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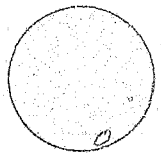

A Paradigm for the Delivery of Mental Health Services in Prisons

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Mental health programs in prisons have traditionally had two primary goals. The first has been to lessen unnecessary distress and suffering among inmates who may be either mentally ill or in some kind of crisis. The second goal has been to facilitate behavior change in inmates. The targeted behaviors may be short-term, such as decreasing the frequency of fighting, or long-term, such as learning to hold down a job or remain crime-free after leaving prison.

Critics have pointed out that mental health professionals have been largely unsuccessful in decreasing recidivism among treated inmates, (CITE) and that facilitation of short-term behavior change is an inapprorpriate use of mental health professionals given the custodial or punitive role of American prisons. Other critics claim that "corrections" programs and "mental health" programs should be mutually exclusive in that mentally ill persons should either be removed from prisons, or never allowed to get there in the first place.

In order to understand the administration of mental health programs in correctional settings, these criticisms must be addressed. First, in responding to the notion that mental health services have no place in prison, it must be noted that like people everywhere, inmates sometimes get sick. No one doubts the responsibility of the government which incarcerated them to attend to their necessary medical needs. Similarly, inmates sometimes are admitted with or develop mental disorders. The effects of these mental disorders are as disabling as medical problems and can result in an inability to take part in prison work or training programs or even death. The criticism that the mentally disabled should be diverted from prison in the first place is irrelevant in ~~so much as~~ our society has decided that, except in rare instances where people are held to

be "not guilty by reason of insanity", individuals are assumed to be responsible for their actions. More to the point, they are there. Estimates of inmates needing serious psychiatric or psychological care range from five to fifteen percent.

Regarding long-term behavior changes such as the reduction of recidivism, it is true that the mental health professionals have met with mixed success. Despite this, there has always been an American correctional commitment to allowing inmates the opportunity to "rehabilitate" themselves. Moreover, a significant number of inmates, at the lowest estimates one-third, do in fact manage to stay out of prison. It is reasonable to assume that many of these inmates have benefited from participation in activities such as vocational training, educational programs, religious programs, etc. For seriously mentally disabled inmates, however, most of these prisons programs become unavailable either due to the inmates' placement in special segregated housing (away from predatory inmates) or by the very nature of their mental disorder. To refuse these inmates treatment which could return them to the mainstream of prison programming is to deny them a good deal of the opportunity for change which exists in prisons.

Short-term behavior change has often been disparaged as a "security" activity. To this charge the correctional mental health community should reply "guilty". However, Security is a synonym for safety, and increasing the safety of an institution for staff and inmates is perhaps the most psychologically helpful activity imaginable. In fact, there are very few situations in which it is not to the mutual advantage of both the prison, its staff and the inmates to assist them in ceasing disruptive activities.

MISSION STATEMENT

The mission of Mental Health Services in prisons is to provide those programs and services which are designed to evaluate, prevent and treat inmate mental health problems and which contribute to safe, humane prison environments. The mission of mental health

services in the correctional setting includes, but may not be limited to:

1) Psychiatric and psychological evaluation and treatment of acute and chronic mental disorders to aid inmates in adjusting to and profiting from normal prison activities and programs.
2) Programs to facilitate short-term and long-term behavior changes in inmates in order to foster improved adaptation and functioning in the community on release.
3) Specialized services and/or programs that address the needs of special populations within the prison such as the mentally retarded, brain damaged, or substance abusing inmate.
4) Training which can foster growth in life-skills and personal development.
5) On-going assessment of the needs of the prison, its inmate population and staff, as well as individual inmates themselves.
6) Consultation and training to other prison personnel (especially line staff) to aid in accomplishing these goals.

The above services must be delivered with honor and integrity and with the utmost respect for the dignity and the rights of each inmate, and should at all times contribute to the safety of the institution, its staff and inmates. Finally, in view of the limited resources which are available for these populations, these services must be delivered in such a way as to make the maximum positive use of staff resources at all levels and in all areas of correctional work. Consultation, facilitation and staff training are essential in integrating mental health services into the fabric of correctional work. A more detailed description of the necessary elements of prison mental health services will be presented later in the paper.

SERVICE DELIVERY ISSUES

In setting up and delivering mental health programs and systems within correctional environments, several issues are pivotal and must be attended to. They are listed and discussed briefly below:

I. Who pays for services?

II. Who controls the units of service? Who "owns" the units of service?

These questions are discussed together for obvious reasons. Historically, both corrections departments as well as mental health departments have been less than successful in serving the mentally ill inmate. It is clear that Corrections must have access to ~~must pay for and thus be ultimately responsible for~~ the units of services, no matter who serves as the provider. When inmates have had to compete for DMH beds with non-correctional populations, corrections has "fed last at the trough." While this may have been a defensible position for mental health departments to take from their perspective, it has resulted in many states in inadequate services both for inmates and for prisons. By placing these services, whether delivered in-house, inter-agency or by contract, as line items budgeted specifically for services to inmates ~~in corrections budgets, departments of corrections can plan~~ services can be planned and utilized ~~them~~ in an efficient and effective manner. ~~This also directs responsibility for the total care of the inmate where it belongs - the Department of Corrections.~~

III. Who delivers services?

As long as services are delivered in a competent and professional manner, the actual providers can include Departments of Corrections, Department of Mental Health, local mental health agencies, private contractors, universities and medical schools, or any other competent service provider. There are advantages and disadvantages to any of the models or combinations. This decision should be based on local considerations and the

administrative structure of the state, rather than predetermined philosophical beliefs regarding who can do the best job.

