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This Issue in Brief

It's O.K. Supervision Enthusiasts: You Can Come Home Now!—Author Harold B. Wooten asserts that probation systems have lost interest in supervision of offenders; instead, trendy practices which are best described as elaborate monitoring mechanisms have taken the day. But, the author contends, before we rally the supervision loyalists, we should first admit that changing self-defeating behavior of offenders has never been significantly reinforced as a value in probation. The author cites historical reasons for this failure, identifies current barriers to effective supervision of offenders, and offers recommendations to various participants in the process to address effective supervision of offenders.

A Challenge Answered: Changes in the Perception of the Probation Task.—Author Richard Gray responds to the point of view expressed in this issue's article by Harold B. Wooten. Do probation officers actually help probationers or are they primarily paper pushers or law enforcers? According to the author, past experience and current job orientation have caused a change in probation officers' perspective of their job. The author discusses the sociology of knowledge in addressing shifts in task-related perspectives.

Private Enterprise and Institutional Corrections: A Call for Caution.—The current crisis of overcrowding in American prisons and jails, coupled with reduced resources available for corrections, has led to the development of innovative responses to the problems of institutional corrections. One such innovation which has been proposed and is receiving increasing support is the idea of "privatizing" institutional corrections. Authors Lawrence F. Travis III, Edward J. Latessa, Jr., and Gennaro F. Vito examine the movement to contract with private firms for the construction and operation of prisons and jails. Focusing on legal, cost, and accountability issues in such contracting,the authors conclude with a call for caution in the movement to employ private companies for the provision of this governmental service.

Impact of a Job Training Program on CETA-Qualified Offenders.—In this article, author Dennis B. Anderson reports on research—conducted in an industrial midwestern city during 1984—of a job training program for CETA-qualified probationers. Controlling for self-selection and risk factors, the study compared these pro-

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Addressing Inmate Mental Health Problems

A New Direction for Prison Therapeutic Services

BY KENNETH ADAMS, Ph.D.

School of Criminal Justice, State University of New York at Albany

OF ALL THE MAJOR components of the criminal justice system the correctional stage traditionally has had the most explicitly avowed therapeutic purpose. Within the context of prisons, an assortment of therapeutic activities were usually available to inmates. Individual therapy, group therapy, counseling, medication, self-help, and behavior modification are among programs that have been offered. These programs involved a variety of professionals (e.g., psychiatrists, psychologists, social workers), working in a variety of settings (e.g., one-to-one, small groups, residential communities), using a variety of theoretical perspectives (e.g., psychiatric, psychodynamic, behavioral). Over the past decade, however, critics have seriously challenged the fundamental rationales for the therapeutic activities of prisons. Some critics argue that the justifications for providing these services have been greatly oversold because in their opinion when it comes to rehabilitating offenders "nothing work[s]."[1] Others argue that even if we could rehabilitate offenders society should allocate more resources to other functions of the criminal justice system such as deterring potential offenders.[2]

In the process of reevaluating the therapeutic activities of correctional institutions, distinctions have been made among services in terms of the goals they are attempting to achieve and the client populations they are attempting to reach. An important distinction is that between therapeutic services attempting to achieve specific penological goals—the treatment of offenders so that they might become law abiding citizens—and therapeutic services intended to achieve more general health care goals—the treatment of emotionally disordered individuals so that they might function more effectively in social settings. For convenience, we can refer to the former as correctional rehabilitation services and the latter as mental health care services. Having recognized this distinction, it is clear that most of the concern has been with correctional rehabilitation services and that, by comparison, there has been only limited interest in prison mental health services. This article explores the distinction between correctional rehabilitation services and mental health services and discusses the developments which are leading to greater recognition of the need for prison mental health services.

Distinguishing Among Therapeutic Services

One reason why the distinction between mental health services and correctional rehabilitation services has not been emphasized is that the distinction can be as simple as it is complex. Simply stated, correctional rehabilitation services are therapeutic interventions intended to address the causes of criminality in an attempt to reduce criminal propensities, while mental health services are therapeutic interventions intended to address the causes of mental illness in an attempt to alleviate emotional adjustment problems. The distinction is complex because types of behaviors, causes of behaviors, and treatment interventions available to change behaviors cannot always be so neatly compartmentalized.

