Analysis and Commentary

An Introduction to Correctional Psychiatry: Part II

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This article, which is the second of three parts, provides an overview of relevant guidelines/standards for providing mental health services within a correctional setting and describes essential characteristics of mental health systems designed to meet constitutional standards. Part II focuses on organizational issues within correctional mental health systems, staffing issues, and psychiatric screening/evaluation processes.

Part II of this article, presented here, will summarize basic principles of correctional mental health systems pertinent to mission and goal statements, administrative structure, staffing, and psychiatric screening/evaluations of newly admitted inmates to correctional systems. These principles will be based on recommendations by the National Commission on Correctional Health Care (NCCHC)[1, 2]; by a task force of the American Psychiatric Association (APA) that developed guidelines concerning psychiatric services in jails and prisons[3]; and by the American Public Health Association (APHA).[4]

Mission and Goals

A mission and goals statement should be developed that clearly describes the correctional mental health services. This statement will reflect the underlying philosophy and purpose of the mental health services, which will have clear differences from the correctional services. The mission and goals statement of correctional services will generally include the areas of security, classification, and inmate management functions. Prisons usually will have some form of correctional services pertinent to rehabilitation and the parole board. The mental health services' mission and goals statement will usually emphasize the importance of identifying and treating inmates with serious mental illness, although a variety of other treatment services are generally available (e.g., crisis intervention, substance abuse treatment, sex offender treatment) depending on the type of correctional setting.

The mission and goals statement will help clinicians identify potential role conflicts. For example, clinicians should generally not be involved in providing both mental health services and correctional

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services to the same inmate. The role of a clinician can become very blurred if the clinician provides both treatment and a parole board evaluation for the same inmate. Similar problems may exist when mental health clinicians administer psychological testing on a routine basis to inmates in a diagnostic reception unit for purposes of correctional classification in contrast to the use of psychological testing as part of a mental health screening process. Problems may occur concerning the establishment of therapeutic alliance with an inmate unless the purpose of such testing and issues pertinent to confidentiality are clearly explained to the inmate prior to administration of the test.

Potential role conflicts are addressed by the various national standards and guidelines. The APHA standards[4] require that mental health professionals who participate in administrative decision-making processes such as parole decisions should not provide direct therapeutic services to those inmates, to decrease role conflicts for clinicians. The NCCHC standards[1, 2] recommend that correctional health care personnel be prohibited by written policy and procedures from participating in the collection of forensic information because their position as neutral, caring, health care professionals is compromised when they are asked to collect information that may be used against inmates. For similar reasons, participation in executions by health care professionals causes a serious ethical dilemma and undermines the professionals' credibility with their patients.[5, 6] The NCCHC[1] recommends that the services of outside providers be obtained when state laws and regulations require that such acts as mentioned above be performed by health care professionals.

The fundamental policy goal described by the APA guidelines[3] is to provide the same level of mental health services to patients in the criminal justice process that are available in an average community. The priority of providing care to the most severely impaired patients and those with the most severely dangerous and disruptive symptomatologies is emphasized by the APA guidelines.[3] Flexibility is also provided concerning the purpose of mental health treatment depending on the nature of the correctional setting. For example, treatment within a prison setting is often designed to enable inmates to make use of rehabilitative opportunities offered within the prison's general population. The APA guidelines[3] also recognize consultation with other health care providers as well as with correctional administration and staff to be an important program goal.

Cohen and Dvoskin[7] describe the following three reasons for providing mental health treatment within a correctional setting: (1) to reduce the disabling effects of serious mental illness to maximize each inmate's ability to electively participate in correctional programs; (2) to decrease the needless extremes of human suffering caused by mental illness; and (3) to help keep the prison safe for staff, inmates, volunteers, and visitors.

Administrative Structure

The administrative structure of correctional mental health services is a complex issue due to the diversity of correctional

Table 1
Administrative Structure[a]

1. A designated health authority on site is responsible for health care services pursuant to a written agreement, contract, or job description.
2. Responsibilities include arranging for all levels of health care and providing quality, accessible health services to all inmates.
3. The health authority may be a health administrator, government agency (e.g., health department or community mental health center), or for-profit health corporation.
4. When the health authority is other than a physician, medical judgment rests with the designated licensed responsible physician.