IV. Where are services to be delivered?

Whenever possible, services should be delivered in the prison itself. Since mental disorder tends to be periodic and cyclical in nature, (cite) inmates often need services for brief periods and can then return to normal prison routine with outpatient or other follow-up services. (The negative effects of transfers have been well documented, (cite) and the delivery of services in the prison can greatly reduce these negative effects.) Inmates are then able to avoid having to adapt to different sets of rules, different environments and different expectations which can actually reinforce the inmate for being "sick". Further, by keeping the services and the inmates in the prison, it is possible to avoid much of the intra- and inter-agency squabbling over treatment responsibilities. Often the same clinician can manage a case through several different levels of treatment, thus providing good case management and continuity of care, two cornerstones of good clinical practice.

When there is evidence to indicate that a chroncially mentally ill inmate will need long-term, intensive psychiatric treatment and is unlikely to return to normal prison life in the foreseeable future, it may become necessary to transfer him or her to a longer term hospital setting. As noted in the preceeding section, these facilities can be operated in a number of different administrative structures, as long as the quality of care and the safety of the institution are adequate. However, sentenced correctional patients should ideally be separated from civilly committed patients or those found not guilty of crimes by reason of insanity. This

policy is based on both clinical, administrative, and risk management considerations.

V. Who evaluates and sets standards for services delivered?

Ideally, all corrrectional mental health services should seek and meet recognized national standards for accreditation, such as those promulgated by the American Association of Correctional Psychology, the American Correctional Association, the American Medical Association, etc. For correctional hospitals, it is desirable to seek acceditation by the Joint Commission on Accrediation of Hospitals. In addition to or as an alternative to these, this review process can be provided by the State's Department of Mental Health (DMH). In many states licensing and certification services are already provided by DMH to community and private providers. It is important, however, that this interagency activity be advisory in nature rather than regulatory, since it is not likely that a correctional hospital found to be out of compliance could be shut down. Licensure, then, may be an inappropriate activity, while Certification can be accomplished through a number of administrative arrangements which guarantee that the evaluations are not perfunctory or ignored by the Service provider.

VI. What other policy issues need to be considered?

These might include policies on release of information, patient confidentiality, and transfer to inpatient settings. No correctional mental health program should promote or attempt to maintain absolute confidentiality. Inmates, clients and patients should be honestly informed of the limits to their confidentiality. Transfers must be accorded appropriate due process in accordance with applicable Federal and State case law. (See especially Vitek v. Jones)

VII. Who receives services?

VIII. What services are to be offered?

Published professional standards that address prison mental health care typically label service components as either essential or non-essential. We disagree with these labels, as each system's needs and resources will result in different services taking on different levels of importance. Below are listed those programs, services, etc., that the authors have determined to fit under the mission statement given above. Within the discussions of each component, mention may be made of minimum criteria for effectiveness as determined by legislation or case law, by the authors' own expertise, and/or by survey responses collected by one of the authors over a five-year period.

One final observation is needed before listing the service components of a paradigm for prison mental health services. Although many elements listed below are similar to those of what is called the Community Mental Health Model, prison mental health care requires its own paradigm, one that takes into account the societal, historical, cultural, and organizational variables which are unique to prisons. While this paradigm includes and values a number of practical and philosophical features of the Community Mental Health Model, to ignore the unique and special environment of prison would result in the unsuccessful forced application of the Community Mental Health Model to an environment for which it was not originally designed.

The following are mental health service elements that appear to fit within the mission of correctional mental health services:

1. Screening/Assessment: The legislative mandates given to correctional

systems to provide care and custody of both pre-trial and post-trial persons have unique meaning when applied to mental health evaluation. Some systems are legally required to also provide rehabilitative services, which adds a third variable to policy and procedural decisions about mental health screening. The "care" requirement includes the early identification of inmates who require special mental health care or housing and those who may be potentially harmful to themselves. Also included here is a requirement that many systems overlook: Periodic evaluations are required for those inmates who are housed in environments that are typically associated with mental deterioration of those so predisposed. For example, inmates in disciplinary or administrative segregation/detention should be evaluated periodically for signs of mental disorder that may require care.

Custody requirements vary by system, but the most basic requirement of early screening is to identify those inmates who may be a danger to themselves or others or who may be a potential victim if given the wrong classification assignment. Escape potential must be cautiously considered, since an attempted or unsuccessful escape has historically resulted in some sort of harm to the inmate, staff or citizens. These issues are often distasteful to the clinician who sees them as a police role. However, the prevention of physical harm is as important as the prevention of mental deterioration.