The complexity of the relationship between correctional rehabilitation and mental health services stems from the fact that the conceptual and operational development of two services has historically been linked together. In the early nineteenth century, as scientific approaches to the study of crime were starting to appear, psychiatric theories vigorously stressed the notion that mental illness is the major cause of crime. These theories outlined a "medical model" of crime causation which viewed crime as a "disease of the mind" that needed to be "cured." From about the middle of the 19th century to about the middle of the 20th century, psychiatric theories of criminality were widely accepted. Once the proposition that mental illness is the cause of crime was accepted, it followed logically that in order for therapeutic services to be rehabilitative in the penological sense, they must be designed to address mental health problems. From this point of view, there was little to be gained from distinguishing between correctional rehabilitation services and mental health services.

Criminologists have currently forsaken the view that mental illness is a major cause of criminal behavior. This is partly the case because the argument as it is usually stated is circular.[3] Criminal behavior is used as evidence of mental illness and then mental illness is invoked to ex-

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[1] Douglas Lipton, Robert Martinson, and Judith Wilks, *The Effectiveness of Correctional Treatment* (New York: Praeger, 1975); Robert Martinson, "What Works? Questions and Answers about Prison Reform," *The Public Interest*, 35, 1974, pp. 22-54.

[2] Ernest van den Haag, "Could Successful Rehabilitation Reduce the Crime Rate?," *Journal of Criminal Law and Criminology*, 73, 1982, pp. 1022-1035.

[3] Ernest van den Haag, *Punishing Criminals: Concerning a Very Old and Painful Question* (New York: Basic Books, 1975), pp. 117-123.

plain criminal behavior. Scholars now generally agree that only for a small proportion of offenders is mental illness a significant factor in their criminality. Nevertheless, some scholars still maintain that criminality and mental illness are related. Contemporary psychiatric theories of crime tend to view mental illness and crime as dependent upon common causal factors rather than as causally dependent on each other. These theories describe both crime and mental illness as maladaptive responses to stressful experiences that occurred in early life. Seymour Halleck, for example, argues that: (m)ental illness and crime are both adaptations to stress. The stresses that lead to mental illness are often the same stresses that lead to crime.[4] Given that criminologists have yet to agree upon the ways in which the causes of crime differ from the causes of other deviant behavior such as mental illness, or from the causes of any other human behavior, such global theories can be very attractive.

More significantly, as a result of a presumed common origin or family resemblance between criminality and mental illness, correctional rehabilitation therapies have been adapted from mental health therapies developed for more general use in the community. In terms of actual practices, most correctional rehabilitation services are similar if not identical to mental health services for non-correctional clients. The service providers have common educational and training experiences, the treatment modalities do not differ greatly, and the theoretical approaches make the same basic assumptions about the nature of human behavior. In fact, some have argued that the differences between prisons designed to rehabilitate offenders and mental hospitals are largely semantic.[5]

Those who view crime and mental illness as resulting from common etiological factors continue to advocate similarity between services intended to rehabilitate criminals and services intended to cure mental illness. These scholars emphasize the possibility that mental health services which facilitate an individual's adjustment to contemporary settings, and this includes prison settings, may help offenders adjust to community settings in a law-abiding way. They argue, for example, that to the extent criminality and mental illness represent problems of adjustment with similar origins in early socialization experiences, both the criminal and the mentally ill can benefit from similar therapeutic efforts aimed at resocialization.[6] To further support their argument, these authors point out that the technology for changing human behavior is not highly developed nor highly specialized and that it should therefore not be surprising to find that some therapeutic techniques have a number of different applications.

The distinction between correctional rehabilitation services and mental health services is most easily made at the extremes. Within a general prison setting all inmates would be eligible for correctional rehabilitation services since by virtue of their situation they have demonstrated a propensity towards criminal behavior. In contrast, only inmates with verifiable emotional problems would be eligible for mental health services. Depending on what one includes under the heading of emotional problems in need of treatment, very different client populations are identified. If we restrict the definition of emotional problems to major psychiatric disorders, then only inmates with a diagnosable mental illness would be eligible for mental health services. This type of prison mental health system would have a minimum of ambiguity with regard to identifying its client population, and this attribute can be very attractive. Yet, this definition appears restrictive when we survey the variety of professionals who are involved in the delivery of mental health services and the wide range of adjustment problems these professionals treat.