[a] See References 1 and 2.

settings and variety of organizational structures. The NCCHC[1, 2] provides important standards regarding this issue, as summarized in Table 1. The number of hours per week that the designated health authority is on site will depend on the nature of the correctional setting (e.g., small jail versus large prison, the inmate population, etc.). The designated health authority is required to be on-site at least once a week even in a small jail setting.[2]

A proper balance between security and treatment needs is emphasized by the APA task force report[3] with the aim of establishing an effective delivery system for mental health services in correctional settings. The director of mental health services or designee should have direct access to the facility's chief administrator (e.g., warden, sheriff) concerning all administrative decisions affecting mental health care issues.[2] Discussions pertinent to mental health care services should be documented at least quarterly at administrative meetings between the health care authority, chief facility administrator, and other pertinent members of the health care and correctional staffs. Mental health staff meetings should be held at least monthly to review administrative procedural issues and relevant health care services statistics.[1]

There should be clear lines of staff organization concerning authority, responsibility, and accountability.[4] These standards emphasize that staff health care decisions concerning treatment offered to inmates are the sole responsibility of the health care personnel and should not be compromised for security reasons.

The administrative structures of correctional health care systems range from the traditional decentralized model to a totally centralized system with variations between these models. An example of such a variation is a system with a full-time person at the central office who is responsible for various aspects of services statewide but does not have line supervision of any of the health care professionals who report administratively to the facility administrator. The major problem with such an administrative structure is its dependence on the cooperation of wardens for the health care services program.

Correctional health care systems also demonstrate variations concerning the integration of mental health care within the medical care system. These variations include hiring and integrating the psychiatrist(s) within the general medical care services, but having a separate department of psychology outside the administrative structure of the health care services system that provides all other

mental health services. However, there is a trend toward increasing coordination and/or integration of the mental health services with the correctional medical care delivery system. This trend appears to be driven by litigation (which focuses on inadequate medical care services, including psychiatric care) and increasing correctional health costs.[8,9] Correctional systems also use different models to provide inpatient psychiatric treatment for inmates.[10]

Anno[11] described the cost-effectiveness of having a health care system organized under a central health care authority, which protects the clinical autonomy of health providers, improves continuity of care, and facilitates a quality improvement system. The specific model that is used will be determined by a variety of factors including the size and location of the correctional system and the working relationship between the state or county correctional system and the State Department of Mental Health or equivalent agency.

Staffing

The effectiveness and adequacy of the correctional mental health system is closely related to staffing issues. Guidelines/standards developed by the NCCHC,[1,2] APA,[3] and APHA[4] emphasize the importance of having sufficient numbers of qualified mental health personnel available to provide access to inmates for evaluation and treatment consistent with contemporary standards of care. Community standards as defined by licensure and certification and/or registration requirements should be used to establish the training and competence required of the mental health staff.

Guidelines concerning staffing and core services for mental health services in jails within the state of New York were jointly developed by the New York State (NYS) Office of Mental Health, NYS Conference of Local Mental Hygiene Directors, and NYS Commission of Correction.[12] These guidelines are pertinent to the identification and treatment of pretrial detainees with severe and persistent mental illness and/or those inmates requiring crisis services. They did not address staffing requirements for court-ordered evaluations or for inmates in need of substance abuse or diversion services. The generally recommended number of staff expected in a jail setting was summarized by the following two formulas: (1) 2.1 full-time equivalent (FTE) staff per 10,000 annual jail admissions for mental health assessment or crisis intervention services at admission; and (2) 7.6 FTE staff per 1,000 average daily jail census for ongoing mental health treatment and support services following admission.

It should be noted that the staffing guidelines will certainly vary based on local differences and needs. For example, larger jails that need residential treatment units for mentally ill inmates will require additional staffing (e.g., a 12- to 24-bed unit generally requires an additional 7.5 FTE mental health staff positions). Due to the significant differences among correctional institutions, the various national guidelines and standards emphasize the access concept in the context of staffing requirements.

