Commentary: Evolving Toward Equivalency in Correctional Mental Health Care—A View From the Maximum Security Trenches

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Developing and implementing community standards of care in correctional mental health and psychiatric practice will facilitate progress toward attaining equivalency in care in prisons and jails. Specialized therapeutic procedures such as application of restraints and seclusion when properly implemented are valuable tools in the treatment of the chronically mentally ill in prisons. The authors share some useful points for working in maximum-security prisons.

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The publication of the APA Resource Document, "The Use of Restraint and Seclusion in Correctional Mental Health Care,"[1] demonstrates the ongoing commitment of organized psychiatry to the delivery of quality care to all patients, regardless of legal status. As the correctional system in the United States becomes more densely populated with the seriously and persistently mentally ill, the distinctions between mental health care delivery in traditional and correctional settings are becoming less precise. This is a welcome development, as it signifies progress toward achieving a standard of equivalence[2,3] wherein the quality of services delivered should not differ between correctional and noncorrectional settings.

The Resource Document, while endorsing the implementation of national standards consistent with the current community practice, highlights the unique features of the correctional institution where potential for abusive use of restraint and seclusion is inherent due to the possible philosophical conflict between the correctional and mental health systems. Few specialized treatment procedures in correctional mental health care require such well-designed policies, procedures, and staff training as does the therapeutic use of restraint and seclusion. Metzner[4] specifically identifies the dangers of improperly implemented procedures and the need for allocation of additional resources, which are limited in most prisons and jails.

Psychiatric and mental health care practices in jails and prisons usually consist of proper diagnosis, regular medication management, group and individual therapy, and crisis intervention and other supportive therapies. Specialized interventions such as forced medication administration and therapeutic restraints and seclusion, when appropriate for use with agitated, assaultive, and or self-destructive psychotic and depressed offenders, are extremely useful in prisons, especially in maximum-security prisons. As practitioners in a large correctional system in the Midwest, we have come to appreciate the proper use of involuntary medication administration consistent with the decision in *Washington v. Harper*[5] in managing gravely disabled, medication-noncompliant, seriously and persistently mentally ill offenders. Through vigilant monitoring of noncompliant patients and timely implementation of our involuntary medication policy, we have substantially reduced the number of restraint episodes to the point that they can be accurately considered a rare event in our system. We encourage our correctional colleagues to

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advocate for sound and workable involuntary medication policies and to become comfortable with their implementation. In our view, the most severely mentally ill correctional patients cannot be managed successfully without taking this crucial step.

One of the authors (D.L.V.) practices in a maximum-security prison, where he occasionally, using an appropriate amount of jocularity, reminds prison administrators that, whether or not they realize it, they are slowly becoming administrators of psychiatric hospitals. While our administrator colleagues find these comments humorous, they also acknowledge the essential truth of this evolving reality. We are fortunate to have had the privilege of working with enlightened and compassionate administrators who see the need for a team approach when managing the severely mentally ill in a correctional facility. In this spirit of teamwork and commitment lies the potential for a very positive future for correctional mental health care.

As we continue our journey toward equivalency, it is important that correctional psychiatrists remain mindful of their role, and even more important, their social status in the overall correctional system. Most of us are used to working in (noncorrectional) settings where we enjoy considerable respect and the authority to make decisions regarding workplace rules and patient management. In correctional institutions, however, security is primary, and psychiatrists are not necessarily given either respect or authority based solely on their professional credentials. Mental health services are typically valued by nonclinicians only to the extent that they contribute to overall security. For example, a psychiatrist who finds and effectively treats a violent inmate with a previously unappreciated psychiatric illness creates an immediate positive impact on security. Such a psychiatrist also earns considerable credibility in the eyes of nonclinical correctional personnel. With this credibility, which again must be earned, the psychiatrist gains the ability to foster an effective team approach toward management of mentally ill inmates.

It is interesting to consider that an equivalent quality of outcome may not necessarily be achieved by identical models of service delivery. Traditionally, the most seriously mentally ill patients are placed in psychiatric inpatient units for intensive treatment. This seemingly straightforward notion is not so easily achieved in some correctional facilities. Until one works in a correctional facility, he or she will not be likely to contemplate the notion that there are some individuals who are purportedly too sick to go to the hospital. What does this mean? Through difficult experience, we have learned that, on occasion, sending one extremely dangerous and disruptive individual to a psychiatric unit can disrupt the care and well-being of 5, 10, or even more fellow patients. A previously unconsidered but nevertheless logical proposition emerges. In a world with limited resources, the worst of the worst may have to be managed in the prison, at least temporarily, to allow quality care for a greater number of patients in the inpatient unit. Can treatment within the prison even be accomplished? Can it be done humanely? Isn't there something unethical about it? These are all good questions, for which we do not have easy answers.

While contemplating this newfound and cold logic of correctional reality, we are reminded of a quote by, of all characters, Mr. Spock from *Star Trek*. At the end of *Star Trek II*: *The Wrath of Khan*, after knowingly exposing himself to fatal radiation to repair the Enterprise and save the lives of the crew, Mr. Spock was asked why he made such a sacrifice. He answered: "Logic clearly dictates that the needs of the many outweigh the needs of the few." Meaningful words, even if they come from a fictional character.

The problem, though, is that severely disruptive patients at our facilities aren't given an opportunity to make an altruistic sacrifice like Mr. Spock. It is simply decided by others that more people could be served if the inmate were not sent to the hospital. We submit that such decisions are quietly made every day in our correctional systems, and further, that if we make such decisions, we have an obligation to create an equivalent successful clinical outcome for that patient who doesn't go to the hospital.

This unpleasant reality drives home the need for standards of care that will be delivered outside a hospital. The Joint Reference Committee's resource document is a timely contribution indeed. It also makes clear the need for psychiatrist leadership to create a team approach that allows successful outcomes in very ill patients who do not go to the hospital.

The team approach, by which we mean the active participation of clinical staff, correctional officers, and administrators, has some benefits that may not seem apparent at first glance. When correctional facilities achieve successful clinical outcomes, espe-

cially in cases that were previously referred to another facility, the overall confidence level of the treating facility grows. Eventually, front-line correctional staff begin to enjoy the role of being the eyes and ears of the treatment team, and realize the crucial part they play in the overall process. Administrators become more accepting and appreciative of mental health input and are more willing to consider the creative interventions that are sometimes needed to achieve a good clinical outcome. Take a step back from this process, and you will see a startling and wonderful phenomenon: correctional workers are starting to think like hospital staff. Isn't this what we wanted to achieve in the first place? Isn't this equivalence?

References

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