As we expand the definitional boundary of mental disorder an increasing proportion of inmates becomes eligible for services, but the task of distinguishing inmates who are eligible for mental health services from inmates who are not eligible becomes more difficult, and the goals and activities of the services delivery system become more diffuse. At some point a majority of inmates becomes eligible for therapeutic services and the service delivery system begins to resemble one based on correctional rehabilitation goals. This would happen, for example, if we consider drug and alcohol dependence and antisocial personality disorders as falling within the definition of mental illness. Broad definitions of mental disorder applied to inmate populations make it difficult to maintain a distinction between correctional rehabilitation services and mental health services.

While we have pointed to some conceptual difficulties in distinguishing among therapeutic services, there are a few generalizations we can make about service delivery systems. Prison mental health services tend to be allied with other health care services, and they tend to have a psychiatric emphasis. This means that in comparison to correctional rehabilitation services, mental health services are more likely to emphasize services for inmates with diagnoses of major mental disorders, are more likely to involve the use of medication as a treatment technique, and are more likely to emphasize an inmate's adjustment to the immediate social environment.

Among factors that have made the distinction between mental health services and correctional rehabilitation ser-

[4] Seymour Halleck, *Psychiatry and the Dilemmas of Crime* (Berkeley: University of California Press, 1971), p. 46.

[5] Jay Katz, Joseph Goldstein, and Alan Dershowitz, *Psychoanalysis, Psychiatry and the Law* (New York: Free Press, 1967), pp. 700-702.

[6] Hans Toch, "Perspectives on Treatment," in Hans Toch (ed.), *Psychology of Crime and Criminal Justice* (New York: Holt, Rinehart and Winston, 1979), pp. 269-286; Halleck, op. cit., pp. 45-46.

vices important are a consensus among experts that mental disorder is a significant health care problem in prisons, speculation that the number of mentally ill inmates may be increasing, judicial determination of a legal "right to treatment" for mental health services, and involvement of professional groups in setting prison mental care standards. Each of these developments augurs an expansion of mental health service delivery systems in prisons. Similar developments have not occurred with respect to correctional rehabilitation services, and in many instances developments have occurred that would move the system in a direction of retrenchment.

Mental Disorder Among Inmate Populations

Professionals agree that mental disorder represents a significant health care problem among inmate populations and have identified several factors which contribute to this situation. One such factor is that inmate populations tend to be disproportionately drawn from social groups which have a high rate of mental illness.[7] This fact can relate to a higher than average incidence of emotional disorder in two ways. Some inmates may enter prison who suffer from specific chronic mental disorder while other inmates may enter prison with a general predisposition to mental illness or enhanced vulnerability to stress.

Gresham Sykes coined the phrase "pains of imprisonment" to characterize the physical and psychological deprivations which inmates experience as a result of being incarcerated.[8] Picking up on this theme, Seymour Halleck argues that characteristics of prison life such as isolation from family and loved ones, lack of close interpersonal relationships, idleness, boredom, extensive rules, rigid daily routines, lack of socially acceptable outlets for sexual or hostile feelings, and the experience of solitary confinement lead to adverse psychological states such as loss of self-esteem, loss of identity, loss of personal autonomy, and feelings of helplessness.[9] Indeed, research by Hans Toch and his colleagues shows that aspects of prison life can variously combine to produce highly stressful environments for some inmates.[10]

Epidemiological studies have produced widely varying estimates of the proportion of inmates with mental disorders. One review of studies in the United States found estimates ranging from a low of 38 percent to a high of 95 percent based on psychiatric interviews.[11] A review of similar studies in the United Kingdom produced a comparable range of estimates.[12] This wide variation in estimates of emotional disorder among inmate populations is partly a function of where the line between mental health and mental illness is drawn. As we might expect, the broader one's definition of mental illness, the greater the proportion of inmates who will be identified as mentally ill.