A blue ribbon consultation panel[13] con-

vened in Massachusetts in 1997 recommended a ratio of about one psychiatrist to 100 to 120 inmates/patients in a prison setting to provide adequate attention to diagnostic, medication, and crisis situations requiring a psychiatrist's special expertise. This recommendation was made in the context of mental health services being provided by adequate numbers of other mental health professionals.

Continuing education and training for the staff are necessary to encourage professional growth and to decrease burnout. Hiring part-time consultants can minimize the negative aspects of institutionalization (e.g., rigid thinking and decreased job satisfaction) that often impact full-time staff. The national guidelines/standards are clear in prohibiting the use of inmates as mental health personnel either in clerical roles or as providers of patient care.[1, 2] This means that inmates should not be used to schedule clinic appointments, triage health care complaints, work as file clerks, or function in other similar positions.

A community mental health center model, which uses a multidisciplinary approach, has been used in many systems to provide cost-effective treatment to inmates.[3, 7, 14] This model refers to mental health services that occur outside a hospital and focus not only on the individual patient but also on system issues. Thus, attempts are made to examine factors in the environment that impinge on the individual and to work with other individuals and populations who are particularly vulnerable or "at risk." There is also an emphasis on prevention and on the promotion of mental health.[15]

The adoption of a psychiatric liaison model, which includes regular meetings between mental health staff and correctional officers (especially in administrative and/or disciplinary segregation units), is very useful for case findings, primary prevention, and assessment of treatment progress. A psychiatric liaison model, which generally refers to the area of clinical psychiatry that includes all diagnostic, therapeutic, teaching, and research activities of mental health clinicians in the nonpsychiatric parts of a general hospital, can be modified and adapted to the correctional setting.

Training for the correctional officers, which includes basic concepts concerning mental illness, suicide prevention, and identification of mentally ill inmates, is an essential element of an adequate mental health system. The establishment of a cooperative relationship between correctional and mental health staff will result in the correctional staff becoming more willing to receive input concerning general environmental conditions. Consulting with correctional staff regarding "difficult" inmates who are not mentally ill will foster such a cooperative relationship. The training relevant to mental health issues for correctional staff should be more detailed and intensive for security staff who regularly interact with inmates who have serious mental illnesses (e.g., correctional staff working in a residential treatment unit).

Identification of Inmates with Mental Illness

Three separate processes designed to identify inmates requiring psychiatric treatment are described by the APA.[3]

Receiving Mental Health Screening Receiving mental health screening is a system of observation and structured questions designed to assure that the newly arriving prisoner at the correctional facility who may require mental health evaluation is identified, appropriately referred, and placed in the proper living environment. This initial screening process should take place immediately following admission to the correctional facility and is usually performed by trained correctional staff or qualified health care personnel.

A receiving mental health screening form should be used that documents review of pertinent records accompanying the inmate and answers to structured questions designed to identify inmates with significant psychiatric disturbances (e.g., disorganized thinking, bizarre behavior, hallucinations, suicidal and/or homicidal thinking). An immediate referral for a comprehensive mental health evaluation to be performed by an appropriately trained clinician is submitted when positive findings are obtained.

Intake Mental Health Screening This second screening process, which is also designed to identify inmates with mental illness, is performed by appropriate health care staff as part of the comprehensive medical evaluation provided to every inmate upon entering a correctional system. Components of this screening include obtaining a history of past psychiatric treatment, substance abuse, and psychotropic medication use, as well as performing a mental status examination. The screening is often performed by a nonpsychiatric physician, nurse practitioner, or physician assistant as part of the admitting physical examination of the inmate for purposes of cost-effectiveness. The timing for this screening is usually 7 to 14 days following the arrival of the inmate in the correctional institution, although it varies depending on the type of correctional facility.

Mental Health Evaluation The third identification procedure is the administration of a mental health evaluation provided by appropriately trained mental health clinicians and generally in response to referrals from a screening examination or from other staff, or to a self-referral. These assessments are comprehensive evaluations that follow the format of a standard mental health examination.

Other Screening/Evaluation Models NCCHC standards[1,2] also require a receiving screening, which is performed by qualified health care personnel on all inmates immediately upon their arrival at the prison or jail. A postadmission mental health evaluation of all inmates by qualified mental health care personnel within 14 days of admission to a correctional facility is also required by NCCHC standards.[1,2] The elements of the postadmission mental health evaluation are summarized in Table 2.

