

# Prisons, Adolescents, and the Right to Quality Medical Care

## The Time Is Now

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*A comprehensive medical program was established within a teenage detention facility. Although a large part of the detained population suffered from preexisting poor health, frequently worsened by an antisocial life-style, much could be accomplished in the prevention and treatment of disease within the prison setting.*

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### Introduction

Recent events at the Attica, Rikers Island, and San Quentin penitentiaries have focused attention on the frustrations and inadequacies of this country's prisons. Among the problems highlighted has been the delivery of health care in penal institutions. Medical care in such settings is typically provided by an individual physician, assisted by a few nurses, and is crisis-oriented. Little health rehabilitation is undertaken and programs of preventive medicine or of health education are rare. A recent editorial in the medical literature ended with the plea that physicians would "cast . . . an occasional thought for the needs of the sick and for the way of life of the healthy who are involuntary guests of our society."<sup>1</sup>

The experience of the Division of Adolescent Medicine of Montefiore Hospital and Medical Center over the past 60 months with adolescent prisoners suggests that the medical needs of those in detention, whether adults or adolescents,

may be well served by a team of health professionals with the backing of a medical center. In addition, much is to be gained in the area of staff education by the medical center providing support for such a program. To encourage other medical centers to become involved in this heretofore largely neglected area of health care, we report this experience.

### Background

The Juvenile Centers of the City of New York were established for the temporary detention of children between the ages of 8 and 18 years from the five boroughs of the City who are adjudged either "delinquent" or "persons in need of supervision." They are placed in detention by the Family or Juvenile Courts for an average stay of 2 weeks while disposition plans are completed by probation officers. The centers at present are operated by an executive branch of the municipal government, the New York City Human Resources Administration.

There are approximately 6,000 admissions each year. Boys outnumber girls in a ratio of 2:1. Between 200 and 400 teenagers are in residence at one time, housed within two facilities located about 7 miles south of Montefiore

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Hospital in a high population density, high crime area of the Bronx which is relatively inaccessible by public transportation. The mandate of temporary, yet secure, detention, a high turnover rate, and a small custodial-counseling staff has precluded meaningful rehabilitation programs within the centers to date, although all children attend school and participate in recreational programs.

After leaving the centers, a majority of the children return home on probation. Twenty per cent are transferred to State Training Schools (juvenile prisons) and the remainder may be placed in smaller municipal or state penal programs, which are urban, suburban, or rural in locale. Local drug rehabilitation programs also receive a number of these youths.

Prior to the Montefiore Hospital affiliation program, medical care was provided by a physician who visited the centers for 1 hr each weekday, assisted by nurses. There was no program of upgrading or in-service education of the nursing staff, no routine diagnostic screening program for the inmates, and medical evaluation apparently consisted of a cursory physical examination. Only "court-ordered" laboratory procedures, such as the VDRL, vaginal smears for the gonococcus, and pregnancy tests for girls who were home runaways, or electroencephalograms on those who "acted out," were consistently performed. Those in need of emergency care or hospitalization were cared for in the busy emergency room of a nearby municipal hospital. The infirmary was a small, dark area with peeling paint, poor ventilation, broken venetian blinds, dirt-encrusted window screens, and illumination which was deemed secure, but offered little light. There was no system of communication between patient rooms and the nurses' area. Furthermore, at night the children were locked in their rooms, which contained neither sinks nor toilets. The program now operates out of a modern, cheerful area designed to meet patients' and physicians' needs. A complete dental unit, pharmacy, laboratory, modern equipment for diagnosis and treatment, and a recreation room now exist, in addition to an 18-bed infirmary and appropriate examination and treatment rooms.

### Methods and Materials

The Montefiore Hospital program, under an affiliation contract, commenced on July 1, 1968, and consisted of three components: quality patient care, professional and patient education, and health data collection. The service program consisted of a system of delivering care to those more seriously ill teenagers in need of hospitalization within the infirmary at the S. Center or on the Adolescent In-Patient unit at Montefiore Hospital. An ambulatory program was designed which segregated the general medical screening of new admissions and ongoing care for those already in residence. The latter was divided into "sick-call" and "medication call" programs and several specialty programs.

Intake screening was performed at the time of admission to the facility by nurses who evaluated the need

for immediate attention by a physician and, if none existed, they obtained and recorded vital signs, height, and weight, and implanted a tuberculosis screening test. The following day, or immediately if indicated, the patient was seen by a house officer who obtained a medical history and performed a complete physical examination. The following diagnostic tests were regularly performed on all inmates in a laboratory set up on the premises and staffed by two technicians: urinalysis, hematocrit, sickle cell anemia screening test, and VDRL. A pregnancy test and vaginal culture for gonorrhea were obtained on all sexually active females, while liver function studies were routinely obtained on all drug users. Immunization inoculations were brought up to date. The patient was screened by a dental hygienist who offered instruction on the care of teeth and referred those in need of further dental care to a dental intern and oral surgeon within the center's health area.