Recently, Monahan and Steadman reviewed the epidemiological literature and concluded that among inmate populations the prevalence rate of psychotic disorders is between 1 percent and 7 percent while the rate of neurotic disorders varies between 0.3 percent to 40 percent.[13] They also concluded that the incidence of major psychiatric disorders among inmate populations is no greater than that among class-matched community populations. We can anticipate that the incidence of mental disorder among inmates may vary considerably among prison systems and that this variation will be influenced by the demographic characteristics of inmate populations. Also, we see that even conservative estimates indicate that mental illness is a significant health care problem among inmate populations. This fact gains importance when we realize that within a prison system emotionally disordered inmates tend to be concentrated at institutions where therapeutic services are more available. This means that the proportion of mentally ill inmates at some prisons is likely to be much greater than the proportion within the prison system.

Restrictions on the Hospitalization of Mentally Ill Inmates

Within the past decade there have been a number of changes in the laws governing the hospitalization of mentally ill inmates and other individuals. These changes involve a tightening of the substantive criteria for commitment and an expansion of the procedural safeguards available to potential patients. In combination, these changes have had the direct effect of reducing the number of people (including inmates) in mental hospitals. One consequence of this action has been to increase the need for mental health services among inmate populations.

Until recently, the delivery of mental health services to inmate populations was centered on a population classified as criminally insane. The term "criminally insane" as it is generally used includes four groups of in-

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[7] August Hollingshed and Frederick Redlich, *Social Class and Mental Illness* (New York: John Wiley and Sons, 1958); Bruce Dohrenwend and Barbara Dohrenwend, *Social Status and Psychological Disorder: A Causal Inquiry* (New York: John Wiley, 1969).

[8] Gresham Sykes, *The Society of Captives: A Study of a Maximum Security Prison* (New York: Athenum, 1965), pp. 63-83.

[9] Halleck, op. cit., p. 287.

[10] Hans Toch, *Men in Crisis: Human Breakdowns in Prison* (Chicago: Aldine, 1975).

[11] Stanley Brodskey, "Clinical Models and Assumptions," in Stanley Brodskey (ed.) *Psychologists in the Criminal Justice System* (Urbana, Illinois: University of Illinois Press, 1973), pp. 61-67.

[12] M. Faulk, "A Psychiatric Study of Men Serving a Sentence in Winchester Prison," *Medicine, Science and the Law*, 16, 1976, pp. 244-251.

[13] John Monahan and Henry Steadman, "Crime and Mental Disorder: An Epidemiological Approach," in Michael Tonry and Norval Morris (eds.) *Crime and Criminal Justice: An Annual Review of Research, Volume 4* (Chicago: University of Chicago Press, 1983),pp. 145-189.

dividuals: (1) defendants found incompetent to stand trial, (2) defendants found not guilty by reason of insanity, (3) mentally ill inmates, and (4) dangerously mentally ill civil patients. Of these four groups, mentally ill inmates have the most general reason for being involved with mental health services and therefore probably encompass the widest range of mental health problems. Mentally ill inmates are also the only group under sentence for having committed a criminal act. Although each subgroup of criminally insane has different reasons for being involved with mental health services and each has a different legal status, traditionally they have been confined together in specially designated, high-security, hospital-like facilities. It is significant that emotionally disordered inmates were counted among the criminally insane and confined in special institutions because this led to a centralization of prison mental health services.

A highly centralized approach to the delivery of mental health services proved convenient when inmates could be easily transferred from prison to hospital as it was deemed necessary. However, courts have been requiring increased due process protections for criminal commitments which parallel the procedures required for civil commitments.[14] This trend has recently culminated in *Vitek* v. *Jones* in which the U.S. Supreme Court ruled that before an inmate can be committed to a psychiatric hospital he must be afforded adequate written notice, an adversarial hearing before an independent decisionmaker, an opportunity to present testimony and cross-examine witnesses, access to legal counsel, and a written statement detailing the outcome and the reasons for the decision.[15] Judicial scrutiny of laws concerning the psychiatric hospitalization of inmates has made highly centralized service delivery systems less serviceable.

