Testimony

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SUB-COMMITTEE on CRIME and CORRECTIONS

Mental Health Problems and Medical Care

SCI-Chester

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Good afternoon Chairman Birmelin, subcommittee members, and staff. My name is Fred Maue, and I have been with the Department of Corrections for the past four years. I am Chief of Clinical Services with the Pennsylvania Department of Corrections. I have worked as a corrections physician and psychiatrist since 1981. Seated with me are Catherine McVey, Director of the Bureau of Health Care Services, and Dr. Lance Couturier, Chief Psychologist. We manage medical and psychiatric services for the Department. Also seated with me is Raymond Colleran, Superintendent of the Department's Forensic Treatment Center, SCI-Waymart. The main focus of our efforts, and the team of professionals with whom we work, is to ensure quality health care for every inmate/patient in our system. This is a challenging task.

As you know, many of our inmates come from difficult socio-economic backgrounds. Access to preventive health care for them was limited. Many have histories of drug or alcohol abuse. Many could not afford medical care. As a result, infectious diseases such as HIV-AIDS, TB and Hepatitis are not uncommon. Preventive dental care was limited or ignored. Smoking is prevalent, and complaints of asthmatic symptoms and

cardiac chest pain are higher. In general, we see inmates at risk to develop diseases at younger ages and often have multiple medical and mental health problems.

Mental illness is identified in 13.7% of our population, and 3.1% have serious mental illness interfering with their ability to adjust to prison rules and routine. Schizophrenia is diagnosed more frequently than in community populations. Personality disorders, such as anti-social and borderline, are more prevalent and severe. Mental retardation is seen in 1.25% of our inmates. The double stigma of being mentally ill and an inmate, further complicated by drug abuse, necessitates specialized care in our system. Release planning for this group is complex, requiring carefully planned linkage with community programs.

In 1995, inmates aged 65 and over represented 0.8% of the total Department population. By 1999, elderly inmates represented 1.2% of the total population. Inmates are serving longer sentences; many grow old with us. Elderly medical needs will continue to grow for services such as skilled and personal care as well as treatment for chronic diseases. Our prison at Laurel Highlands specializes in the care of elderly and seriously ill inmates.

In addition to our constitutional duty to deliver health care to inmates, we are committed to providing quality health care that is consistent with community standards. To know of an inmate health problem yet not make an effort to treat that problem or to fail to provide the inmate with access to a proper evaluation for the problem risks a violation of the deliberate indifference standard under the eighth amendment.

The challenge for us is how to prioritize care and resources to those inmates in most need. Moreover, we are tasked with providing quality health care that enhances the safety in our institutions and, improving the public health of Pennsylvania's citizens. Most of our inmates will return to their homes and families. We wish to prevent the further spread of diseases and ensure treatment continues after release.

Finally, as in the private sector, but on a larger scale, treating inmates involves building trust. Inmates fear that health care will not be provided when they are in need. We, as medical professionals, strive to build trust by using sound medical knowledge in a dignified, ethical relationship with inmates. This enhances compliance with necessary treatment and thereby helps to prevent the spread of disease and death.

We seek to treat all inmate medical needs. In most cases, I believe we are successful.