperation and in attitude will have to be overcome. Yet it may be only a matter of time before a legal decision renders this move mandatory. There is no reason to wait for legal force to be the impetus behind a humane and constitutionally just equalization of services for prisoners.

Provision of services to prisons by community organizations is certainly one direction to be pursued. A second method for enhancing the quality of medical care is the development of a complaint mechanism for prisoners and/or clients in other corrections programs. This is currently recommended by the American Hospital Association and is identified as a patient representative program.[30] States such as Michigan and Pennsylvania now have clients rights programs which are essentially complaints processing systems.[31,32] These systems use a rights advisor as a medium for "feeding back" information regarding service system performance to the managers and providers of the system.[33] Both state programs have been

[27] *Ibid* p. 116ff.
[28] Rudovsky, David. *op. cit.* p. 88.
[29] *Ibid* p. 88.
[30] American Hospital Association, Patient Representative Program Model Series, AHA, Chicago, Illinois.
[31] Office of Recipient Rights, Rights Manual, State of Michigan, 1979.
[32] Ziegenfuss, J.T., Clients Rights Resource Manual, Office of Client Rights, Pennsylvania Dept. of Public Welfare, Harrisburg, PA, 1980, 315 pp.
[33] Ziegenfuss, J.T., "The Varied Role of the Patients Rights Advisor," Pennsylvania Dept. of Public Welfare, Office of Client Rights, Harrisburg, PA, July, 1981.

evaluated and have been found to successfully contribute to the quality of care.[34,35]

The linkage between rights protection and quality assurance is the significant one. While some advocates stop after identifying rights abuses, the real challenge is in the design and continuous redesign of programs and systems so that they do not violate rights in the first place.[36,37,38,39,40] To do this, further work in the following areas is needed to address the prison medical care problem:

(1) Analyses of the technical problems of community hospitals providing prison care.
(2) Designs for the administrative structuring of shared services with the prisons' administration.
(3) Analyses of community medical personnel willingness and attitudes toward rendering prison care.
(4) Models of grievance programs for prison medical care.
(5) Legal analyses of the liability issues in shared services (prison and community hospital).
(6) Comparative studies of the costs of prison-based and community-based care.
(7) Analyses of the political and organizational development barriers to implementation.
(8) Models for analyzing the success or failure of the programs.

There is increasing interest in attacking the prison medical care problem.[41,42] Those involved need both study and action assistance.

In summary, the medical care and rights problem is, in fact, one of designing a system capable of providing quality care. The system must be capable of self adaptation, correcting structures and processes which are rights violating in nature. Outside care providers and internal complaint mechanisms would both assist the system development process.

[34]Freddolino, P.P., *Assessing Advocacy Services for the Mentally Disabled: An Evaluation of the Mental Health Advocacy Project* Amer. Bar Association, 1979.
[35]Ziegenfuss, J.T., "Assessment of the Pilot Rights Advisor Program," Pennsylvania Dept. of Public Welfare, Office of Client Rights, Harrisburg, PA, January, 1981, 157 pp.
[36]Ziegenfuss, J.T., Gaughan-Fickes, J., "Alternatives to Prison Programs and Clients Civil Rights: A Question," *Contemporary Drug Problems*, Summer, 1976.
[37]Ziegenfuss, J.T., "The Therapeutic Community: Toward A Model for Implementing Patients Rights in Psychiatric Treatment Programs," *Journal of Clinical Psychology* 33(4) 1977.
[38]Ziegenfuss, J.T., *Patients Rights and Organizational Models: Sociotechnical Systems Research on Mental Health Programs*, Washington, D.C.: University Press of America, 1983.
[39]Ziegenfuss, J.T., "Patients Rights and Organizational Planning," unpublished paper, 1983.
[40]Ziegenfuss, J.T., *Patients Rights and Professional Practice*, N.Y.: Van Nostrand Reinhold, 1983.
[41]Sandrick, K., "Health Care in Correctional Facilities," *Quality Review Bulletin*, 7(5), May 1981.
[42]Sandrick, K.M., "Health Care in Correctional Institutions in the United States, England, Canada, Poland and France," *Quality Review Bulletin*, 7(7), July 1981.