Court decisions which make the psychiatric commitment of inmates more difficult usually represent a mixed blessing when the decisions are first handed down. As a result of expanded procedural protections, the incidence of unnecessary hospitalization is likely to be reduced. Yet, the narrowing of hospital admission criteria means that there will be some inmates with legitimate mental health problems who can no longer be hospitalized but who nonetheless require attention. This latter development has put many prison administrators in the position of having to expand the availability of mental health services within their prison. As judicial decisions make it more difficult for inmates to be placed in hospital settings, we can anticipate that the demand for mental health services in prison settings will increase.

Some scholars speculate that changes in laws governing the psychiatric hospitalization of civil patients may have also increased the demand for mental health services in prisons.[16] They argue that changes in civil commitment criteria which deemphasize the "need for treatment" by including a requirement of "dangerous to self or others" may have led to an increasing number of persons with mental health problems being arrested and sent to prison. Research by Steadman and his colleagues which is relevant to the issue does not provide support for this hypothesis.[17] The proportion of prison admissions with a history of psychiatric hospitalization did not increase dramatically between 1968 and 1978. This finding indicates that patients who were returned to the community as a result of the deinstitutionalization movement did not find their way into a prison setting. However, this research examines the hospitalization experiences of inmates during a period when it became increasingly difficult to gain entrance to a psychiatric hospital. These policy changes introduce a negative bias into the data if we use hospitalization experiences as an indicator of mental disorder. If the commitment laws had remained constant, we could expect that a greater proportion of inmates now under custody would have a history of psychiatric hospitalization. Likewise, we could expect that some inmates presently under custody would instead be in a psychiatric hospital under the old commitment laws. Thus, the research by Steadman and his collegues does not fully address the question of whether restrictions on civil commitment criteria have led an increasing proportion of persons with mental health problems (as distinct from former hospital patients) to become involved with the criminal justice system.

Legal Right to Treatment

Another factor which has led to an increased demand for prison mental health services is judicial recognition of an inmate's right to receive such services. By and large, court decisions have established that inmates have a right to treatment that subsumes mental health services, but they do not have a right to treatment that covers correctional rehabilitation services.[18]

The control of prisons over the lives of its inhabitants is so pervasive that inmates depend upon those who run the institution to provide the most basic conditions necessary for human survival. Inmates must rely on

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[14] Comment, "Transfer of Prisoners to Mental Institutions," *Journal of Criminal Law and Criminology*, 69, 1978, pp. 337-352.; Michael Churgin, "The Transfer of Inmates to Mental Health Facilities," in John Monahan and Henry Steadman (eds.) *Mentally Disordered Offenders: Perspectives from Law and Social Science* (New York: Plenum Press, 1983), pp. 207-232.

[15] *Vitek* v. *Jones*, 445 U.S. 480 (1980).

[16] M. Abramson, "The Criminalization of Mentally Disordered Behavior: Possible Side Effect of a New Mental Health Law," *Hospital and Community Psychiatry*, 23, 1972, pp. 101-105.

[17] Henry Steadman, John Monahan, Barbara Duffee, Elliot Hartstone, and Pamela Clark Robbins, "The Impact of State Hospital Deinstitutionalization on United States Prison Populations, 1968-1978," *Journal of Criminal Law and Criminology*, 75, 1984, pp. 474-490.

[18] See generally, Fred Cohen, *The Law of Deprivation of Liberty: A Study in Social Control* (St. Paul, Minnesota: West Publishing Co., 1980.)

prison administrators to furnish health care services, including those related to mental health. In view of the often harmful and irreversible consequences of inadequate medical care, courts have found justification for a constitutional right to adequate health services within the eighth amendment prohibition against cruel and unusual punishment.

Although court decisions establishing the right of inmates to adequate health care have existed for quite some time, only recently has this right been extended to mental health services. In 1972, a Federal district court in *Newman* v. *Alabama* ruled that the medical services throughout the entire Alabama penal system were so deficient that they violated the constitutional prohibition against cruel and unusual punishment.[19] Although the issues before the court concerned medical care in general, the court gave specific emphasis in its decision to the lack of mental health services. Several years after the *Newman* decision, a constitutional standard for judging the adequancy of inmate health care was established by the Supreme Court in *Estelle* v. *Gamble*.[20] The standard enunciated was "deliberate indifference to an inmate's serious medical needs." Subsequently, in light of the "deliberate indifference" standard established in *Estelle,* a Federal district court directly addressed the issue of an inmate's constitutional right to mental health care in *Bowring* v. *Goodwin*.[21] In *Bowring* the court found that there was no basis for distinguishing between medical care for physical and mental ills and ruled that the same constitutional standard should be applied to both.