Services to those inmates in residence consisted of a twice daily "sick call." The centralized medical area and infirmary at S. Center staffed by nurses and house officers also supplied a 24-hr telephone consultative service to the other center. The infirmary was available at all times for emergency care with trans-shipment of patients to Montefiore Hospital if the situation warranted.

Medications were dispensed by nurses and pharmacists utilizing a unit dose system after preparation by the pharmacy staff from Montefiore located in the prison. Weekly clinics were established at the center for surgical, prenatal, and gynecological problems. Daily dental clinics at the center to effect emergency, as well as restorative, care are now in session.

The infirmary was used for inmates with communicable diseases, drug withdrawal, severe infections, trauma, gynecological disorders, and a variety of medical problems of a more serious nature. Those patients in need of surgical or intensive medical care were transferred to the In-Patient Adolescent Unit at Montefiore Hospital.

An average of 2,000 patients leave the center each year who require aftercare for unresolved medical problems. Previously, the only mechanism available for dealing with this problem was submission of letters to the patient's parents or guardian with no method for determining whether adequate follow-up care was being received. For this reason, a follow-up program utilizing family health

TABLE 1—Health Problems Identified in 31,323 Adolescents through Medical Laboratory Screening Procedures upon Admission to a Youth Detention Facility

Health Problem	No.
Hepatitis, subclinical	2,845*
Venereal disease	824
Tuberculin positive	591
Pregnancy	505
Sickle cell trait	804
Urinary tract infection	480

\*Refers to abnormal serum chemical analyses performed on 9,486 drug users and not necessarily acute viral hepatitis.

workers was designed and became operational in 1972. The program guarantees that any teenager found to have medical problems while at the center will be enrolled in an appropriate health facility near his or her residence and that other members of the family with the same condition will be identified and similarly treated.

Training is considered to be a vital function of this prison health program. Twenty nurses, three pharmacists, and two laboratory technicians are involved in ongoing in-service training through conferences, visiting attending physician rounds, and periodic rotations back to Montefiore Hospital where they received their initial training. A resident, intern, and medical student from the Albert Einstein College of Medicine participate in the program, including a night call rotation for a 4- to 6-week period. Staff physicians at the prison have full-time academic appointments at the Albert Einstein College of Medicine and participate in all aspects of the Division of Adolescent Medicine at Montefiore Hospital.

### Results

In the 60 months since the program was instituted, 31,323 patients have been evaluated. Forty-six per cent of these presumably healthy teenagers were found to have medical problems. A list of the most common of these, found on the basis of laboratory screening alone, is found in Table 1.

One-third of the teenagers entering the center have been identified as drug abusers on the basis of medical history and physical examination.<sup>2</sup>

Of the drug users, 2,845, or 30 per cent, were found to have elevations of serum glutamic pyruvic transaminase values at the time of admission to the center. Liver biopsy was performed on 85 of those whose chemical abnormalities persisted for at least 3 months with the finding of chronic persistent hepatitis in most.<sup>3</sup> The diagnosis of venereal disease was based either on the finding of a positive VDRL, confirmed by a positive fluorescent treponemal antibody-absorption test, or a positive culture for gonorrhea on Lester Martin media. Only one patient was found to have active pulmonary tuberculosis, but 591 adolescents received isoniazid therapy because of a positive tuberculin skin test of indeterminate duration. Of 9,077 patients tested, 804 were found to have sickle trait, although no patients with homozygous sickle cell disease were detected. Counseling of those with the trait was conducted by the Nursing Supervisor.

The diagnosis of pregnancy was made upon admission in 4.5 per cent of the girls with an average age of 14.5 years. None of these patients had used contraception. Only 19 per cent chose to have an abortion, despite easy availability of elective termination of pregnancy in New York State since 1970.

Asymptomatic urinary tract infection was diagnosed in 480 (381 females and 99 males) on the basis of a urine culture showing greater than 100,000 bacterial colonies performed after the screening urinalysis revealed pyuria.

There have been 1,935 patients admitted to the infirmary; in addition, 369 patients required transfer to the Adolescent In-Patient Unit at Montefiore Hospital. An analysis of admission diagnoses for these groups is found in Table 2.