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Legal Assistance to Federal Prisoners

BY ARTHUR R. GOUSSY

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THE FEDERAL BUREAU OF PRISONS under the United States Department of Justice has a unique legal program in Michigan. Specifically, the Federal Correctional Institution, located at Milan, Michigan, has designed a contractual arrangement for a visiting attorney to that institution. I was the contractual attorney of record from February 1981 until September 1983.

While there is not a statutory mandate that these legal services be provided, it is noted that the Federal courts have consistently ruled that Federal prisoners must have access to the courts. This has meant that mail sent by prisoners to the courts (or their legal counsel) cannot be censored or impeded. Further, it implies that the institutions must act in good faith not to thwart the efforts of prisoners to seek redress of legal grievances pertaining to their cases. In order to facilitate this "good faith" requirement, the Federal Bureau of Prisons has provided law libraries to assist the prisoners in articulating their grievances. These law library facilities have been in place for several years. Parenthetically, this has relieved a serious burden to the Federal courts since they would have inherited the chore of correcting erroneous motions, writs and the like.

In addition to the right of the prisoners to maintain channels of communication with the Federal court, an observer quickly learns that the prisoners have rights connected with their presence in prison. Living conditions, activities, and disciplinary action are all subject to review, "due process," and possible court action. Thus, punishment or deprivation of privileges without "equal protection" and "due process" probably will constitute constitutional violations. Again, in order to safeguard against such violations, the Federal Bureau of Prisons provides a well-structured, administrative procedure to deal with grievances. And again, the Federal courts have been spared the task of dealing with these grievances until the "administrative" remedy has been exhausted.

Finally, the Federal Bureau of Prisons has been empowered through statutory language (title 41, United States Code, section 252 (c) (4)) to contract for human and educational services that are conducive to the well-being and rehabilitation of prisoners. Consequently, at the Federal Correctional Institution at Milan, Michigan, there is a budget provided for contractual services that bring teachers, psychiatrists, psychologists, medical doctors, and, now, attorneys into their institution.

In this area of legal aid to prisoners, the institution, through its vested contractual powers, can enlist the services of a law school, a law firm, or a single, legal practitioner.

To summarize, the Federal Bureau of Prisons sees itself as having a court-directed mandate to provide legal resources for the inmates regarding their criminal cases although not specifically required to provide routine legal assistance. Additionally, the Bureau finds itself required to operate an ongoing grievance procedure attendant to prisoner privileges and discipline. Lastly, the Bureau is aware that legal problems impact on the rehabilitation process in their facilities. Since they have a budget to contract for services, they are able to provide legal aid to help the inmates (and themselves) meet the perceived needs.

Overview of the Current Legal Aid Contract (Milan, Michigan)

The current contract for legal services states the following description of duties: "(1) To provide legal advice to inmates sentenced to the Federal Correctional Institution, Milan, Michigan. Advice may be given on the full range of legal concerns expressed by inmates. (2) Provide assistance to inmates in preparing legal papers. (3) Assist in arranging for representation of the inmate by other attorneys on contingent fee basis or through community legal aide services." It provides further that "the incumbent will be proscribed from actual representation of inmates as a part of this contract, and from serving in a capacity as private attorney for any inmate assigned to FCI, Milan. The incumbent may not receive any compensation in behalf of these duties except as provided for under this contract."

As noted, the thrust of the contract is to provide answers and assistance to the inmates in terms of their full range of legal problems but not to provide the visiting attorney as their legal representative in legal actions. This distinction is important. It clearly defined the role of the legal aid attorney. That role is as a paid legal consultant rather than as a solicitating private practitioner. One can perceive the desire on the part of the Bureau of Prisons to avoid conflict of interest. Certainly one can understand

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