"Right to treatment" lawsuits have had a dramatic effect on the level of service delivery in civil hospitals,[22] and in a few instances similar lawsuits have been successfully litigated for prison settings.[23] Yet, some observers are pessimistic about the likelihood that the right to treatment doctrine will bring dramatic improvement in the range and quality of inmate mental health services. The constitutional right is limited since it applies only to the treatment of serious mental health problems, and it appears that any reasonable attempt to provide services to seriously disturbed inmates is enough to satisfy constitutional requirements. One legal scholar argues that mental health services warrant a constitutional standard different from other medical services because in the absence of verifiable physical symptoms some mentally disordered inmates are labeled as malingerers.[24] Courts can have a difficult time deciding whether inaction on the part of prison medical staff amounts to deliberate indifference if staff members claim that an inmate's request for services is primarily motivated by a desire to secure secondary gain (e.g., more favorable conditions of confinement).

More generally, courts will have to deal with the problem that among medical professionals there is less agreement as to the proper diagnosis and treatment of mental ills compared to that of physical ills. Although courts have no particular competence in scientific matters, right to treatment cases for inmate mental health care may put courts in a position of having to resolve legitimate differences in professional opinion. If the benefit of the doubt is consistently weighed in favor of prison mental health staff, only the most flagrant and abusive cases will be decided for the inmate. While this would mean that recourse to the judicial system would not be effective in most cases, judicial remedies in cases where there is flagrant violation of the law can involve extensive reform measures. This leaves open the possibility that a single judicial remedy can have a dramatic effect on the level of mental health services within a prison system. Correctional administrators have probably had enough experience with the courts to recognize that this possibility exists so that in some cases the threat of a lawsuit and of judicial scrutiny may be enough to bring about limited change.

Prison Mental Health Standards

A number of professional organizations have developed standards for mental health services in prisons. Among these organizations are the American Association of Correctional Psychologists,[25] the American Medical Association,[26] the President's Commission on Mental Health,[27] the American Correctional Association,[28] and the American Public Health Association.[29] Some standards are fairly general and deal with prison mental health services as part of an overall health care program. Other standards are exclusively concerned with the delivery of mental health services. Notable among this latter group are the standards set forth by the President's Commission on Mental Health and the American Medical Association.

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19 *Newman* v. *Alabama*, 349 F. Supp. (MD Ala 1972), aff'd 503 F. 2d 1320 (5th Cir. 1974), cert. den. 421 U.S. 958 (1975).

20 *Estelle* v. *Gamble*, 429 U.S. 97 (1976).

21 *Bowring* v. *Goodwin*, 551 F. 2d 44 (4th Cir. 1977).

22 Edward Kaufman, "The Right to Treatment Suit as an Agent of Change," *American Journal of Psychiatry*, 136, 1979, pp. 1428-1432; Alan Stone, "Overview: The Right to Treatment—Comments on the Law and Its Impact," *American Journal of Psychiatry*, 132, 1975, pp. 1125-1134.

23 Edward Kaufman, "The Violation of Psychiatric Standards of Care in Prisons," *American Journal of Psychiatry*, 137, 1980, pp. 566-570.

24 Eric Neisser, "Is There a Doctor in the Joint? The Search for Constitutional Standards for Prison Health Care," *Virginia Law Review*, 63, 1977, pp. 921-973.

25 American Association of Correctional Psychologists, "Standards for Psychological Services in Adult Correctional Institutions," *Criminal Justice and Behavior*, 7, 1980, pp. 81-125.

26 American Medical Association, *Standards for Health Services in Prisons* (Chicago: American Medical Association, 1977).

27 President's Commission on Mental Health, "Mental Health and Human Rights: Review of the Task Force on Legal and Ethical Issues," *Arizona Law Review*, 20, 1978, pp. 49-174.