NCCHC standards[1,2] define qualified mental health personnel to include physicians, psychiatrists, dentists, psychologists, nurses, physician assistants, psychiatric social workers, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

Table 2
Postadmission Mental Health Evaluations[a]

1. A structured interview is conducted by a mental health worker in which inquiries into the following items are made:
   a. history of psychiatric hospitalization and outpatient treatment;
   b. current psychotropic medications;
   c. suicidal ideation and history of suicidal behavior;
   d. drug usage;
   e. alcohol usage;
   f. history of sex offenses;
   g. history of violence initiated as a result of interpersonal altercation where the goal is to injure the other person;
   h. history of victimization due to criminal violence;
   i. special education placement;
   j. history of cerebral trauma or seizures; and
   k. emotional response to incarceration.
2. Intelligence is tested to screen for mental retardation. The standards specifically recommend the use of group tests of intelligence or brief intelligence screening instruments that should be followed, when appropriate, by a comprehensive, individually administered instrument such as the Wechsler Adult Intelligence Scale-Revised.

[a] See References 1 and 2.

A distinction should be made concerning psychological evaluations that are used in correctional facilities predominantly for classification purposes in contrast to such assessments used for mental health screening and diagnostic purposes. Historically, psychological evaluations were often performed by psychologists, working at a reception and diagnostic center, for classification purposes as part of an inmate's entry into the correctional system. However, such assessments, which may include psychological testing, have become a required component for mental health systems to adequately identify and appropriately refer inmates for mental health treatment.[16]

NCCHC standards[1,2] recommend that any inmate who is segregated from the general population (whether for disciplinary, administrative, or protective reasons) be seen by qualified health personnel a minimum of three times per week to determine the individual's health status. The intent of these standards is to ensure that inmates who are placed in a segregated status should have direct access to health care personnel. This standard is generally met by an established sick call process through the medical department and generally directly involves either the nursing staff or physician assistants.

NCCHC standards[1] additionally recommends that inmates who had been receiving mental health treatment and who are placed in segregation should be evaluated by mental health personnel within 24 hours of being placed in segregation. This latter recommendation reflects the experience of many clinicians that the environment within many segregation units can negatively impact inmates who have serious mental illnesses. It is partially for this reason that many prisons require periodic mental health evaluations of all inmates placed in segregated housing. It is recommended that a mental health clinician make "rounds" once a week in all segregated housing units for purposes of case findings and, when appropriate, supportive interventions. These rounds should include cell-front contact with all inmates and consultation with the correctional staff.

Discussion

There are many models used in correctional systems for mental health screening and evaluation purposes. The differences among these models involve whether all inmates receive mental health screening and/or evaluation as part of the admission process, the routine use of psychological testing as part of the assessment process, the credentials and/or training of the staff who provide mental health screening and/or evaluations, the presence or absence of confidentiality regarding the screening/evaluation results, and whether the assessment results are used for health care and/or correctional classification purposes.[16]

Virtually all departments of corrections (DOCs) provide reception mental health screening or prompt intake mental health screening to all newly admitted inmates. Most of these DOCs use health care professionals (not necessarily mental health staff) to provide reception mental health screening. Forty-two DOCs provide some combination of intake mental health screening and/or mental health evaluations for all newly admitted inmates. Twenty-six percent of DOCs have exceeded the recommendations of the APA task force by providing all three types of screening/evaluations for all newly admitted inmates in the prison system. The routine administration of standard psychological tests to all newly admitted inmates appears to be a common practice within DOCs.[16]

The recommendations by the APA task force guidelines[3] provide a practical and cost-effective mechanism for mental health screening and evaluation processes. These guidelines require that all inmates receive the two types of mental health screening processes, but only inmates with positive screens need undergo a comprehensive mental health evaluation. The routine use of psychological testing for screening purposes is a poor use of limited resources, although for many clinical reasons standard psychological tests can be very helpful in selected cases.

Part III of this article will review the nature of treatment programs offered to inmates in correctional facilities with a focus on providing mental health services for inmates with serious mental illnesses.

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