The third element is rehabilitation. This places unique requirements

on the initial evaluation process in that every inmate must also be evaluated for rehabilitation needs as defined by the system's philosophy and existing programs. As with mental health care delivery in general, the basic problem is clearly identifying the nature of the system and its resultant needs. In our experience, mental health screening/evaluation systems tend to cycle between the unfortunate extremes of "overkill" on one hand and virtual neglect on the other. If the system is substantially lacking in quality, a changeover in administration or a court mandate typically results in the precipitant creation of a system that too thoroughly evaluates every aspect of the inmate's psyche. After a while, this "overkill" system is recognized by someone as wastefully expensive and providing no useful product. The evaluation process is then stripped to bare bones, again resulting in an inadequate system. In summary, the system's needs for mental health and evaluation and screening must be specified so that objectives and resultant procedures can be planned, written and implemented.

2. Treatment Services/Programs for seriously disordered offenders:

   a. Severely disordered inmates require services that narrowly focused systems typically define as the only necessary mental health care. Certainly, if the mental health care delivery system is not adequate for the seriously mentally disordered inmate, it cannot be called adequate. These services must include an in-depth evaluation with an individualized treatment plan carried out and reviewed by qualified mental health professionals. Treatment must include more than segregation and supervision. The prescription and administration of

behavior-altering medication must be under appropriate supervision and with periodic review. The medication cannot be given in dangerous amounts or by dangerous methods. Accurate, complete records must be kept appropriately confidential.

In addition to providing services and programs, difficult procedural issues including psychiatric transfer, commitment to outside hospitals, informed consent and involuntary treatment must be addressed. A growing body of case law has helped to define some of the criteria for necessary policy and procedure, but most must be based on the current state of professional practice.

Two areas that are commonly overlooked when considering services for the seriously mentally disordered are (1) formalized training for non-mental health staff in the recognition and management of mentally disordered offenders and (2) formal, documented evaluation of those inmates housed in situations typically associated with mental deterioration, especially the various types of segregation or isolation. The care and treatment of potentially suicidal inmates require special written procedures and policy. All staff need to be trained in these procedures and in their particular responsibilities. The policy and procedures should address screening, referral, evaluation, management/treatment, documentation, and authority.

b. In addition to the more common groups of seriously mentally disordered inmates, more and more states (and some courts) are mandating treatment for sex offenders, substance abusers

(especially DWI or DUI), geriatric inmates and brain-damaged inmates. These are areas too long ignored as serious mental health needs. Unfortunately, too many of the programs that do exist for these special needs inmates are ineffective or just "paper programs." As society demands more results, more literature and program standards will have to be produced for these services to be effective.

c. Special mention needs to be made about programs for the mentally retarded. These programs require a special sensitivity to the balance between strengths and limitations. Some mentally retarded inmates are easy prey and require insulation from the prison population. Others are quickly able to adapt, defend themselves and their property, maintain desirable prison jobs, and take part in the range of prison programs and services. Assessment of these inmates should include a thorough look at the skills necessary to live in prison by a person trained and experienced in both corrections and work with the mentally retarded.

3. Adjustment to Incarceration: For pragmatic as well as obvious humanitarian reasons, prison mental health care should include those services that can help the inmate adjust to incarceration. Crisis intervention is often reported in surveys and time studies as consuming the largest portion of a mental health professional's time. This is obviously a crucial component of mental health care, but more importantly, one that can be shared by all correctional staff.

Other programs which may be considered preventive mental health care include: mental health education; initial orientation to surviving the prison environment; stress management training; marriage/family programs; recreational activities; and special programs for protective custody inmates, repetitively violent inmates, and self-mutilating inmates.

4. Personal Development Programs for Inmates: Various programs have been developed that focus on helping the inmate to acquire new interpersonal skills that will facilitate success both in and out of prison. These programs typically consist of an initial didactic period wherein the inmate learns the theory and basics of the program and a later advanced phase where the new skills can be refined and practiced. Examples of programs which have been used are: life skills training; anger management; stress management; interpersonal communication skills; rational behavior training; criminal personality training; transactional analysis; self-image seminars; EST training; conflict resoluation; etc.

5. Services/Programs for Staff: To completely fulfill the mission of prison mental health services as presented above, various services should be made available to staff (1) to assist them in safe, humane, and smooth management of the prison, and (2) to make them knowledgeable of mental health care so that treatment programs can be more effective. A caveat must be given here: the roles of the prison mental health professional as evaluator of and/or therapist to the staff must be defined carefully, since the more indepth and confidential this role becomes, the more the mental health professional will be excluded by other correctional staff as not being a

member of their team. One would do well to keep staff counseling services on a short-term referral basis that utilizes outside resources as much as possible. With the above caveat in mind, mental health services to staff should include but not be limited to the following: personnel selection; employee assistance programs (counseling); mental health education and training; personal development programs, especially stress management and occupational development programs; positive oriented management development programs; and general management consultation and training.