28 American Correctional Association, *Manual of Standards for Adult Correctional Institutions* (Rockville, Maryland: American Correctional Association, 1979).

29 American Public Health Association, *Standards for Health Services in Correctional Institutions* (Washington, D.C.: American Public Health Association, 1976).

The President's Commission on Mental Health, Task Force on Legal and Ethical Issues, took the position that the availability of mental health services in prisons should be comparable to that in the general society. The commission recommended that mental health services be provided to any inmate who is or who is perceived to be mentally handicapped or mentally disabled. In order to achieve this goal, it was recommended that Federal health care reimbursements be extended to inmate mental health services. While the suggestions of the President's Commission may be difficult to realize, especially in view of the fact that Federal financing of inmate mental health services has not been forthcoming, this report demonstrates that concern over the level of mental health services available to inmates has reached the national level. Recognition of this sort may motivate solutions on the local level to at least some of the problems relating to inmate mental health care.

The American Medical Association created a special task force on psychiatric standards for correctional facilities. This task force developed a set of standards which addresses issues such as levels of staffing, qualifications of staff, and types of therapeutic services. These mental health standards were developed as part of an ongoing project aimed at improving the level of medical services in prisons and have been incorporated into a larger set of health care standards. A related accreditation process has been instituted and prisions seeking medical accreditation must meet the mental health standards among others. The standards issued by the American Medical Association are significant because they represent the involvement of a professional organization that has not traditionally been interested in prison issues. This organization has a great deal of prestige among professional communities, and its standards will be hard to ignore.

The establishment of mental health standards represents a significant development because these standards can be used by judges and other government officials as a criterion for identifying inadequacies in existing service delivery systems and as a guide for remedial action. The American Medical Association applied its standards to 30 pilot correctional facilities and found that none could be accredited.[30] Six months later the situation had not changed. In an evaluation of the level of psychiatric care in three state prisons, services were found to be inadequate when judged against several sets of standards.[31] As a result of this finding, lawsuits were initiated in these jurisdictions to improve the level of mental health care. Finally, a report by the U.S. Comptroller General strongly criticized the level of mental health care in prisons, emphasizing that very limited progress has been made toward meeting the adoption of professional standards.[32] The report called for an upgrading of mental health services in the Federal prison system as well as increased Federal assistance to states so that they could make tangible progress.

Administrative Concerns

Some scholars argue that therapeutic activities are an integral component of prison operations and that they should be maintained as part of a renewed emphasis on establishing humane institutional environments.[33] They take the position that many of the therapeutic activities of prisons intended to meet rehabilitative goals can be justified on humanitarian grounds.

As part of a change in justification for providing therapeutic services from rehabilitating offenders to maintaining humane institutional environments, the concerns of prison administrators take on new perspective. Whereas administrators previously were concerned with inmate adjustment problems in terms of how they relate to future adjustment problems in the community, the focus of concern can now shift to looking at inmate adjustment problems as they relate to an inmate's ability to cope with the experiences of incarceration. To the extent that prison administrators emphasize a short-term perspective of inmate adjustment problems, the perceived need for inmate mental health services could increase.

Prison administrators have some very practical reasons for trying to increase the level of inmate mental health services. One of these reasons is the current prison overcrowding situation. According to statistics collected by the Federal government the prison population of the United States is currently at an all-time high.[34] At midyear 1983, there were 394,380 inmates under the jurisdiction of state and Federal prison authorities. This represents a 7 percent increase in just 6 months and a dramatic 72 percent increase over the past 7½ years. As a result, nearly all state prison systems are overcrowded, and many prison systems are so severely overcrowded that they are under court order to reduce inmate populations.

Serious inmate overcrowding can increase prison stressors and raise tensions in the social environment. This is particularly true where program capacity has not been expanded so that many inmates are idle.[35] Under these conditions, some inmates with serious emotional problems will have greater difficulty adjusting to prison life, and there will be a greater need for mental health serv-

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[30] Rob Wilson, "Who Will Care for the 'Mad and Bad,' ", *Corrections Magazine*, 6, 1980, p. 17.

[31] Kaufman, supra note 22.