### Discussion

Rotation through the medical service of a detention facility exposes health professionals from all disciplines to a group of patients who have had little prior medical care at a time when their social and emotional problems are of greater concern to them than physical illness. As many of the medical problems are inextricably related to the patient's social environment, the role of the health professional goes

TABLE 2—Diagnostic Categories of Health Problems Identified in 2,304 Teenagers Either Admitted to the Prison Infirmary or Referred to the In-Patient Adolescent Unit during a 60-Month Period

Category	No.
1. Infections	
Respiratory	294
Cardiovascular	27
Dermatological	121
Central nervous system	7
Venereal	229
Gastrointestinal	90
Hepatic	249
Genitourinary	32
Dental	12
Other	46
2. Metabolic problems	
Diabetes	40
Hematuria	28
Proteinuria	23
Hypertension	9
Other	34
3. Trauma	
Skull	61
Extremities	93
Other	39
4. Neoplasms	
Malignant	5
Nonmalignant	30
5. Toxic reactions	
Overdose syndromes	61
Abstinence syndromes	282*
6. Congenital malformations	
Genitourinary	89
Cardiac	9
Other	23
7. Allergic problems	
Asthma	30
8. Psychiatric disorders	61
9. Miscellaneous problems	280

\* An additional 944 patients were detoxified on an ambulatory basis.

beyond that within the traditional hospital setting. It is not sufficient, for example, to diagnose and treat peptic ulcer disease in the teenage girl at the center. One must ask where the patient will go for follow-up medical care and how the court's disposition might affect the disease process or its therapy. In addition, consideration must be given to whether incarceration in a penal institution may affect disruption in pathophysiology as in diabetes, asthma, peptic ulcer, and epilepsy, as well as complicate the differential diagnosis of amenorrhea, for example. The medical students and house officers rotating through the center rapidly become proficient in identifying physical signs of drug abuse, in taking a drug abuse history, in treating narcotic and barbiturate abstinence syndromes, and in detecting and treating the somatic consequences and complications of drug abuse. Less tangible effects of this exposure accrue from the inevitable process of introspection that accompanies a short, but intense, relationship with the young drug user; from the frustration of seeing a patient detoxified and returned to his original environment, only to return again to prison once more addicted; from the conflict of the confidentiality of the doctor-patient relationship as one relates to the courts and the importance of knowing that the disposition resides ultimately with the judiciary, not with the doctor, as in a traditional hospital setting.

Although our experience has been with teenage "prisoners," the system of delivering medical care described herein could be equally applicable to a detained population of adults. Adult prisoners, for the most part, also come from inner city areas and would therefore be expected to suffer from many of the same medical problems as the adolescents described here. Reports of medical complications in adult heroin addicts, who might constitute a significant proportion of the prison population, suggest that they have additional problems, such as tuberculosis, ulcer disease, and tetanus.<sup>4</sup>

In a long term secure detention facility a full-time staff of health professionals—physicians, nurses, laboratory technicians, pharmacists, dentists, dental hygienists, and social workers—may also serve the inmates in a training capacity, teaching selected, responsible inmates to function as paramedical personnel and health aides. This would not only provide additional skilled manpower for the in-prison medical service, but would also serve as an excellent rehabilitation program for some prisoners. It would offer meaningful work activities during the period of their detention, as well as training and experience that would assist them in obtaining employment after release.

The presence of a discipline other than correction or law enforcement within the closed detention facility has the advantage of introducing innovations to the administration. For example, the refusal to lock adolescents in their rooms in the infirmary area was initially greeted with concern, if not alarm, on the part of the personnel. Subsequent experience that no staff member was injured by those whose rooms were not secured prompted the adoption of an "open door" policy in the rest of the facility. The admission of more than 300 teenagers from the center to the nonsecure environment of the Adolescent Unit at Montefiore Hospital with an "elopement" rate of 5 per cent also reinforced in some probation and correctional personnel the concept that many teenagers did not need secure detention. Partially as a result of these observations, a program of foster home and small group home placements for many of these adolescents is now operational and expanding in New York City.

In summary, the experience of the Division of Adolescent Medicine's affiliation with a youth detention facility has shown that the detained population suffers from preexisting poor health by virtue of lack of medical care prior to detention and that certain medical conditions are by-products of the life-style of those who eventually become imprisoned. Much can be done medically for detainees, even during a short period of remand, and opportunities for epidemiological surveillance of illness are great. Easy access to quality medical care also reduces tension and frustration within a prison setting. It is suggested that certain carefully selected prisoners detained for a long period of time may be excellent candidates for training as allied health workers by the medical staff. Lastly, we believe it is beneficial for health professionals in training to be exposed to the turmoil, the frustration and also the rewards of prison medicine if we hope to alter the life-style of the imprisoned.

## References

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