[32] U.S. Comptroller General, *Report to the Congress: Prison Mental Health Care Can Be Improved By Better Management and More Effective Federal Aid* (Washington, D.C.: U.S. Government Printing Office, 1979).

[33] Lucien Lombardo, "Mental Health Work in Jails and Prisons: Inmate Adjustment and Indigenous Correction Personnel," *Criminal Justice and Behavior*, 12, 1985, pp. 17-27.

[34] U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners at Midyear 1983* (Washington, D.C.: U.S. Government Printing Office, October 1983).

[35] Hans Toch, "Warehouses for People?" *The Annals of AAPSS*, 478, 1985, pp. 58-72.

ices to ameliorate their emotional problems. For inmates who do not have serious emotional problems, mental health services can provide an occasional amelioration from the stresses of prison life. They can at least give inmates an opportunity to express distressed or negative feelings in a cathartic manner.

Inmates who have continual emotional difficulty adjusting to prison can create serious custodial problems. Research suggests that inmates with a history of psychiatric disorder tend to have higher than average disciplinary infraction rates.[36] Another factor to be considered is the effect that emotionally disordered inmates can have on the institutional climate. It is likely that inmates view the mentally ill as dangerously unpredictable individuals. This would mean that as emotionally disordered inmates become increasingly visible in prisons, concerns about physical safety among inmates will increase. As safety concerns increase, inmate behaviors may become more defensive and populations more difficult to control. If mental health services help to reduce the disruptive behavior of inmates with serious emotional problems, the task of custodial staff would be made easier and tensions among the inmate population would be relieved.

Mental health services are but one of many prison program activities that serve latent custodial goals. Moreover, where legitimate requests for programs are not adequately met, the perceived nonresponsive attitude of prison administrators could help create an atmosphere of disaffection among the inmate population, which would make the job of prison staff more difficult. An analysis of the recent inmate uprising at Ossining prison in New York illustrates how this type of situation can evolve.[37]

Mental health administrators are likely to attempt to increase the level of prison services through whatever means possible. It it is possible to increase the level of prison therapeutic services by arguing that these services are necessary for maintaining a humane institutional environment, we can expect that this lead will be followed and that the demand for mental health services will become more insistent.

Conclusion

While enthusiasm for correctional rehabilitation services has waned, there have been a number of developments pushing for an expansion of prison mental health services. To be sure, the distinction between these two types of services is not always precise. The ambiguity results from etiological theories which view crime and mental illness as implicated in the same causal chains and from the functional interchangeability of treatment techniques. Given a broad enough definition of mental illness, it may be impossible to distinguish a prison service delivery system based on mental health goals from a system based on correctional rehabilitation goals.

It remains to be determined how the transition from correctional rehabilitation goals to mental health goals will affect the daily therapeutic activities of most prison systems. For some institutions the availability of therapeutic services may increase, for other institutions it may decrease, while for still other institutions it may remain the same. If legal concerns become the primary motivating factor behind an expansion of prison mental health services, the service delivery systems are likely to be more circumscribed than if other considerations predominate. In addition to changes in the availability of therapeutic services, there may also be changes in client populations and in preferred treatment techniques.

The decline of the rehabilitative ideal might have led some to envision scenarios in which the therapeutic activities of prisons are substantially curtailed or perhaps even eliminated. But the therapeutic perspective as a frame of reference for action has become firmly rooted in the correctional system. It is unlikely that therapeutic activities can be altogether eliminated, and it is just as unlikely that we will return to an era where there is consensus that rehabilitation is the primary goal of prisions. The question we face today is not whether prisons will provide therapeutic services, but what is to be the role of services that are provided. In many respects the latter is the more difficult question because it requires that we redefine the therapeutic activities of prisons in light of a somber reassessment of current etiological theories and of available treatment techniques.

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[36] Kenneth Adams, "Former Mental Patients in a Prison and Parole System: A Study of Socially Disruptive Behavior," *Criminal Justice and Behavior*, 10, 1983, pp. 358-384.

[37] Lawrence Kurlander, *Report to Mario M. Cuomo: The Disturbance at Ossining Correctional Facility*, January 8-11, 1983 (Albany, New York: Executive Chamber, 1983).